Annual Report 2019 - 2020

NHS
The Princess Alexandra Hospital
NHS Trust

Your future • Our hospital

respectful • caring • responsible • committed

Contents

The performance report 2019-20

Overview

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

Foreword from the chair and the chief executive officer

As we reflect on the last year at The Princess Alexandra Hospital NHS Trust (PAHT); all that our people have achieved and the high quality care they have provided every day to our patients, we are facing the most unprecedented demand on us all as we respond to the impact of the coronavirus (Covid -19) pandemic.

Much will be recorded about the challenges that we have faced and that we can expect to continue to face for many months to come in 2020 - 21. For PAHT, we would like to put on record our thanks to our amazing people who have put in place a huge range of changes to how we provide care, to how we utilise our clinical spaces and also to how we ensure that our people have the resources and equipment they need. It is their professionalism and commitment to high quality care that has continued to make a difference to the people they care for and the people they work alongside. We are proud to know that in the most critical of situations that PAHT people have shown great resilience and compassion.

After many years of developing our case for our patients and our people, in September 2019 we learnt the fantastic news of a commitment from Government to fund a new hospital for the communities we serve. Behind the scenes, there is a lot of work being undertaken in developing the essential business cases to take this amazing change forward. A new hospital gives us a real opportunity to create a fit for purpose, modern setting that provides an environment for the 21st century that is designed to maximise both the efficiency of how care is delivered and is also a great place to work and receive care. We look forward to continuing to work together with our people and our local communities to create the best hospital and services for our patients and our people.

A new hospital that maximises the use of technology and new ways of delivering care in a purpose built setting aligns with PAHT 2030, our ten year plan for developing and transforming the way we deliver care. PAHT 2030 will make a real difference to our patients and to everyone at PAHT as we continue our focus on our journey to being an outstanding organisation.

Our PAHT 2030 plan also aligns with the NHS Long Term Plan that aims to bring the NHS and social care colleagues more closely together to meet the needs of patients now and into the future. Meeting these needs is central to our ongoing quality improvement work and in January (2020) we were pleased that PAHT was recognised

for our commitment to improvement when we became the second hospital in the country to be formally accredited by the Academy of Fabulous NHS Stuff.

Another important step towards preparing for the future and achieving the objectives detailed in both the PAHT 2030 plan and the NHS long term plan is enhancing integrated working across health and social care. In light of this we are pleased that PAHT 2030 is taking a leading role in the One Health and Car partnership that was established in June 2019. The partnership will give people greater control over their own health and care, basing services on the health needs of the local population and working together, create an outstanding health and social care system for local people.

In July 2019, we saw a positive improvement in the ratings awarded to us by the Care Quality Commission (CQC) following their inspection of our core services in March and April (2019). Although our overall rating remains unchanged we are much closer to achieving a Good rating and our focus on continuing to improve remains clear and strong.

We are pleased that these improvements were also reflected in the results of our annual NHS staff survey, which showed that our people rate the quality of care provided to their patients as being above average compared with hospitals across the country.

Responses from our clinicians, corporate and support staff from teams based at The Princess Alexandra Hospital in Harlow, St Margaret's Hospital in Epping and Herts and Essex Hospital in Bishop's Stortford also showed an improvement in our people being happy both with the quality of care they give to patients and being able to provide the care they aspire to.

A huge success this year has been a dedicated nurse recruitment campaign that included increasing our recruitment of nurses from overseas. The campaign began in the summer (2019) when the vacancy rate for registered nurses was 24%. A high vacancy rate has been a longstanding challenge for PAHT and impacts on both our patients and our people, as nurses on our wards will have less time to spend with each patient.

We are delighted that a significant improvement in the registered nurse vacancy rate has been achieved and at the end of 2019-20 we now have a rate of 8% with a Band 5 vacancy rate of 4.3%. It seems fitting, as 2020 is the Year of the Nurse and Midwife, that we have been fortunate to welcome many new nurses to PAHT and further strengthen our nursing workforce.

We hope that you will find this annual report interesting and informative and we thank the individuals and teams who have put this report together during a period of unprecedented challenge and intense pressure on their time.

All that PAHT has achieved in 2019 – 20 has only been made possible by the hard work, commitment and passion to deliver high quality care to our patients by everyone at PAHT – we thank them all. They are amazing.

Steve Clarke
Chair

Lance McCarthy
Chief executive officer

Celebrating our amazing staff: Staff awards 2019-20

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: • Colposcopy • Hysteroscopy • Termination of Pregnancy Services	Surgical assessment unit
Audiology	Dietetics	High Dependency Unit	Pathology
Breast screening	Early Pregnancy Unit	Intensive Care unit	Patient appliances
		Infection control services	Pharmacy services
Breast surgery	Emergency Department	Interventional radiology	Physiotherapy and occupational therapy
Cardiology	Endoscopy services	Maternity comprising: • Antenatal clinic • Ultrasound scanning • Labour Ward • Antenatal Ward • Postnatal Ward • Maternal Foetal Assessment Unit • Breast feeding support • Birthing Unit • Community midwifery services	Pre op assessments
Chemotherapy	Endocrinology	Maxilla-facial surgery	Radiology
Clinical Decision Unit	ENT	Medical Oncology	Respiratory Medicine
	Frailty service	Neonatal critical care – special care baby	Rheumatology

		unit and neonatal community nurses	
		New-born Hearing Screening	
Clinical Haematology	Gastroenterology	Neurology	
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
		Oncology services	Tongue tie service
Colorectal services	Geriatric medicine	Paediatrics – on-patients, out-patients, ambulatory care	Trauma and orthopaedics
Day surgery	Vascular services	Paediatric diabetic Medicine	Urology
Dermatology	Gynaecology ambulatory service	Paediatric Emergency Department	

Strategic objectives

Over the last 12 months the trust has further defined its vision and courageous goals:

Vision: To deliver outstanding healthcare to the community

Courageous goals:

Outstanding
We will deliver healthcare that our patients deserve and makes us proud.

Integrated
We will work as one to provide joined up healthcare that puts patients first.

Modern
We will always use up to date treatments, technology and facilities.

Underpinning the trust's ambition to achieve outstanding healthcare is the five Ps. The trust board set five strategic objectives for the 2019-20 year focussed on delivering the Five Ps.

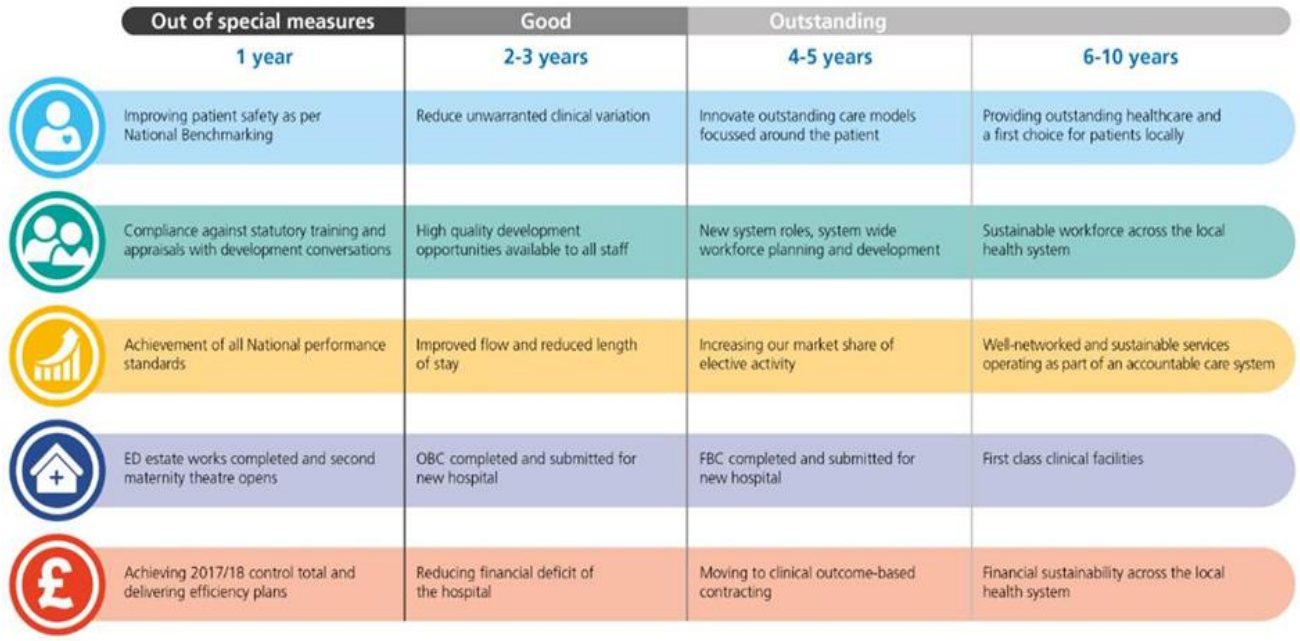
Five Ps	Trust objectives
	**Our patients** Continue to improve the quality of care and experiences that we provide **our patients** and families, integrating care with our partners and improving our CQC rating.
	**Our people** Support and develop **our people** to deliver high quality care within a culture that improves, engagement, recruitment and retention and results in further improvements in our staff survey results.
	**Our performance** Meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators.
	**Our places** Maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC for a new build, aligned with the development of our local Integrated Care Partnership.
	**Our pounds** Manage **our pounds** effectively and modernise our corporate services to achieve our agreed financial control total for 2019-20 and our local system control total.

The trust also 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

The trust has continued to work towards 'outstanding' along the existing roadmap and milestones of "Your future, Our hospital", captured below, which takes us along the 5 year journey to outstanding and beyond:



During 2019-20, the trust embarked upon the development of a 10 year strategy '*PAHT 2030'*, which facilitates the delivery of the trusts vision and courageous goals:

Strategic priority one	Technology and Innovation including electronic -patient record
Strategic priority two	Integrated care development
Strategic priority three	New hospital programme
Strategic priority four	Organisational culture
Strategic priority five	Non-clinical support service modernisation

PAHT 2030 has been developed in alignment with the:

- NHS Long Term Plan
- Hertfordshire and West Essex 'A healthier future; delivering improved health and care in Hertfordshire and West Essex'
- West Essex One Health and Care Partnership five year transformation plan

The trust recognises the active role we play in ensuring the ambitions of each of these strategies are achieved and have developed our strategic priorities in line with the national, regional and local system priorities, illustrated below:

Clinical strategy

Our role in both regional and local integrated care, our new hospital and the changes in technology and innovation requires a change to the way in which we deliver care to adapt to our changing environments. Over 2019-20 the trust has also begun to develop a 10 year clinical strategy.

The **PAHT 2030 clinical strategy** programme has been led by our clinical teams and developed at speciality and pathway level, allowing us to build our strategy from the ground up. Through the development of our clinical strategy we have begun growing our suite of integrated patient outcome measures ensuring patient care is measured on true quality of life outcomes, proposing how our role in the prevention of ill health can support people to live well and stay well for longer, and implementing best practice treatment pathways across all areas to ensure care is standardised and cost effective.

Integrated care development

The trust remains of the view that a sustainable future for the services currently provided by PAHT would be best pursued through forming strategic partnerships with neighbouring NHS hospitals and primary and community care to facilitate closer working both regionally and locally.

From a local perspective the West Essex One Health and Care Partnership (OHCP) brings together NHS organisations, local hospitals, GP's, social care and the charity and voluntary sector in West Essex to put local people, and the quality of health and care services, at the centre of what we do. Our core partners are West Essex CCG, Essex County Council, Essex Partnership University Trust and our Primary Care Networks.

Over 2019-20 we have worked with our OHCP partners to begin formalising our partnership arrangements. This will include working collegiately to meet system control total requirements, creating a shared vision and strategy, a 'whole system' governance agreement and shared clinical strategies.

The OHCP has also published an ambitious transformational plan across the following priority areas for the West Essex system:

- Delivery of urgent and emergency care, frailty and complex care in a more efficient, integrated and outcomes based approach.
- Modernisation of outpatients
- Investment in mental health services with the aim to achieve the Mental Health Investment Standard (MHIS) and work towards integration of physical and mental health conditions.
- Improvement of outcomes for people who live with one or more long term conditions and that we continuously work on preventing disease, decline and mortality.
- Improvement of safety in maternity by reducing rates of stillbirth, neonatal death, maternal death by 50% and brain injury during birth by 20% by 2023.
- Improvement of health and outcomes for children and young people and their families including mental health.
- Enabling functions such as medicines optimisation, estates, finance, digital and workforce are embedded within all the programmes and support delivery of the plan by transforming the way we work.
- Increasing support for people so they have more control over their own health and more personalised care.

From a regional perspective PAHT has continued to work closely with organisations within the Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP) on programmes where there is greatest opportunity for more effective and efficient health and care services, and where working as one partnership on pathways is more beneficial than local design and delivery.

During 2019-20 the trust has worked collaboratively to deliver against the three key priorities for transformation and service change; frailty, children and maternity, and planned care. Through a population health management approach we have worked with HWE STP partnering organisations to segment the population into three groups based on their broad level of need, therefore identifying groups of people within our population who are at risk of deteriorating health and wellbeing. These three population groups are:

1. Generally well - our largest segment with a population of over 1 million,

2. People who have one or more long term conditions – approximately 300,000 people, and

3. Severely frail and/or in their last year of life - our analysis has shown that the most

severely frail comprise about 11% of the total population and we spend around 45% of our total budget on this group of people.

New hospital programme

In October 2019 PAHT secured funding to build a new hospital in Harlow through the first phase of the Governments Health Infrastructure Plan (HIP1). This new hospital site will provide fit for purpose facilities which maintain the quality of clinical services for patients and support financially sustainable service transformation to integrated care. It is also essential for ensuring that the future needs of the local population are met.

This flagship project represents the largest capital investment in the trusts history and is therefore recognised for its scale, complexity, profile and strategic importance. The trust has begun to work at pace, within a robust system of governance, to produce and submit an Outline Business Case (OBC) by December 2020 to include the strategic fit, option appraisal, achievability, assumptions about costs, benefits, risks and funding. Following submission of the OBC we will move forward to the next stage of the programme through the development of a Full Business Case (FBC) outlining the procurement of the value for money solution and ensuring successful delivery.

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 2019-20 were variation in clinical outcomes, nurse recruitment, our estate, delivery of the Emergency Department standard and our finances. 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 Ps	Highest scoring risks on board assurance framework 2019-20
	**Outcomes** Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality
	**Nurse recruitment** Inability to recruit to critical nursing roles.
	**Estates and infrastructure** Concerns about potential failure of the trust's estate and infrastructure and consequences for service delivery
	**4 hour Emergency Department constitutional standard** Failure to achieve ED standard
	**Finance** Concerns around failure to meet financial plan including cash shortfall.

Going concern

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:

i) The Board considers the trust operates a significant portfolio of clinical services. The Trust has signed a two year allocative contract (expiring 31 March 2021) with its main Commissioner. The trust has not been made aware of any plans from any Commissioner to disinvestment. The Trust is expanding and taking on lead responsibility for services e.g. musculoskeletal services.

West Essex System partners aim to form an Integrated Care Trust (ICT) by 2022. The ICT will be made up of Primary Care, Community Care and Acute care providers. The development of 'One Health and Care Partnership' during 2020/21 will be a key transitional point towards the ICT.

ii) In October 2019 the trust received notification of financial improvement trajectories and Financial Recovery Fund (FRF) allocations for each year up to 2023/24. These trajectories outline a reduction in deficit with indicative FRF set to meet a breakeven position. Subsequent amendments to reflect policy changes and the debt write off regime were notified in January 2020 with the trust's trajectory of £28.6m deficit in 2020-21 to be matched by FRF. It should be noted that due to Covid-19 operational planning guidance was suspended with the introduction of an adapted financial regime intended to cover the full costs of service delivery. The detail of the block and top-up payments to be received by the Trust have been received.

iii) The trust has included an estimate of £40.9m of capital requirements in its 2020/21 operating plan. This plan includes £9.9m of internally generated funds, £9.5m for the development of a Medical Assessment Unit, £5m emergency capital and £9.2m to progress a Strategic Outline Business Case (SOC) for Hospital redevelopment. Support for the new Hospital development has been received from senior Department of Health officials and the Prime Minister.

iv) 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. Such uncertainties include delivery of a cost improvement programme for the following 12 months to levels that secure FRF funding in 2020/21 and beyond. The Board has considered this position and, although there remains uncertainty regarding the overarching financial regime beyond July 2020, assesses it is reasonable that identified savings will be delivered. This position is supported by existence of both a Transformational agenda, actions of the Recovery and Restoration cell as part of the response to Covid-19 and a continued track record of the Trust to delivery cost and efficiency improvements.

On that basis and for the reasons outlined above the Board of Directors considers it is appropriate to prepare the 2019/20 Accounts on a going

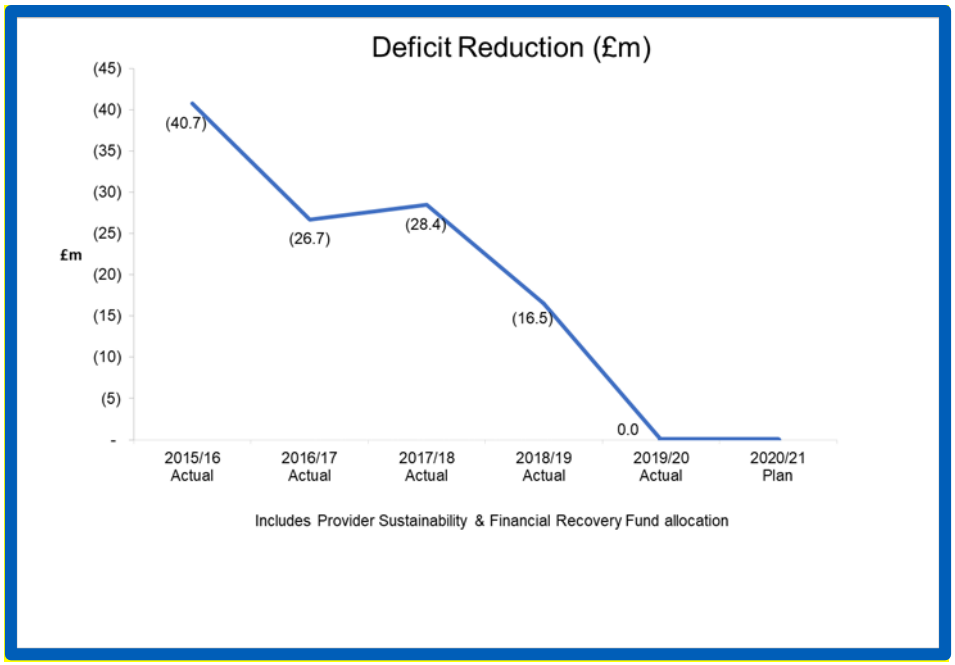
concern basis and the financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Performance Analysis

Financial Performance

The trusts 2019-20 net control total target deficit i.e. including Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) set by NHSI/E was £6.2m (gross deficit excluding PSF and FRF £29.6m). The trust's outturn was a £50k surplus being a £6.2m underspend against the net control target. This compares to a £16.6m deficit in 2018-19 and the trust's first recorded surplus since 2012/13.

	Control Target	Actual Outturn	Under-spend
	£000's	£000's	£000's
Net Control Total - 2019/20	(6,168)	50	**6,218**



Key elements of the trusts financial results:

- Delivery of our cost improvement target of £10m.
- Temporary staff costs were £35.1m (agency £10.9m, bank £24.2m).
- Moved towards block contract arrangements with an allocative contract formally established with West Essex CCG and additional funding flows covering winter pressures, Covid-19 costs and additional activities.
- Eligibility to earn additional Financial Recovery Fund and Provider Sustainability funding of £28m from delivery of financial performance targets.

NHS Trust Financial Duties

The key financial results for 2019-20:

- The Trust delivered an adjusted retained surplus of £50k.
- The Trust spent £17.3m on capital (Medical Equipment, IT and Estates). This was an increase in the £11.9m investment in 2018/19. The Trust underspent against Capital Resource Limit by £0.5m.

	2019/20 £000's
Gross capital expenditure	17,412
Less: Donated and granted capital additions	(98)
Charge against Capital Resource Limit	**17,314**
Capital Resource Limit	17,721
Unadjusted CRL	**407**
Adjusted financial performance (management control total basis):	
CT Scanner funding deferred to 20/21 included in 19/20 limit	(447)
COVID CRL Support for 2019/20 to be adjusted in 20/21	509
Underspend against CRL	**469**

- The Trust underspent against its 2019-20 external financial limit by £0.1m. This was an improvement on the 2018/19 position.

	2019/20 £000's
External financing limit (EFL)	30,083
Cashflow financing	29,489
Unadjusted EFL	**594**
Adjusted financial performance (management control total basis):	
CT Scanner funding deferred to 20/21 included in 19/20 limit	(447)
Underspend against EFL	**147**

The Trusts external auditors have issued a qualified opinion on its financial statements in that the accounts present a true and fair view of the trust's financial position for the 2019-20 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 2019-20 has continued to improve compared to 2018-19.

Performance is summarised as follows:

	2019/20	2019/20	2018/19	2018/19
Non-NHS Payables	**Number**	**£000's**	**Number**	**£000's**
Total non-NHS trade invoices paid in the year	49,002	76,083	51,665	67,947
Total non-NHS trade invoices paid within target	43,722	64,320	36,583	49,942
Percentage of non-NHS trade invoices paid within target	**89.2%**	**84.5%**	**70.8%**	**73.5%**
NHS Payables				
Total NHS trade invoices paid in the year	2,227	56,446	2,553	42,033
Total NHS trade invoices paid within target	1,805	47,379	1,810	36,631
Percentage of NHS trade invoices paid within target	**81.1%**	**83.9%**	**70.9%**	**87.1%**

Financial plan 2020-2021

The trust is looking to build upon the significant progress made in the last financial year. This includes an unqualified Value for Money opinion for the 2018/19 Accounts and securing 'Good' for its Use of Resources assessment.

The trust has set an interim budget for 2020-21 in light of the adapted financial regime associated with Covid-19. The trust will be tracking and managing its resources closely to ensure full cost recording and recovery for its pandemic response, both in terms of operational spend and capital investment. Its focus will remain on cost control and temporary staffing reductions together with quality and cost improvement. A very significant and successful international nurse recruitment programme in 2019-20 has much improved nurse vacancy rates at the Trust, nursing levels across the wards whilst also providing the potential to reduce its reliance on both bank and agency staff going forward.

The trust also continues to work actively with its health and care partners within the Local Integrated Care Partnership and broader Integrated Care System. Key areas of activity currently include the response to Covid-19 and the development of recovery

plans, this is in addition to the integration of its services for patients and users and, where appropriate, the development and consolidation of support services.

The trust is part of the National Health Improvement Programme (HIP) Phase 1 and is urgently progressing its Outline Business Case for a new hospital development for 2025.

Having delivered its first operating surplus since 2012-13 and having increased its capital investment significantly across recent years, the trust has further opportunities and potential to take these successes forward.

The trust's indicative capital investment for 2020-21 is planned to increase to £40.9m. This includes £9.2m to progress the development of the new hospital. Other significant planned investments include emergency backlog maintenance and the development of a Medical Assessment Unit, medical equipment and IT infrastructure.

Operational performance

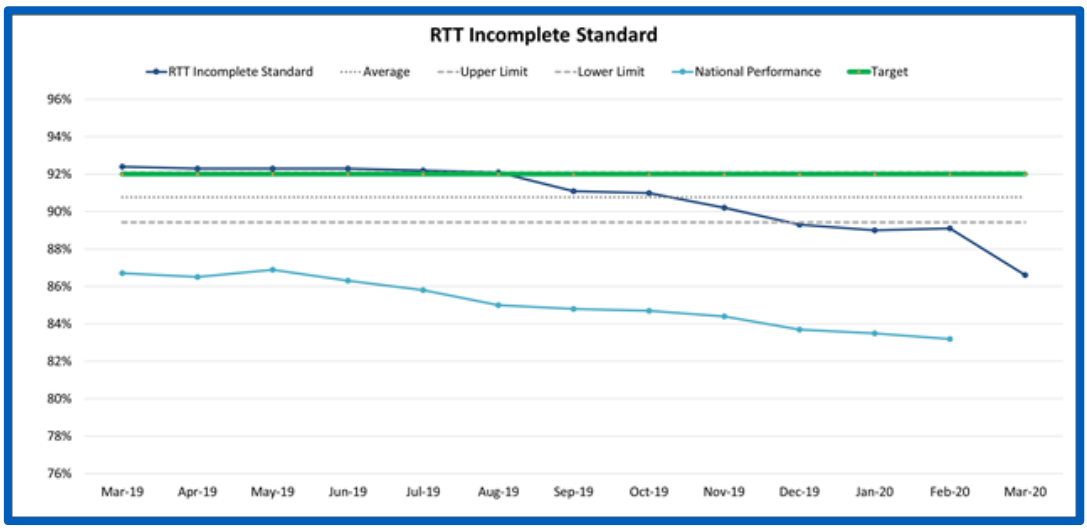
The trust's operational performance against national and local standards is monitored and reviewed at:

- 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

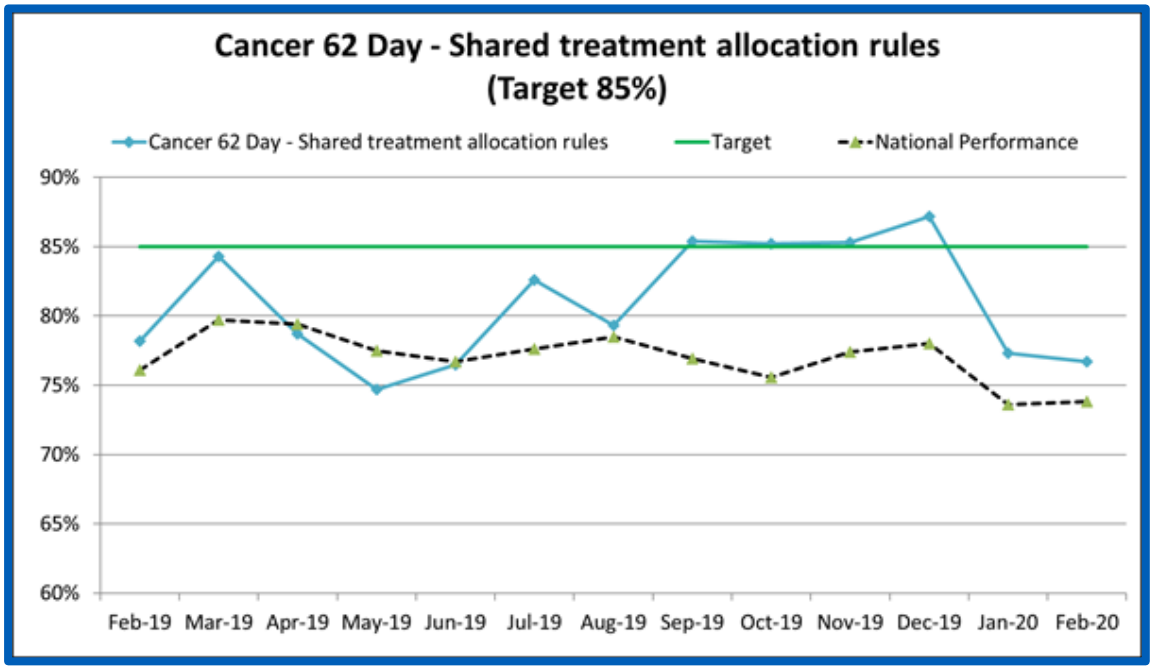
The progress in Referral to Treatment (RTT) standards made in 2018/19 was maintained during the first half of 2019/20, however this deteriorated to 86.6% in the latter half of the year. During the last quarter of 2019 there were unexpected medical staffing gaps in dermatology, diabetes and endocrinology, gastroenterology and hand surgery in trauma and orthopaedics which resulted in the trust focussing on the cancer workload which impacted on RTT performance. However, the trust's performance is still significantly above national performance. The trust was aiming to improve RTT performance to the national standard in April 2020 however performance in February and March 2020 were impacted by COVID-19 which resulted in routine elective operating being postponed to enable re-deployment of clinical staff to support the respiratory emergency demand.



Delivery of the national cancer standards was challenging during 2019-20 due to workforce issues across the medical workforce specifically within dermatology and Lower GI specialties. Cancer recovery plans were implemented across all specialties and led to a sustained improvement in performance from quarter 1 with continued achievement of the cancer standard between September and December 2019.

COVID-19 impacted on cancer performance in the last two months of the year and the trust adopted the national guidance to ensure as far as possible that cancer patients continued to receive appropriate care. All revised diagnostic and treatment decisions are made through the clinical multi-disciplinary meetings and with patient agreement.

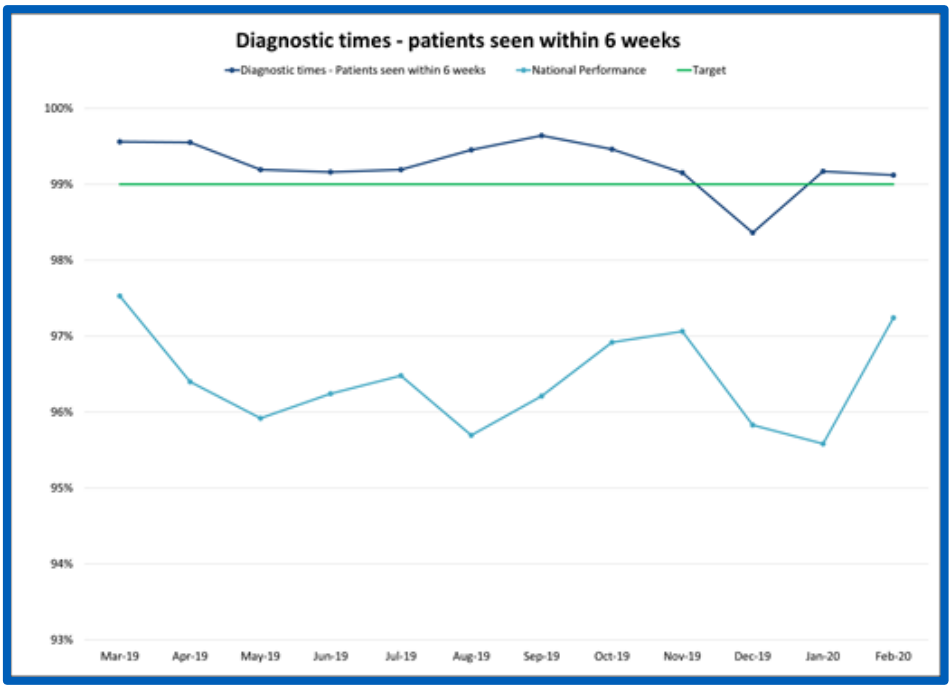
The trust continues to be committed to the delivery of all national cancer standards and plans are now in place to work towards the proposed 28 day faster diagnosis standard which will come into effect during 2020/21.



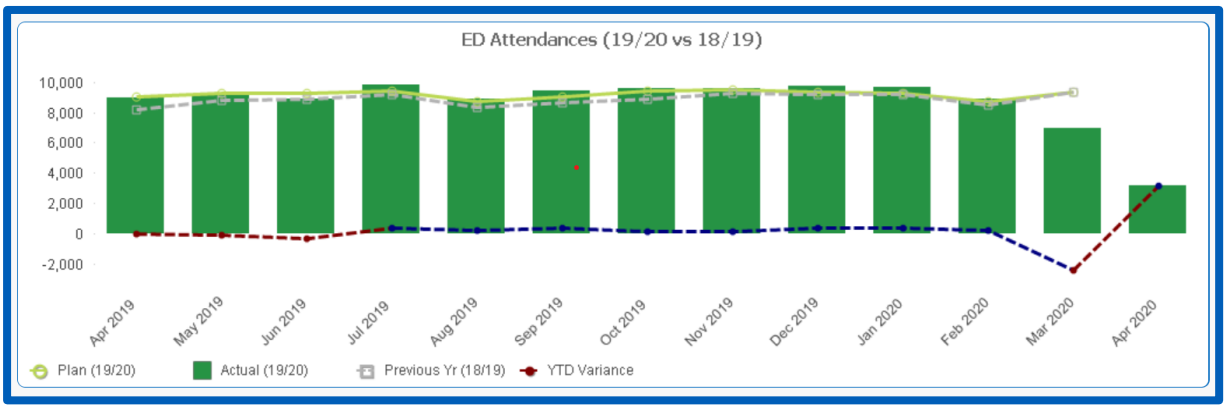
Diagnostic performance

The trust has achieved the 99% diagnostic wait target consistently over the last year and only failed the target for one single month in the last 5 years which was due to an administrative human error. This means that over 99% of all patients waiting for a diagnostic examination have this completed inside 6 weeks of the referral being made. We are proud of consistently maintaining this performance despite a 5% growth in demand, year on year.

The trust has consistently performed circa 3% higher than the national performance each month throughout the last year.

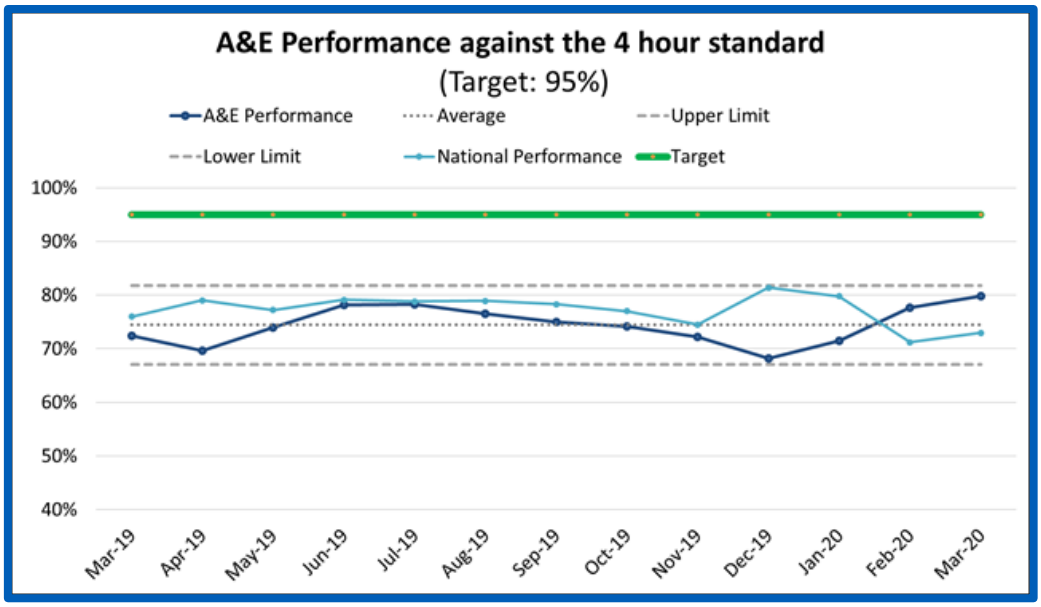


Urgent care and ED performance

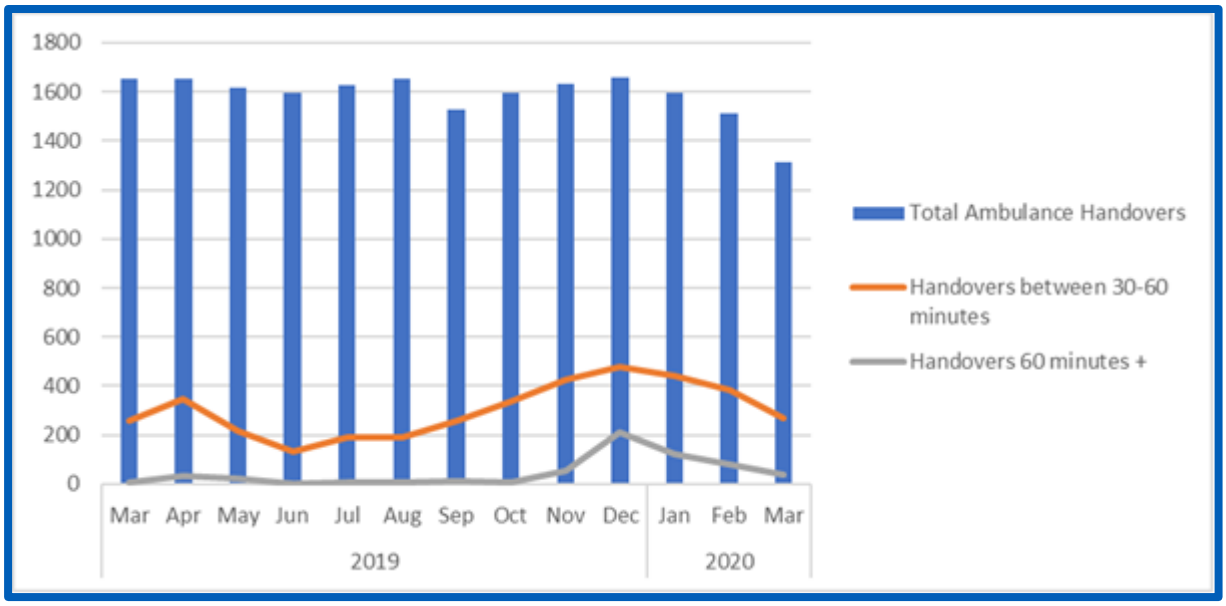


The trust continued to struggle to meet the four hour standard and finished the year end at 79.7%. Whilst we have continued to have workforce challenges, we have also consistently had a high bed occupancy level meaning admissions from the Emergency Department to inpatient wards has often been slower than required. This is despite a further reduction in our length of stay and improvement in our internal and external delays. We have also continued to see an increase in attendances to the Emergency

Department, with an increase of nearly 6% in attendances until the development of COVID-19 in February/March 2020 compared to the same period in 18/19, and an increase of over 10% compared to 17/18. In the last month of the year Emergency Department attendances dropped significantly due to the COVID-19 pandemic and ED performance improved.



Ambulance handover performance has seen a marked improvement over the past year due to the re-design of the Rapid Assessment Treatment (RAT) pathway. With the assistance of the emergency care intensive support team from NHSE/I the RAT pathway is led by an advanced nurse practitioner to ensure swift clinical assessment and decision making improving patient flow through the Emergency department and improving patient experience.

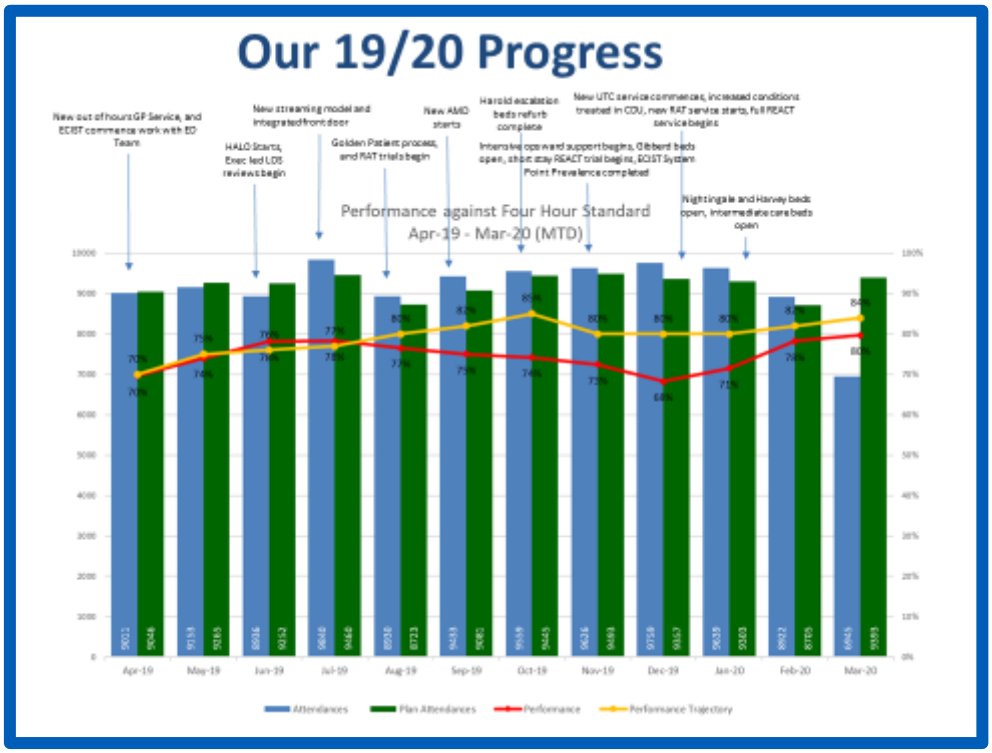


We have continued to work with our system partners to further develop streamlined services that can be delivered in the most effective location and to prevent attendances and admissions to hospital. The local delivery group has continued to forge close working relationships across organisations and enabled improved service provision such as increased intermediate care capacity and patient at home support

for patients with existing care packages. Patient experience has been enhanced by increasing the use of the Clinical Decision Unit and the development of the temporary Surgical Assessment Unit.

The operational teams across the health care system, both providers and commissioners, have worked collaboratively to develop the Urgent Treatment Centre staffed with enhanced nurse practitioners and general practitioners which works flexibly with the Emergency Department to respond to changes in demand.

The graph below shows the development and range of these services:



The trust has consistently exceeded the national delayed transfers of care target of 2.5%. We have also exceeded our long length of stay trajectory and reduced our patients with a length of stay of over 21 days by more than 40%. We have been asked by the Getting it Right First Time (GIRFT) programme to share our methodology to support other organisations.

Further work is planned in 2020-21 to increase our bed capacity and improve our frailty service to improve patient experience.

The urgent care and Emergency Department has risen to the immense challenge created by the COVID-19 pandemic and carried out significant redesign of services in a short space of time. We developed two separate pathways and departments, opening a Respiratory Emergency Department (RED) to work in parallel with the general Emergency Department. This ensures that patients attending the hospital with non COVID-19 emergency conditions are protected from infection as much as possible and both cohorts of patients are cared for by the most appropriately qualified staff. This separation into two departments required the re-provision of the Urgent Treatment Centre into the out-patient department.

Responding in an emergency

Throughout 2019-20 the resilience team have continued to work to ensure that the Trust is in a position to respond to, and recover from a range of emergencies. In the last year we have focused on our staff and trust preparedness through training and exercising, including scenarios related to cyber security and fuel shortages.

During the previous year our largest resilience challenge was preparing for the United Kingdom exiting the European Union. As an organisation we recognise the importance of multi-agency working, and continue to actively engage in the work of the local health resilience partnership and the Essex resilience forum. As required nationally we undertook the NHS England emergency planning, resilience and response core standards for which we were able to provide full assurance to NHS England.

The coming year will see us working alongside our partners and a range of other organisations, as we face the challenges posed by the COVID-19 pandemic. Further detail on how the Trust is managing this virus is included in the infection prevention and control section below.

Clinical performance

Infection prevention and control

The trust has robust infection prevention and control (IP&C) measures in place that are part of a safety culture that helps control healthcare associated infections (HCAIs). This year PAHT has continued to maintain excellent control of HCAIs and antimicrobial resistance (AMR). Commitment by clinical and management staff to work together and maintain the 'board to ward' model supported by audit and feedback, helped to provide a safe environment for our patients.

The trust remains in a favourable positon nationally for various alert organisms. For trust apportioned Meticillin sensitive Staphylococcus aureus bacteraemia (MSSA) control we are amongst the best in England. We continue to do well with *Clostridium difficile* (C *difficile*) management. NHS England requested our control plan for gram negative bacteraemias as we are a Trust that has shown significant improvement compared to previous years.

An unexpected threat in the form of the respiratory virus; COVID-19 brought new challenges to the trust from the end of January 2020. The virus tested every aspect of infection prevention and control. Dealing with the pandemic has given us a new perspective on organisational IP&C, and shown the Trust to be versatile and responsive.

MRSA bacteraemia

During 2019-20, there were two cases of trust apportioned cases of MRSA bacteraemia and two cases of non-trust apportioned MRSA bacteraemia. Although numbers are small, these are higher case numbers than in previous years and the

IP&C team worked with colleagues in our local CCGs, to address any learning in relation to these cases.

Clostridium difficile

The trust was set a challenging trajectory of 27 cases for 2019-20 combining for the first time hospital associated cases and community cases where the patient had been in hospital during the preceding month. This target reflects our excellent *C difficile* numbers in previous years, as the target is based on previous case numbers. We have coped well with this target, ending the year below the trajectory, with 23 cases in total.

Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia

The trust remains in an excellent position as one of the top performing NHS organisations in the country in terms of low MSSA blood infections (bacteraemia). This was noted by the CQC inspectors on their last visit to the trust. This year there have been six trust apportioned cases. This is a reduction from eight trust apportioned cases last year. Non-trust apportioned cases are the usual source of MSSA bacteraemia and we had 36 patients who presented to our Emergency Department with this infection.

Aggressive treatment of all MSSA bacteraemias is undertaken to reduce mortality associated with this infection.

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

In April 2017, a new national target to halve healthcare associated GNBSI by 2021 was introduced. Initially, the focus was on reducing healthcare associated *E. coli* BSIs because they represent 55% of all gram-negative BSIs. Now attention is also being given to other GNBSIs.

Numbers of trust-apportioned *E.coli* cases remain low this year and the trust is in a favourable position when compared with other hospitals nationally. During 2019-20 we had a total of 163 cases; of these 150 were found to have an *E. coli* bacteraemia on admission and the remaining 13 cases were considered to have been hospital associated.

Klebsiella sp. blood stream infections (classified as GNBSIs)

During 2019-20 we had a total of 41 cases. Of these 38 were found to have a bacteraemia on admission and the remaining three cases were hospital associated. We have achieved a significant reduction in our hospital associated cases from eight cases last year to three cases.

Pseudomonas aeruginosa blood stream infections (also classified as GNBSIs)

During 2019-20 we had a total of 22 cases. Of these, 19 had a bacteraemia on admission and three cases were hospital associated. Our hospital associated cases remain under control largely due to control of CaUTIs as pseudomonas aeruginosa is

an organism often associated with catheters. The team managing the trust catheter pathway have worked hard to control of this infection.

Outbreaks and incidents

Norovirus

Five norovirus outbreaks occurred in the trust in 2019-20. Isolated incidents occurred in April, October, two outbreaks occurred in December 2019 and the last outbreak occurred in February 2020. The trust has systems in place for the management of outbreaks with daily meetings for the duration of the outbreak, led by the IP&C Team supported by the director of infection prevention and control or director of nursing, midwifery and allied health professionals.

MRSA transmissions

Four wards had more MRSA transmissions than expected during the year. 54 of the 71 MRSA transmissions that occurred in the Trust, occurred on Gibberd, Harold, Lister and Ray wards. There was no increase in MRSA infections. Regular MRSA control meetings were held with the IP&C Team, clinical and management staff and the transmissions were brought under control. Sustained transmission occurred on Harold and Lister wards, especially affecting the latter ward and this was deemed to be an outbreak. It was decided to rectify estates issues and refurbish Lister ward as part of managing the outbreak.

Vancomycin resistant enterococci (VRE)

A VRE outbreak started in critical care in January 2019, and was declared over in July 2019. However, due to on-going low grade VRE in the summer, apart from carrying on with the usual IPC standards, it was decided to refurbish both HDU and ITU to rectify estates issues, put in modern sinks and create more isolation facilities. ITU now has two isolation pods rather than one, HDU has one side room rather than none.

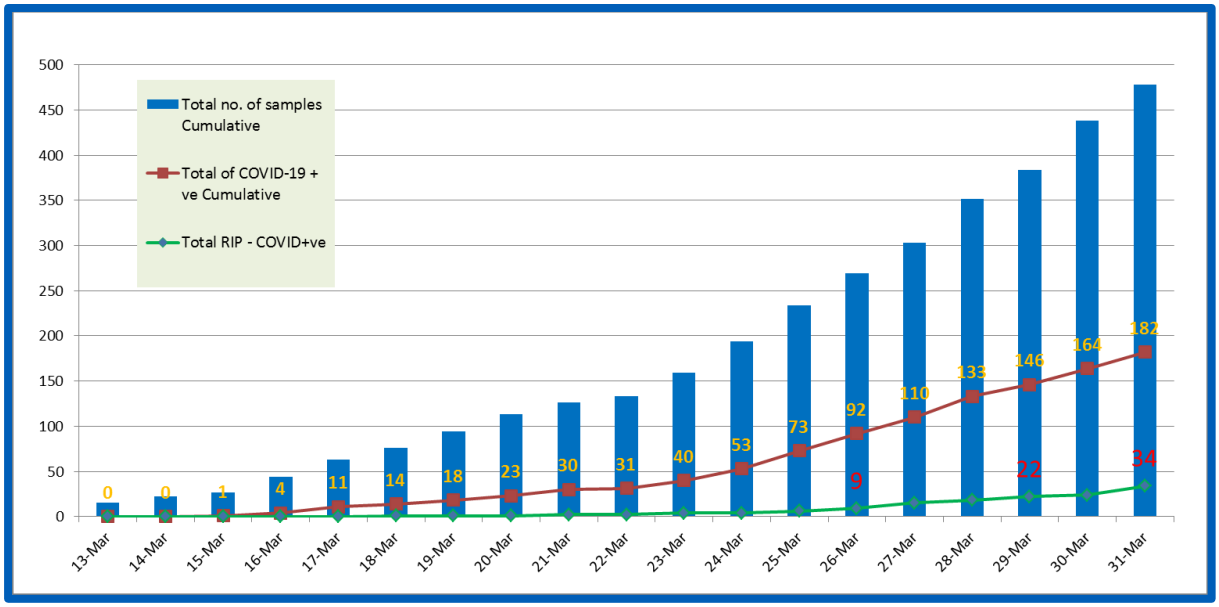
There were no clinical infections due to VRE on ITU or HDU during 2019. A few colonised patients were treated as a precaution, such as patients with vascular grafts.

COVID-19

The Covid-19 pandemic required a change to the way the organisation and the IP&C Team functioned. Being relatively close to London meant PAHT experienced a significant COVID-19 case load. Different ways of working to ensure compliance with social distancing including home working with remote access helped reduce virus transmission both in primary and secondary care between staff, and between staff and patients. Efforts focussed on ensuring the hospital had sufficient ward capacity and Critical care capacity to manage case numbers. Most elective surgery was stopped and the hospital was ‘zoned’ to manage COVID-19 and non COVID-19 patients.

A meeting structure was introduced to manage all aspects of the pandemic in the organisation. Apart from an IPC cell, there was a clinical cell, an operations cell, a people cell and strategic Cell. The IPC cell focussed exclusively on IPC matters linked to COVID-19 including the roll out of personal protective equipment (PPE) and any staff concerns or queries around the programme. The groups met daily and the IPC cell was chaired by the director of nursing, midwifery and allied health professionals.

From 13 March 2020, when PAHT had its first COVID-19 inpatients to 31 March 2020 a total of 478 samples were tested for the virus. 182 of those tests were positive and 34 deaths were reported in this period. All deaths were, and continue to be reviewed as the pandemic continues to be managed during 2020.



Our approach to PPE was fully co-ordinated across the trust. It was consistent and supportive, with clear messages endorsed by regular education and Fit testing of FFP3 respirators for staff groups who need FFP3. Training was provided to staff across the Trust and team work and communication improved as time passed.

A fully co-ordinated procurement process for securing PPE supplies was put in place with NHS approved stocks received from a central procurement pathway. Ten PPE safety marshals were appointed to work alongside the IP&C team to support and monitor the PPE programme.

PPE was just one of a complete IPC package which included respiratory segregation, testing of respiratory in-patients for COVID-19 with appropriate isolation, ward cleaning, twice daily cleaning of frequently touched surfaces, hand washing, respiratory etiquette, social distancing of patients from each other and staff from each other, and staff wearing PPE in ED, critical care and across all COVID-19 wards.

Staff were supported by the staff health and well-being service (SHaW) as well as the people team. A staff swabbing programme and a process for monitoring sickness were introduced.

The above changes were introduced over a period of weeks from February 2020 as experience in dealing with this very complex virus grew.

"Thank you very much to all of the staff, nurses, care assistants, doctors, anaesthetists and surgeons.

"You were all fantastic at this difficult time and your professionalism, hard work and care shone through.

"Thanks for treating and caring for my Mum, she has not stopped saying how wonderful everybody was."

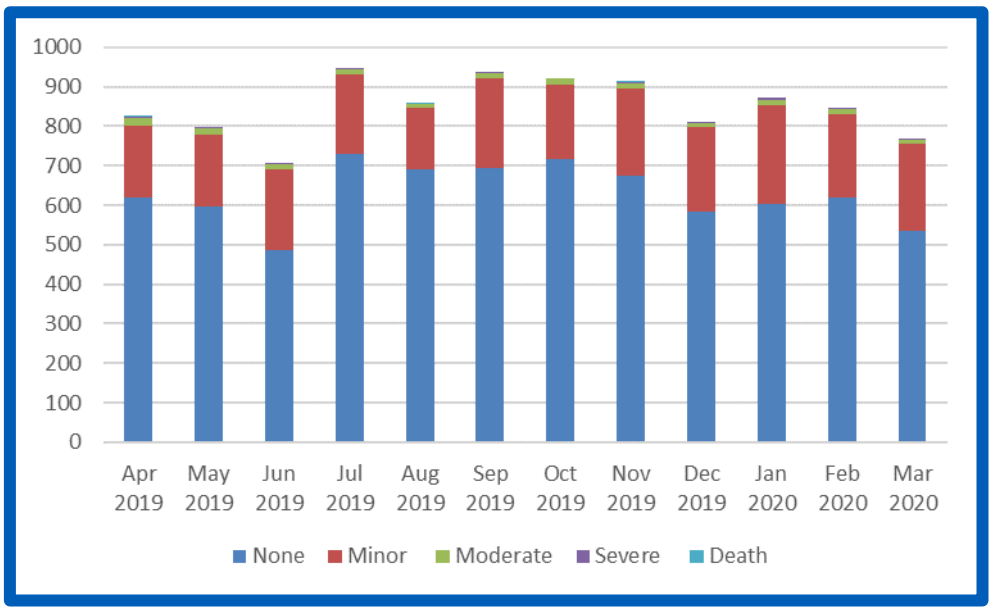
-Patient's daughter-

Learning from incidents

Patient safety is a trust priority, we continually strive to ensure incidents are managed effectively and most importantly that we learn and share the improvements that arise from them. A patient safety incident is defined as 'any unintended or unexpected incident which could or did lead to harm for one or more patients receiving NHS funded care'.

During 2019-20 the trust reported a total of 10,204 incidents. Of these incidents 98.17% resulted in either no or low harm, the remaining resulting in moderate (1.48%), severe (0.29%) or death (0.06%).

The total number of incidents reported has increased by 8.9% when compared with 2018-19. Overall incident severity ratings have remained consistent. The increase in incidents reported demonstrates that our staff are conscious of patient safety and our organisation can continue to improve through critical review.



All patient safety incidents are reported to the National Reporting and Learning System (NRLS) to enable learning and comparison with other similar organisations to occur.

We have embedded robust processes to enable learning to take place across the organisation to support prevention of the same or similar incidents from occurring again. Following investigations into patient falls, work commenced to develop effective falls risk assessments, safety handovers, and a process to effectively nurse high risk falls patients. This improvement work continues with the trust currently developing an organisational wide approach to reduce in-patient falls.

Incident reviews within the maternity department have led the department to re-define the criteria for admission of women with specific health needs to the labour ward rather than the birthing unit (low risk births). There has been increased training for staff in monitoring of both the mother and the baby during labour to ensure that an abnormality is recognised and acted upon promptly. An additional scan at 38 weeks takes place to monitor the growth of babies of women who smoke during pregnancy so any slowing of growth can be promptly identified.

An investigation within paediatrics saw the introduction of a pre-assessment tool for children waiting to be seen by the triage nurse when attending the children's Emergency Department. This pre-assessment tool enables effective identification of children becoming increasingly unwell whilst waiting to be clinically assessed and that they are prioritised for medical attention.

Never events

There were no never events in 2019-20.

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)

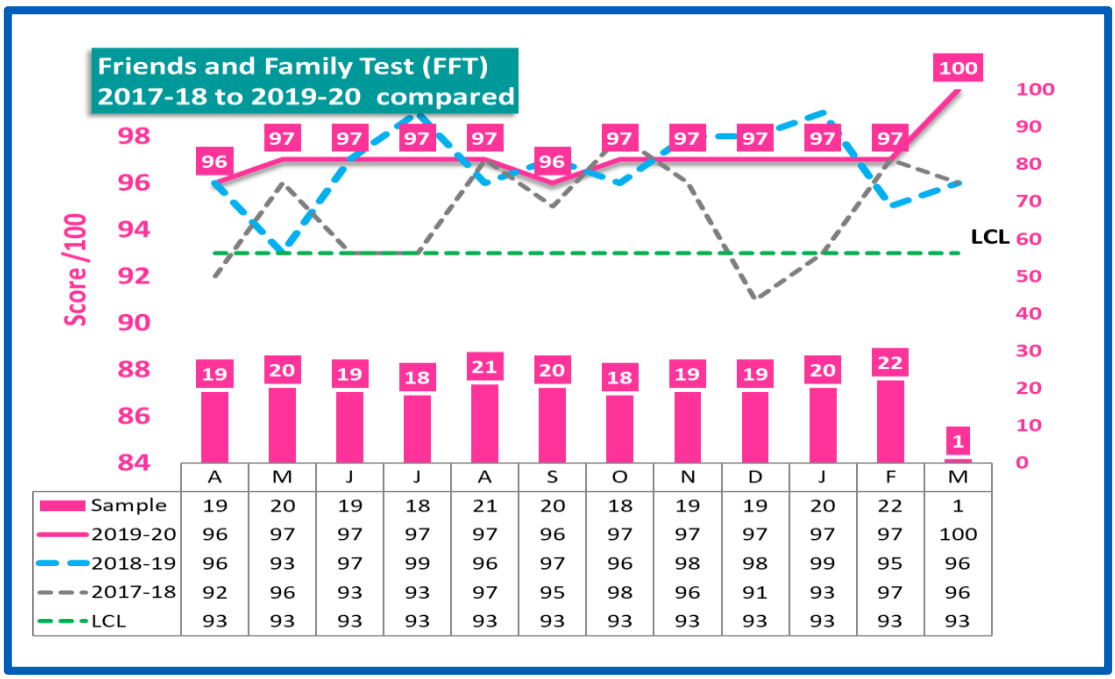
The national average for a composite friends and family test score in England is 93%. The trust is well above the national average with a composite average score for the year to date (excluding March data due to COVID-19) of 97.1%.

The evidence in the graph below shows some variation in sampling as well as a significant drop at the end of the year as measurement was suspended due to the pandemic, giving the trust data from the first few days of March 2020.

Cross checking this data with evidence from wider measures of activity in patient advice and liaison services, the trust responded to 6103 contacts either in the form of compliments, questions or concerns and saw a decrease in complaints from 205 to 172 consistent with the improvements in scoring for the friends and family test.

A number of key projects took place this year including:

- The development of voluntary services projects such as butterfly volunteers and a £25k of funding from NHSE/I to support Emergency Department volunteering.
- The establishment of a carers working group as part of work to address the communication issues raised often raised by carers in complaints.
- Effective patient stories at board meetings including a story that led to changes in how we implement reasonable adjustments for patients with a mental health issue and at the end of life.
- The implementation of fifteen steps, a schedule of visits by senior members of staff and board members to clinics, wards and teams to support our people.



	A	M	J	J	A	S	O	N	D	J	F	M
Sample	19	20	19	18	21	20	18	19	19	20	22	1
2019-20	96	97	97	97	97	96	97	97	97	97	97	100
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
LCL	93	93	93	93	93	93	93	93	93	93	93	93

Mortality

Some of the statistical markers for mortality have been higher than expected for 2019-20.

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

HSMR

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths.

The trust's rolling HSMR and SMR reported for the last 12 months have been higher than expected. For the period December 2018 to November 2019 (including a time lag of one month) the trust's HSMR was 122 (higher than expected).

PAHT is 1 of 6 trusts within the peer group of 15 that sit within the 'higher expected' range.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI for the period November 2018 to October 2019 is 111.15 (as expected).

Progress over the past year:

Mortality governance is a key priority for the trust board. The chief medical officer has executive responsibility for the learning from deaths agenda and a non-executive director has responsibility for oversight of progress.

A trust wide improvement programme and Mortality Improvement Board was established in 2019-20 utilising quality improvement methodology to deliver improvements in patient outcomes and mortality rates.

Over the past year the national medical examiners system has been fully implemented and 100% of all inpatient deaths were, and continue to be, reviewed and scrutinised. The national system of structured judgement reviews has also been rolled out across the trust. Themes identified from these reviews inform the quality improvement projects to be undertaken and learning from mortality reviews is shared across the organisation.

A lead nurse for mortality and quality was also appointed to facilitate the mortality review process.

The COVID-19 pandemic has increased and will continue to increase the actual and the expected number of deaths both nationally and at PAHT. The first COVID-19 death at PAHT was reported on 18th March 2020. All deaths related to COVID-19 are included in the structured judgement review process.

"There are not enough words to say thank you.

"My family have needed PAH a fair bit lately and all of you are amazing.

"I'm so thankful and feel so proud, you all deserve a round of applause."

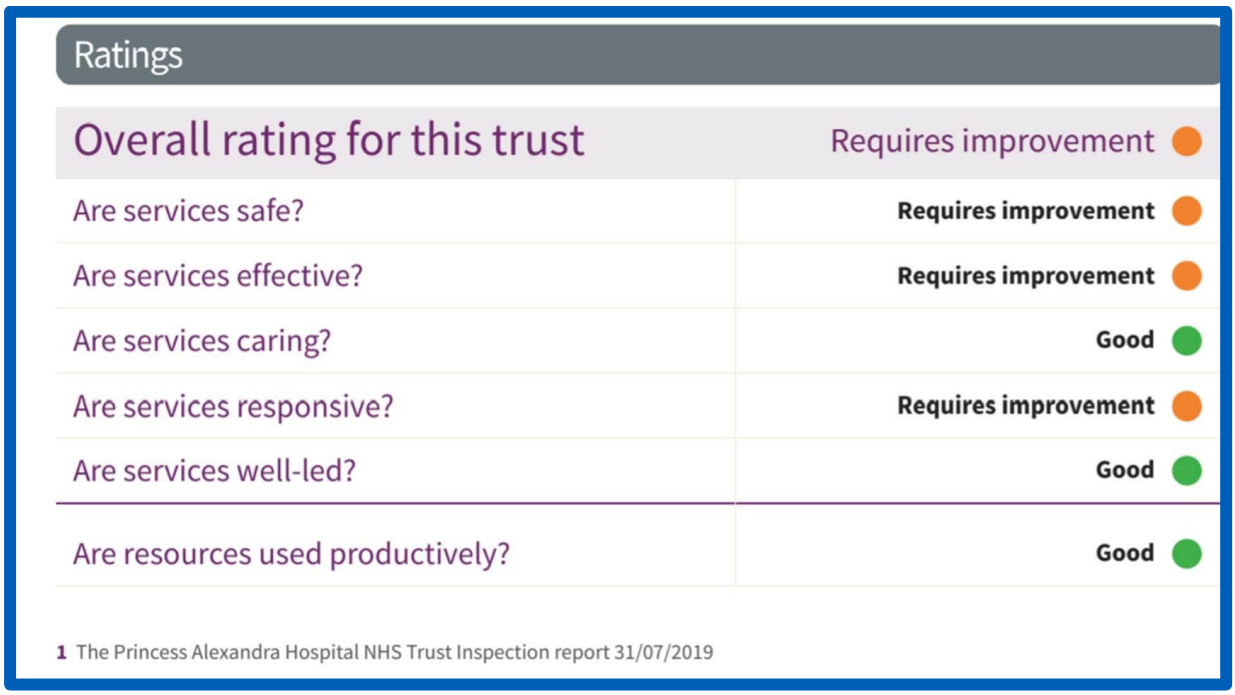
-Patient-

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.

The trust was inspected by CQC during March and April 2019 and the outcome of those inspections reported in July 2019 showed further improvements, with five of the trust's core services rated as **Good**. The trust received an **outstanding** rating for caring for children and young people. The overall quality rating for the trust remained the same; **requires Improvement**. However, the trust received an overall rating of **Good** for both the well-led assessment and also for the use of resources assessment.

The trust's current CQC ratings (based on the inspection report published on 31 July 2019) are reflected below:



Ratings	
Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good
Are resources used productively?	Good

1 The Princess Alexandra Hospital NHS Trust Inspection report 31/07/2019

In 2017 the trust developed a whole system approach to quality improvement. The quality first team works alongside the patient safety and quality department which is aligned to quality governance and patient safety. 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

The quality first team defines their purpose as:

'Inspiring our people to put quality first for the benefit of our patients, staff and wider community by building confidence and capability in quality improvement'

The team is led by a senior doctor, nurse and manager and work alongside 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.

Our patients are our most important partners. 'Co-production means that we are there at the beginning, we are sitting at the table as an equal, and we will contribute to the decision about whether something is needed or not' (Ann Nutt, Chair of Patient Panel). For co-production to become part of the way we work, we have created a culture where the following values and behaviours are the norm:

- ownership, understanding and support of co-production by all
- a culture of openness and honesty
- a commitment to sharing power and decision making with patients, families and community
- clear communication in plain English
- a culture in which people are valued and respected

The improvement partnership

The 'Improvement Partnership' is our programme 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:

The improvement partnership is an enabler addresses the leadership, culture and organisational development required to embed quality improvement at PAHT.

Our highest quality improvement priority

A key focus has been on improving the trust's mortality rate. Programmes of work have been developed and the quality improvement methodology is embedded into practice and approach.

Celebrating success

For two consecutive years PAHT have won champion organisation at the annual academy of fabulous stuff national awards. In January 2020 the trust became the second hospital in the country to be formally accredited by the Academy of Fabulous NHS Stuff. It is a testament to the energy and effort of teams across the hospital that our work to continually improve the quality of our services has been recognised nationally.

A number of notable highlights of the year include:

Event in a Tent quality improvement day - 25 September 2019

On Wednesday 25 September the quality first team joined forces with colleagues from across the organisation to facilitate a quality improvement day during Event in a Tent.

The day was an opportunity to share and celebrate the fantastic quality improvement work taking place at PAHT. The day started with a poster celebration event showcasing all of the quality improvement projects at PAHT. Following this, there was a celebratory event to congratulate all of our new Improvement Partners at PAHT. The afternoon kicked off with a quality improvement café, a fun and interactive speed dating style session with 9 teams from across PAHT demonstrating how they can help support staff in their roles across the organisation. The final part of the day was ideas worth sharing, 8 inspirational short talks from various speakers such as Chris Pointon (#Hellomynameis), Roy Lilley and Terri Porrett (Academy of fabulous stuff), as well as Lance McCarthy, PAHT chief executive officer. The day was a huge success.

Fri-QI-Day - 6 September 2019

Fri-QI-day was established on 6 September 2019 as an opportunity to get together every two weeks and discuss all things quality improvement. The sessions are working well and offer a peer support network to strengthen junior doctors' involvement and leadership in the delivery of quality improvement with assistance and support from the quality first team.

World Sepsis Day - 13 September 2019

On the 13 September, the trust recognised and celebrated World Sepsis Day. The day was a great opportunity to raise the awareness of Sepsis across the organisation to both patients and staff highlighting what sepsis is, the symptoms and treatment of Sepsis.

World Patient Safety Day - 17 September 2019

On Tuesday 17 September it was World Patient Safety Day organised by the World Health Organisation (WHO). The Princess Alexandra Hospital NHS Trust (PAHT) was keen to support the event to highlight its efforts and achievements in improving patient safety.

Clinicians and NHS hospital teams are committed to keeping patients safe, day in, day out and the aim of the national day is to urge them to demonstrate their commitment to making healthcare even safer. Through education, improved hygiene and awareness raising, the campaign aims to make patient care safer. The day was a great day to celebrate and share the achievements of patient safety at PAHT.

Fab Change Day - 16 October 2019

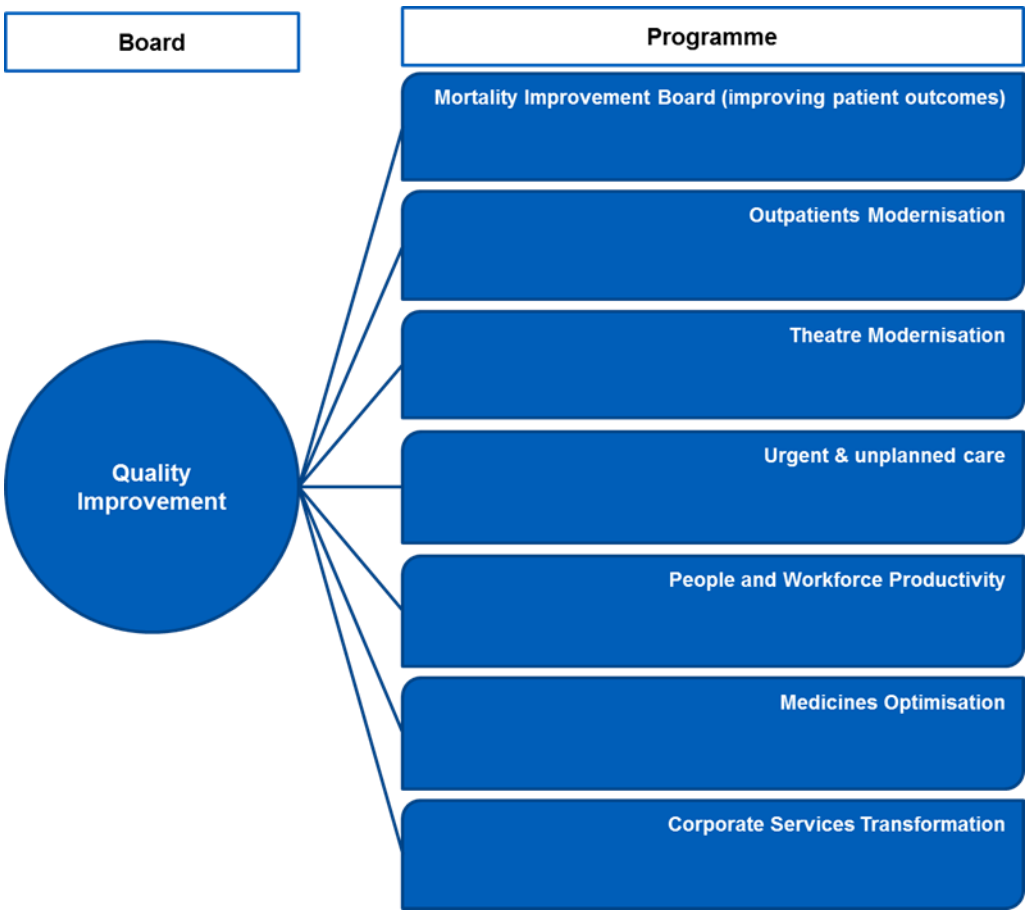
On the 16 October (fab change day) the quality first team manned the stands outside of the canteen showcasing the quality improvement project posters that staff had submitted for Event in a Tent in September, the posters showcased all of the outstanding quality improvement projects in place at PAHT.

Another focus of the day was to encourage staff to recognise a member of their team or wider staff at the trust who deserves a high 5 and recognition for all of their hard work.

It was a fabulous day seeing staff take time out of their busy roles to recognise, share and celebrate all of the outstanding work our teams are achieving here at PAHT.

Transformation programme

The trust has embarked on a number of transformation programmes with the goal of developing and delivering the change required to deliver outstanding healthcare to the community using the trust's quality improvement methodology. There are seven transformation programmes aligned with the trust's strategic objectives and the cost improvement programme (CIP) for 2020-21.



All projects operate within a defined framework of roles and responsibilities, having executive directors as accountable officers as well as clinical sponsors working alongside work stream and project leaders who are responsible for the day-to-day project activity.

The quality first team are working with the healthcare groups, executive team, corporate teams, and senior management and system partners to ensure delivery of this programme aligns to PAHT's quality improvement strategy (2019-2022).

The following four measures have been identified as key determining factors for 'success criteria' against the quality improvement strategy i.e. if the goals are achieved, the strategy will have been a success. It is recognised and understood that the delivery of healthcare can be complex and multifactorial, and the work associated with delivering the quality improvement strategy will not be the only factors that dictate success.

ID	Description	Source	Goal
1	Mortality rates (HSMR)	Dr Foster HSMR	Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.
2	Length of Stay	Dr Foster average non-elective length of stay for each specialty	Achieve national average (or better) across each of the specialities by March 2021 and to be sustained.
3	Annual Patient experience survey	Survey results, Q68 – overall experience (inpatient, outpatient and A&E)	Achieve top quartile by March 2022.
4	Harm	Information team	Achieve top quartile against National Reporting Learning System (NRLS) March 2022.

Dr Foster, Model Hospital and GIRFT tools and analysis will be used to benchmark throughout life time of quality improvement strategy.

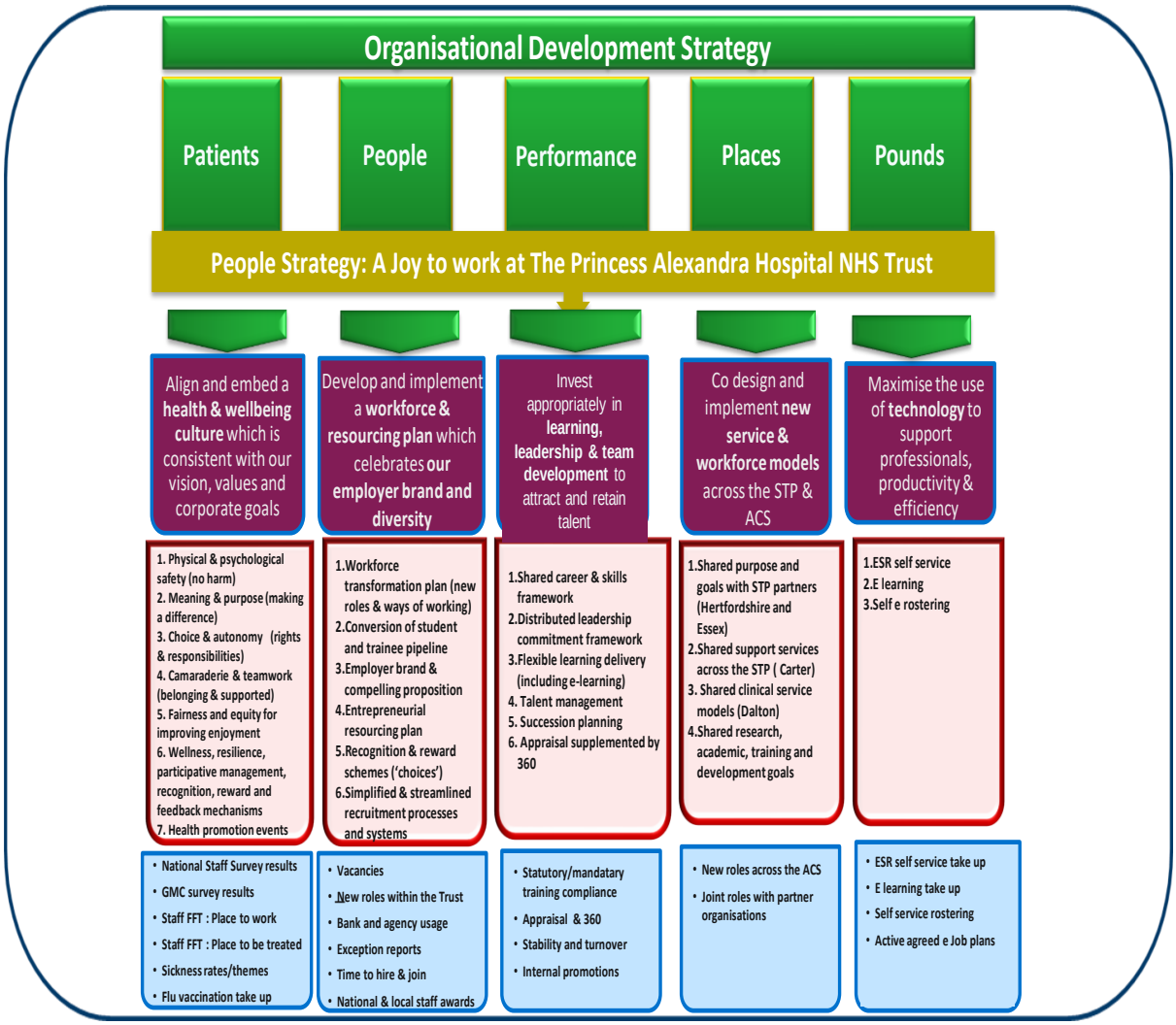
People performance

In 2019-20 overall vacancy rates continued to reduce with notable improvements in recruitment and retention processes as well as time to hire. We have also seen an increase in our “grow our own” initiatives with the start of the new four year nursing degree apprenticeship programme as well as exceeding our required 25%+ clinical placement capacity expansion target for new student nurses (adult and child) and midwives. We have now welcomed over 60%+ additional first year students into the trust to complete their training.

People KPI	2019-20 target	Year to date performance
Vacancy rate	8%	8.6%
Sickness absence	3.7%	4.3%
Voluntary turnover	12%	10.7%
Statutory and mandatory training	90%	92%
Appraisal	90%	89%
Flu	80%	80.1%
Time to hire	31 days	Average 42 days

The diagram below summarises the outputs that form our people framework and clarifies the five key pillars of the people strategy which are as follows:

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



Throughout 2019-20 the people directorate have aligned work streams to the five pillars and have delivered the following:

- We undertook an ambitious medical and nursing recruitment programme, both domestic and international which saw our overall nursing vacancy rate reduce from 40% to 10% in 2019-20 bringing the overall trust vacancy rate down to 9.8%
- Our talent management programme cohort 1 commenced in November 2019.
- Our equality and diversity steering group is fully established with a focus on a specific protected characteristic each month
- We established an integrated musculoskeletal service with partner organisations
- Exceeded our flu target for 2019-20 with 80% of our front line staff having the flu vaccine
- Achieved core statutory and mandatory training compliance of 93%
- 80 apprentices work across the organisation
- "Event in a Tent" held for the third year to celebrate our amazing people
- Increased our mental health first aiders to 26, with plans to build on this in 2020

- Maximised efficiencies within our roster systems and now rolling out to non-clinical areas of the trust
- Our first group of 10 ‘home grown’ registered nurses commenced work in March 2020
- 3 new graduate management trainees joined the trust in March 2020
- Increased our provision of leadership and management development programmes, including the introduction of an induction programme for new managers, covering HR and operational requirements
- Coordinated over 200 work experience placements for local students interested in NHS careers
- Organised and hosted the 2019 health careers expo, with almost 600 attendees from local schools and colleges

Culture health and wellbeing

The objective is for The Princess Alexandra Hospital NHS Trust to lead on **joy at work** and have a positive impact on the **health and wellbeing** of our staff team**.**

During 2019-20 we continued to embed a culture of health and wellbeing consistent with our values and ran a number of events supported by the equality and diversity steering group, this included International Men’s day and World Religion Day. A number of mental health events also took place throughout the year

We continued to recognise and celebrate the great work of our staff with awards ceremonies both locally and trust wide, long service awards for staff who have worked for the trust for 20 years or more and Our Amazing People programme which highlights the achievements of our staff through various communications channels throughout the hospital. All of which were celebrated at the trusts annual Event in a Tent.

We developed our culture and leadership programmes over the last year with our “in my shoes” programme which included unconscious bias training and was delivered to both managers and staff across the organisation. 250 supervisors, /managers and leaders have attended this training so far with a further 100 booked to attend by end of March 2020.

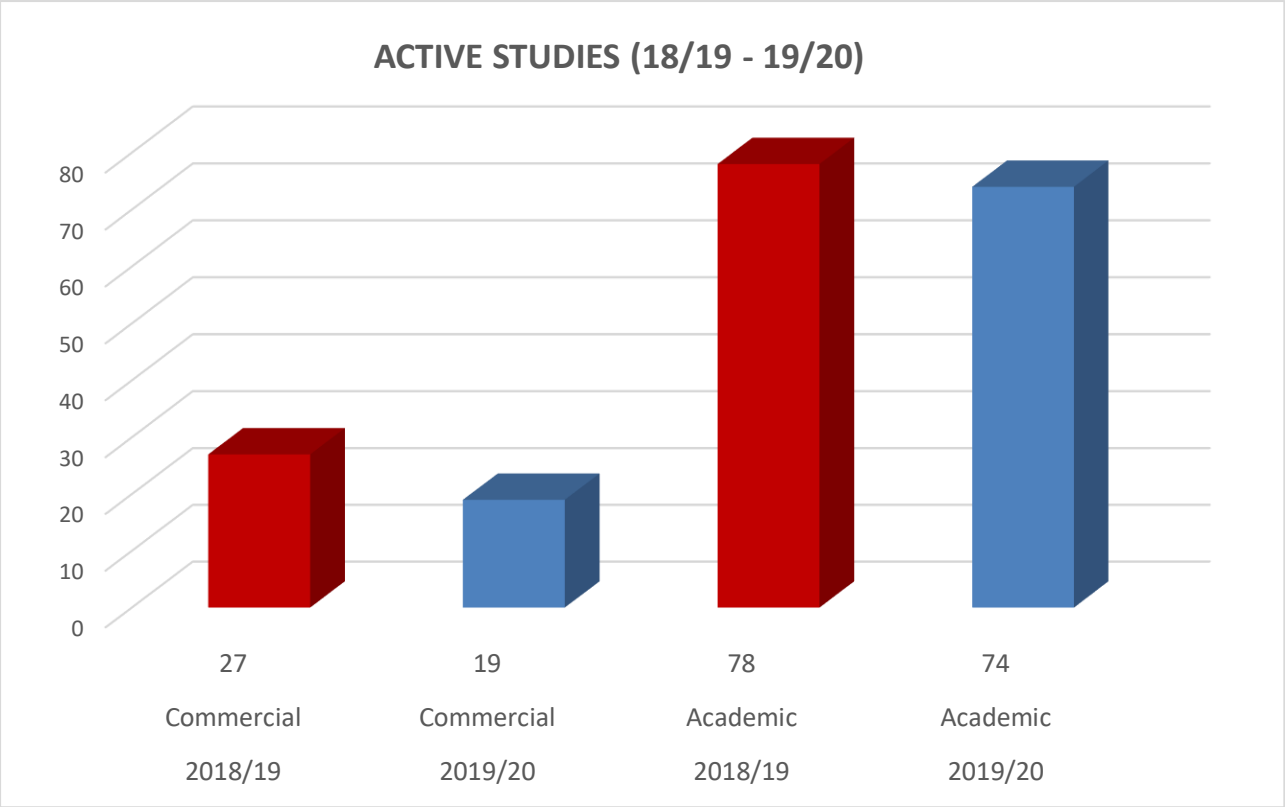
Staff engagement

We continued to drive improvement in staff experience using our staff survey results; this is an ongoing programme of work and will continue throughout 2020/21 via local staff experience groups, the staff engagement group and staff council.

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.



There was a significant drop in commercial activity in 2019-20 for several reasons including:

- The availability of commercial trials that were feasible for the trust to participate in.
- Several studies closed in year, as expected and replacement studies were paused due to the Covid-19 outbreak.

Recruitment target

The North Thames Clinical Research Network did not set a target for recruitment of participants into National Institute for Health Research (NIHR) portfolio adopted trials in 2019-20. This was as a result of budget cuts. As of 11 March 2020, the number of participants recruited into research at PAHT was **501.**

Recruitment by speciality

Recruitment	Speciality	Directorate	Commercial/ non commercial
Portfolio activity			
48	Cancer	CCCS	Non-commercial
126	Gastroenterology	Medical	Non-commercial
17	Respiratory	Medical	Non-commercial
43	Cardiology	CCCS	Non-commercial
3	Dermatology	Medical	Non-commercial
13	Rheumatology	Medical	Non-commercial
11	Ophthalmology	Surgery	Non-commercial
110	Maternity	FaWs	Non-commercial
17	Surgical	Surgery	Non-commercial
41	Anaesthetics	Surgery	Non-commercial
1	Infection, Prevention and Control	CCCS	Non-commercial
28	Emergency	Medical	Commercial
36	Urology	Surgery	Commercial
3	Cancer	CCCS	Commercial
2	Rheumatology	Medical	Commercial
2	Dermatology	Medical	Commercial

Good news stories

OPTIMA trial

We were recognised by the sponsors of this non-commercial breast cancer trial due to our significant increase in recruitment. By the end of 2019, PAHT were ranked the 16th highest recruiting site internationally, out of 100 sites in total.

Penthrox PASS Trial

This commercial emergency study, evaluating the risks from administration of Methoxyflurane (Penthrox) for pain relief, closed to recruitment in 2019. PAHT are pleased to have recruited a total of 333 participants – over 100% of its target.

Study 15

PAHT were the highest recruiting smaller site for this non-commercial cancer study.

REACH: pregnancy circles study

PAHT was recognised as one of the fastest sites to open to recruitment by the sponsors of this non-commercial maternity study. The trust was recognised as having recruited the 1000th patient study-wide.

QIST study

PAHT are now top of the study leader board for data entry as a result of entering 100% of follow-up data required.

Improving our estate

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.

The approved capital programme for 2019-20 included schemes to the value of over £11m. The programme is made up of three key elements:

- Capital investment schemes - £3.5m
- Backlog maintenance - £2.1m
- Emergency backlog maintenance - £5.4m

The trust has a number of capital investment schemes under development including one for an urgently needed medical assessment unit.

The trust secured office accommodation at Kao Park, enabling the relocation of some non-clinical staff to modern off-site accommodation.

This project is an opportunity to address the wider accommodation issues the trust is facing whilst allowing modernisation and co-location of our workforce.

During 2019-20 works commenced to build a new fracture clinic (repatriation of services from the Herts and Essex hospital) with a build programme from April 2019 with planned completion in July 2020.

In 2019-20 the trust addressed the following areas of backlog maintenance:

- **Theatres air handling units – critical function chiller replacement works**

  This scheme was part of an ongoing project that commenced in 2018-19 with final commissioning of the plant in late November 2019. This project has resolved concerns with theatre temperature controls which need to be constantly monitored and managed manually.

- **Generator – North side installation**

  A generator has been installed with final testing completed in July 2019. The installation provides site resilience and a backup facility for the existing generator set.

- **ITU refurbishment and HTM ventilation system**

  This project was initially to be a relatively simple upgrade of the ward space however, on starting the work it was established that the entire air handling system needed replacing. The scheme was delayed as a result, however, despite a challenging programme, the facility was opened before the official commencement of 'winter pressures'.

Sustainability

To ensure NHS trusts are delivering high quality health care service with minimal negative impact on the environment, the Sustainable Development Unit (SDU) in association with NHSI instituted the Sustainable Development Management Plan (SDMP) outline to guide and to enable trusts evidence their commitments to sustainability. In compliance with the SDMP guidance and to fulfil our moral responsibilities the trust board approved its SDMP (2018-2020) which set out the key measures and actions that enable the trust to contribute to global sustainability goals and the NHS target to reduce carbon emission by 28% by 2020 (from 2013 baseline).

Our sustainability achievements 2019-20

The trust is able to report significant progress on its SDMP for the 2019-20 financial year. We achieved the key success measure (28% energy carbon footprint reduction by 2020) in 2019 and continue to undertake measures to further reduce our environmental impact and contribute towards achieving the UK Government's new net zero carbon emissions target and or carbon neutrality by 2050.

The trust placed emphasis on the following areas of its SDMP in 2019-20: energy, waste, water and purchasing.

Energy: The trust achieved its goal for energy related carbon emission in 2019-20; reduced building energy carbon emissions and complied with Environmental Agency's (EA) Carbon Reduction Commitment (CRC) regulation. To achieve this, the trust reduced its gas and electricity consumption by 24% and 3% respectively from 2018/19 usage levels. The total carbon emission from our energy consumption for this year was also reduced significantly to 5,364 (tCO_2) equivalent to 29.3% reduction from 2013 baseline of 7,588 (tCO_2). The set national target was achieved with circa £35k cost savings on our energy costs. To further reduce our energy consumption and carbon footprint, the NHSI funded Light-Emitting Diode (LED) lighting project works commenced as planned on the 29 January 2020 with a revised completion date of 30 April 2020 due to the COVID-19 pandemic.

Waste: The trust now has an approved waste management plan in place to enable compliance with HTM 07-01 recommendations and to ensure 100% of our waste is reused, recycled or reprocessed. This is in line with the trust's Sustainable Strategy to reduce waste and negative environmental impacts. The trust's waste carbon emission for 2019 is 16.4 tonnes.

Waste recycling efforts and process changes put in place have yielded positive results this year; we have sent 'zero waste' to landfill and recycled over 22% of our waste. This was achieved through segregating our waste into the below waste streams and sending the non-recycled waste for Energy from waste (EfW) incineration:

- Cardboard: baling of cardboard boxes
- Metal: using a separate receptacle for all metal waste
- Food waste: removing food waste separately for Anaerobic Digestion (AD)

Water: The trust's water portfolio use is approximately 150,000 m3 per annum (water, sewerage and trade effluent) equating to 60 tonnes of CO2 per annum. Water consumption has reduced by 5.63% since baseline.

The ongoing repairs and maintenance to plumbing and heating services across the site will help to further reduce water usage and the related carbon emissions.

Purchasing: The aim in the SDMP is to work collaboratively with our supply chain partners to fully integrate sustainable and ethical procurement practices into our supplies and procurement strategy, policy and processes for all goods and services.

We have recently formalised our energy contract and the source of our electricity as

specified the source of our electricity as 'renewable' (not fossil) sources; we will continue to specify environmentally friendly practises to our supply chain partners.

2020-2021 look ahead

In 2020-21 the trust will continue to explore all opportunities to deliver high standard healthcare services to our local communities with minimal negative impact to the environment. We will progress the successes made in our energy, waste, water and purchasing activities and ensure completion of the LED lighting project to actualise the projected carbon and cost savings from the project.

In addition, the trust will look into implementing its approved 'Green Travel Plan', Electric Vehicle (EV) infrastructure and carpooling projects to reduce the Trusts' travel carbon footprint.

The trust will further explore opportunities to replace single use plastic with suitable alternatives in compliance to the NHS plastic pledge.

There will be a concerted effort to ensure sustainability actions and trajectories are made visible to the staff through the intranet and other communication platforms.

The Trust will review its SDMP activities and timelines to align them to the new 'Green Plan' (formerly known as Sustainable Development Management Plan – SDMP) guideline introduced by the SDU, NHS England and NHSI in January 2020. The 'Green Plan' template is published to further guide NHS Trusts' endeavours in the fulfilment of NHS environmental targets and UK government's regulations; as well as ensuring services remain fit for purpose today and for the future.

Lance McCarthy
Chief executive officer

"A big thank you to all the staff who looked after my wife.

"From the moment she arrived by ambulance in A&E, to the Intensive Care Unit and finally the ward, she was cared for and looked after by so many fantastic, dedicated people.

"I cannot thank you enough."

-Patient's husband-

The Accountability Report 2019-20

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 2019-20

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	27.03.20
Stephanie Lawton	Chief operating officer	Y	02.03.16	Current
James McLeish	Director of quality improvement	N	01.04.16	Current
Sharon McNally	Director of nursing and midwifery	Y	01.10.18	Current
Ogechi Emeadi	Director of people, OD and communications	N	01.08.18	Current
Michael Meredith	Director of strategy	N	04.06.18	Current
Marcelle Michail	Acting chief medical officer	Y	30.03.20	Current
Non-Executive Directors:				
Steve Clarke	Chairman	Y	03.12.18	Current
Andrew Holden	Non-executive director (Chair of PAF until 01.01.20)	Y	01.01.15	31.03.20
George Wood	Senior independent director (Chair of Audit Committee)	Y	01.07.19	30.06.21
Pam Court	Non-executive director (Chair of CFC until 01.01.20 and Chair of PAF from 01.01.20)	Y	28.09.15	27.09.21
John Hogan	Non-executive director (Chair of QSC until 01.01.20 and	Y	01.08.17	31.07.20

	Chair of Strategy Committee from 01.01.20)			
Helen Glenister	Non-executive director (Chair of CFC until 01.01.20 and Chair of Quality and Safety Committee from 01.01.20)	Y	01.04.18	31.03.20
Helen Howe	Associate non-executive director (Chair of Workforce Committee from 01.04.20)	N	11.06.18	10.06.20
John Keddie	Associate non-executive director (Chair of Charitable Funds Committee from 01.01.20)	N	01.07.19	30.06.21

Attendance at board meetings

Number of board members present at board meetings in 2019-20:

	27.04.19	02.05.19	23.05.19	06.06.19	04.07.19	01.08.19	05.09.19	03.10.19	07.11.19	05.12.19	09.01.20	06.02.20	05.03.20
	Public & Private	Private Board	Extra-Ordinary Trust Board	Public & Private	Private Board	Public & Private	Private Board	Public & Private	Private Board	Public & Private	No meeting held	Public & Private	Private Board
Public	12/14	10/14	11/14	14/14	15/16	13/16	14/16	15/16	16/16	15/16		15/16	14/16
Private	12/14			14/14		14/16		15/16		15/16		15/16	

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 trust board to obtain assurance that high standards of care are provided by the trust and that adequate and appropriate governance structures, processes and controls are in place throughout the trust to enable it to deliver a quality service according to each of the dimensions of quality set out in High Quality Care for All and enshrined through the Health and Social Care Act 2012.

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 trust board on all aspects of workforce and organisational development and provide leadership and oversight for the trust on workforce issues that support delivery of the trust's annual objectives
- Assure the trust board that the trust has adequate staff with the necessary skills and competencies to meet both the current and future needs of the trust and ensure delivery of efficient services to patients and service users
- Assure the trust board that legal and regulatory requirements relating to workforce are met

Strategy Committee

The Strategy Committee is responsible for overseeing the development of the strategy to deliver the trust board's vision of PAH being an excellent provider of integrated acute care services. The purpose of the Committee is to establish a sustainable vehicle and model for acute care services in West Essex and East Hertfordshire and maintain oversight of its delivery and the trust's contribution to the system wide strategy as well as the trusts strategic ambition of delivery of a new hospital.

Charitable Funds Committee

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

Statement of board members' interests 2019-20

Name	Title	Interests/Memberships declared
Steve Clarke	Chairman	• Trustee and honorary treasurer of Dementia UK • Independent director, University of Suffolk
Andrew Holden	Non-executive director	• Board director, liaison financial services
Pam Court	Non-executive director	• Chief executive officer of Saint Francis Hospice
Helen Glenister	Non-executive director	• Chair of Accelerate CIC Limited • Vice Chair of Isabel Hospice
Helen Howe	Associate non-executive director	• Trustee of Addenbrooke's Charitable Trust • Honorary professor pharmacy/chairman of pharmacy pre-registration training advisory group (HEE funded) for East of England • Member UEA undergraduate Pharmacy advisory group • Associate/accreditation panel member for undergraduate pharmacy degrees and independent prescribing courses
John Hogan	Non-executive director	• Self-employed at private medical practice. • Consultant cardiologist at Barts Health NHS Trust • Director Whitfield Academy Trust
George Wood	Non-executive director	• Chairman of the King George's Hospital Charity
John Keddie	Associate non-executive director	• Governor, Anglia Ruskin University • Trustee, Anglia Trust • Chair, West Essex Enterprise Zone Board • Chair, Discover Harlow Board

		• Deputy Chair, London Stansted Cambridge Consortium
Lance McCarthy	Chief executive officer	• Trustee, NHS Providers
Trevor Smith	Chief financial officer	• No Interests declared
Ogechi Emeadi	Director of people, organisational development and communications	• Sister employed by Newham and Waltham Forest CCG • Brother-in-law employed by Highgate Surgery
Michael Meredith	Director of strategy and estates	• No interests declared
Sharon McNally	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 • Daughter is student nurse, Anglia Ruskin University
Andy Morris	Chief medical officer	• Member of East of England NHS Clinical Senate
Marcelle Michail	Acting chief medical officer	• No interests declared

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

Statement of director's responsibilities

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

The statement of accounting officer's responsibilities

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS trust development authority, has designated that the chief executive should be the

accountable officer of the trust. The relevant responsibilities of accountable officers are set out in the NHS trust accountable officer memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the trust
- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place
- 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 2020

The Princess Alexandra Hospital Annual Governance Statement 2019-20

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the trust during 2019-20. During the year, we continued to review and strengthen our governance arrangements and took into account the findings of our last CQC inspection together with continuing feedback and support from NHS England and 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 trust has received from the external auditors a qualified opinion on its financial statements in that the accounts present a true and fair view on the trust's financial position for the 2019-20 financial year.

The Trusts revenue outturn was £0.1m surplus after accounting for Financial Recovery Funds (FRF) and Provider Sustainability Fund (PSF). This compares to a £16.5m deficit in 2018-19.

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Princess Alexandra Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The

Princess Alexandra Hospital NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

The governance framework of the organisation

The governance framework describes the structure and systems that are in place for the direction and control of the Trust to fulfil the functions as set out in the Statutory Instrument 1994 No. 3179. These mechanisms include the board, its committees, management arrangements, governance manual and risk management strategy.

The trust board is responsible for making sure we provide safe, effective and compassionate care to our patients at the same time as supporting their families, relatives and carers. It does this by making the key decisions that affect our hospital and setting the values, aims and strategic direction for the trust.

It also reviews performance against our objectives, as well as against national standards and targets. It has overall responsibility for the effective control of the Trust and is accountable, through its chairman, to NHS Improvement and the Secretary of State for Health and Social Care. The trust board consists of:

- a chairman
- five voting non-executive directors and two non-voting associate non-executive directors
- five voting executive directors (chief executive officer, chief financial officer, chief medical officer, chief operating officer and director of nursing, Midwifery and AHPs) and three further executive directors without voting rights; the director of people, OD and communications, the director of strategy and the director of quality improvement.

In July 2019, the trust appointed one non-executive director and one associate non-executive director.

There was one change to the executive team in 2019/20; the chief medical officer was seconded to NHSE/I to support COVID-19 planning and the deputy chief medical officer (strategy) was appointed as the acting chief medical officer with effect from 30 March 2020.

Attendance at board and committee meetings throughout 2019/20 has been monitored and is recorded in the Annual Report.

The trust board has established the following committees to discharge its responsibilities in relation to Board assurance:

- Audit Committee
- Quality and Safety Committee
- Performance and Finance Committee
- Workforce Committee

- Strategy Committee
- Remuneration and Nominations Committee
- Charitable Funds Committee

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

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

Capacity to handle risk

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

I am responsible for ensuring that the trust is in a position to provide overall assurance that the organisation has in place the necessary controls to manage its risk exposure. In discharging these responsibilities I was assisted by the following directors during 2019/20:

- 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 for ensuring that information governance arrangements at the trust are suitable and is the trust's Senior Information Risk Owner (SIRO).
- The director of nursing, midwifery and AHPs 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 them. 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, organisational development 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 trust's transformation and modernisation programme as well as the quality first team and implementing the quality improvement strategy.
- The director of strategy has delegated responsibility for managing the development of the new hospital, the estates strategy and the capital programme for the trust.

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

All 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 healthcare 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 healthcare 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 BAF risks (scoring 20) throughout 2019/20 were the risks relating to our estate/infrastructure, delivery of the ED standard and our financial position. Further detail on these risks and their management is outlined in the annual report.

Following the annual review of the BAF 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, midwifery and allied healthcare professionals who, with the chief medical officer, ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. For any transformational change required, they are supported by the trust's quality first team.

Each of the trust's four healthcare groups has a patient safety and quality group where themes and trends from reviews of incidents and complaints and learning are reported.

Performance is reviewed at monthly performance review meetings and at the Quality and Safety Committee each healthcare group presents a quarterly overview of its performance on a rolling programme, in line with the CQC key lines of enquiry. Throughout 2019-20, the Quality and 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.

A review of the quality governance framework was undertaken in quarter 4 and a new structure for the meeting groups reporting to the Quality and Safety Committee was agreed and will be implemented during 2020-21.

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 2019-20.

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. To address this problem a trust wide Mortality improvement programme was established which utilised quality improvement methodology to deliver improvements in patient outcomes across a number of identified work streams. Medical examiners have been appointed and structured judgement reviews are undertaken. Quality and Safety Committee receives monthly reports on mortality and learning from deaths whilst the trust board receives an update at every public board meeting (held bi-monthly).

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. The vacancy rate for band five nurses has been a long standing challenge for the trust with a vacancy rate as high as 41% during 2018/19 however following an international nurse recruitment programme the overall vacancy rate reduced to 12.7% in February 2020 and to 8% in March 2020 with the band 5 vacancy rate at 4.3%. The objective of achieving a vacancy rate for qualified nurses of less than 10% by the end of 2019/20 has therefore been achieved.

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 2019-20.

Well-Led reviews

The board conducted a self-assessment against the CQC's well-led framework at a Board Development session in January 2020. An overall rating of 'Good' was assigned. The CQC rated the trust as 'good' for well-led.

Compliance with NHS provider licence

The trust completed self-assessments 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 annual self-declarations are undertaken and following the review undertaken in January 2020 full compliance was achieved and reported to the Workforce Committee in March 2020.

Developing workforce safeguards

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

- The integrated performance report (IPR) is received at each public trust board meeting and details a range of staffing metrics including vacancy rates, sickness absence, turnover, appraisal rates, friends and family test results, statutory and mandatory training compliance
- A workforce report is presented to the Workforce Committee bi-monthly where the metrics listed above are scrutinised
- The safer nurse staffing report is presented to the Quality and Safety Committee monthly and bi-monthly to the Workforce Committee and trust board; this details the actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff as well as providing an update on nursing vacancy rates, and in 2019-20, the plans to further reduce the vacancy rate to achieve the target vacancy rate.
- Trust board reporting is underpinned by monthly performance review reports which detail a range of performance indicators including vacancy rates, sickness absence, turnover, maternity leave, training and average absence
- Freedom to speak up guardians and guardian of safe working reports are presented to the trust board and Workforce Committee
- Electronic job planning processes are in place for medical staff
- Bi-annual nursing and midwifery establishment reviews are undertaken and reported to the Workforce Committee, Quality and Safety Committee and the trust board. The reviews utilise the Safer Nursing Care Tool (SNCT) for adult ward areas, the Baseline Emergency Staffing Tool (BEST) for the Emergency department and Birth rate plus for the maternity department
- The trust's workforce plan underpins the trust's annual operating plan which is reviewed by the Performance and Finance Committee and approved by the trust board
- The trust remains focussed on increasing and retaining its core nursing workforce, utilising new roles such as nursing associates, paramedics and physician associates whilst continuing to further develop and embed new workforce models. Working with our STP partners we will continue to explore opportunities for joint roles as we identify workforce models that support integrated working.

Managing conflicts of interest

The trust has published an up-to-date register of interests, including gifts and hospitality for decision-making staff within the past twelve months, as required by the managing conflicts of interest in the NHS guidance. The trust's Audit Committee monitors and approves the registers of interest.

Care Quality Commission

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

During March 2019, the CQC inspected six core services provided by the trust namely urgent and emergency care, medical care (including older people's services) surgery, maternity, children and young people's services and end of life care. The well-led inspection took place in April 2019. The overall rating assigned to the trust remained 'requires improvement'.

The use of resources assessment took place in March 2019 and the trust received a rating of 'good' for this assessment.

Following the CQC Winter Assurance visit on 3 February 2020, the CQC issued a Section 29a warning notice in relation to the following issues:

- The trust has still not taken enough action to ensure that records of care and treatment are clear, up to date and easily accessible
- GI bleed out of hour's rota – the trust has not taken actions to mitigate the risks associated with the lack of endoscopy services out of hours

In response to the warning notice the trust developed an action plan, delivery of which is being monitored by the Quality and Safety Committee on a monthly basis.

Key actions in relation to documentation include establishing an overarching documentation transformation task and finish group, reporting to Quality Improvement Board and the Emergency Department has established a documentation improvement working group. In relation to the GI bleed out of hour's rota, the trust continues to work towards gaining support for an agreed an out-of-hours service level agreement through:

- immediate agreement in principle regarding out-of-hours emergency transfer to a tertiary centre
- discussion to formalise this through an SLA, with meetings scheduled to progress

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, performance and finance committee and/or trust board. The performance and finance committee reviews productivity, operational and financial performance and use of resources both at trust and healthcare group level.

The trust was rated 'good' following the use of resources assessment in March 2019. More details of the trust's performance and some specific trust projects aimed at increasing efficiency are included in the annual report. The trust's external auditors are required to consider whether the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee.

Information governance/data security risks

The trust has reported two Information Governance (IG) data security breaches to the Information Commissioners Office (ICO) during 2019/20 and both have been closed.

The first breach occurred due to human error; eleven patient letters were sent out with each of the eleven patients receiving all eleven letters. The ICO has investigated and closed this incident with no further action taken.

The second breach related to accessing patient records in breach of trust policy. Elements of this incident are still being investigated but the ICO has closed the IG incident with no further action taken.

Elective waiting time data

Patients who have been referred to the trust on a cancer waiting time or Referral to Treatment (RTT) pathway are managed daily by the clinical and operational teams, in line with the hospital's access policy.

These pathways are reviewed at weekly Patient Tracker List (PTL) meetings, chaired by the head of performance and planning 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 head of performance and planning or the chief operating officer. The access board also reviews RTT data quality reports and determines required actions to ensure that processes maintain accurate data recording.

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 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:

- Patient transport
- Estates compliance (planned preventative maintenance)

The trust's internal auditors undertook a detailed follow up exercise of the recommendations in relation to the 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 (HoIA) opinion on the effectiveness of the system of internal control for the year ended 31 March 2020:

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.

My opinion is set out as follows:

1. Overall opinion
2. Basis for the opinion
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 2020 (and beyond); these issues are also reflected on the Board Assurance Framework:

Operational performance – A&E standard

The trust has struggled to deliver against this standard throughout the year. Year to date the trust achieved 79.7%. We have also continued to see an increase in attendances to the Emergency Department, with an increase of nearly 6% in attendances compared to the same period in 18/19, and an increase of over 10% compared to 17/18.

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

The Trusts revenue outturn was £0.1m surplus after accounting for Financial Recovery Funds (FRF) and Provider Sustainability Fund (PSF). This compares to a £16.5m deficit in 2018-19. Key elements of the financial results included:

- Delivery of the cost improvement target of £10m.
- Temporary staffing costs of £35.1m (agency £10.9m, bank £24.2m).
- Move towards block contract arrangements with an allocative contract formally established with West Essex CCG. Additional funding flows covering winter pressures, Covid-19 costs and additional activities.
- Eligibility to earn additional Financial Recovery Fund and Provider Sustainability funding of £28m from delivery of financial performance targets.

The Trust invested £17.3m in its estates, facilities, equipment and technology improvements a 50% increase from the £11.9m investment in the prior year.

The Trust is looking to build upon the significant progress made in the last financial year. This includes an unqualified Value for Money opinion for the 2018/19 Accounts and securing 'Good' for its Use of Resources assessment.

The Trust has set an Interim Budget for 2020/21 in light of the adapted financial regime associated with Covid-19. The Trust will be tracking and managing its resources closely to ensure full cost recording and recovery for its pandemic response, both in terms of operational spend and capital investment. Its focus will remain on cost control and temporary staffing reductions together with quality and cost improvement. A very significant and successful international nurse recruitment programme in 2019/20 has much improved nurse vacancy rates at the Trust, nursing levels across the wards whilst also providing the potential to reduce its reliance on both bank and agency staff going forward.

The Trust also continues to work actively with its health and care partners within the Local Integrated Care Partnership and broader Integrated Care System. Key areas of activity currently include the response to Covid-19 and the development of recovery plans, this is in addition to the integration of its services for patients and users and, where appropriate, the development and consolidation of support services.

The Trust is part of the National Health Improvement Programme (HIP) Phase 1 and is urgently progressing its Outline Business Case for a New Hospital Development for 2025. It is also seeking to progress the consideration of its major Clinical Information System, its Electronic Patient Record.

Having delivered its first operating surplus since 2012/13 and having increased its capital investment significant across recent years, the Trust clearly has significant further opportunities and potential to take these successes forward and significantly build upon.

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 includes 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. On 29 September 2019, the Prime Minister announced that The Princess Alexandra Hospital NHS Trust would receive the capital funding required to build a new hospital,

with the expectation that this is completed by 2025. However we still need to deliver high quality, efficient services from the current estate for at least the next 5 to 10 years.

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 2020)

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 2019-20 was £235k-£240k (2018-19, £235k-£240k). This was 10.5 times (2018-19, 10.9 times) the median remuneration of the workforce, which was £23k (2018-19, £22k)
- In 2019-20, no employees received remuneration in excess of the highest paid director (this was the same in 2018-19). Remuneration ranged from the bands £0k-£5k to £235k-£240k (2018-19 £0k-£5k to £235k-£240k)
- 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

2019-20 total expenditure on consultancy and professional services was £3,532k (2018-19 £1,912k).

Employee benefits and staff numbers (subject to audit)

Employee benefits

Gross expenditure	Permanently employed	Other	2019-20 Total	2018-19 Total
	£000's	£000's	£000's	£000's
Salaries and wages	124,549	407	**124,956**	114,601
Social security costs	12,319	0	**12,319**	12,045
Apprenticeship levy	605	0	**605**	566
Employer's contributions to NHS pensions	21,144	0	**21,144**	13,467
Pension costs - other	35	0	**35**	21
Temporary staff	0	35,865	**35,865**	29,182
Total employee benefits	**158,652**	**36,272**	**194,924**	**169,882**
Less: Employee costs capitalised	1,068	726	**1,794**	1,250
Gross employee benefits excluding capitalised costs	**157,584**	**35,546**	**193,130**	**168,632**

Average staff numbers

	Permanent Number	Other Number	2019-20 Total	2018-19 Total
Medical and dental	474	89	**563**	501
Ambulance staff	0	0	0	4
Administration and estates	580	37	617	528
Healthcare assistants and other support staff	370	52	422	787
Nursing, midwifery and health visiting staff	860	169	1,029	910
Nursing, midwifery and health visiting learners	405	105	510	461
Scientific, therapeutic and technical staff	240	0	240	80
Healthcare science staff	0	0	0	14
Social care staff	80	0	80	0
Other	138	1	139	108
Total	3,147	453	3,600	3,394
Staff engaged on capital projects (included in above)	21	13	34	22

Note: In 2019/20 an additional category of social care staff was identified.

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.

Staff sickness absence data can be accessed via NHS Digital using the following link: NHS Digital Staff Sickness Data

Ill Health Retirements	2019-20	2018-19
	Number	**Number**
Number of persons retired early due to ill health grounds	3	0
	£000s	**£000s**
Total additional pensions liabilities accrued in the year	151	0

Reporting of compensation schemes - exit packages 2019-20 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	0	0	**0**
£10,000 - £25,000	0	0	**0**
£25,001 - £50,000	1	0	**1**
£50,001 - £100,000	0	0	**0**
£100,001- £150,000	0	0	**0**
£150,001 - £200,000	0	0	**0**
> £200,000	0	0	**0**
Total	**1**	**0**	**1**
Total resource cost (£)	£44,000	£0	**£44,000**

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 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**

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

	2019-20		2018-19	
	Agreements	**Total value of agreements**	Agreements	Total value of agreements
	Number	**£000's**	Number	£000's
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Total	**-**	**-**	-	-

Off payroll arrangements

No individual holding a Board position was paid directly through an associated limited company. During 2019-20 there were no executive posts covered by off-payroll arrangements. The trust had no off-payroll engagements as of 31 March 2020, and there were no new engagements during the period 1 April 2019 to 31 March 2020.

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

		2019/20				2018/19			
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
Steve Clarke[1]	Chairman	All Year	35 - 40	4,500	35 - 40	03.12.18 - 31.03.19	15 - 20	2500	15 - 20
Andrew Holden	Non-Executive Director	All Year	5 - 10	1,900	5 - 10	All Year	5 - 10	1600	5 - 10
James Anderson	Non-Executive Director	-	-	-	-	-	-	200	0 - 5
Pam Court	Non-Executive Director	All Year	5 - 10	200	5 - 10	All Year	5 - 10	-	5 - 10
Stephen Bright	Non-Executive Director	-	-	-	-	01.04.18 - 02.10.18	0 - 5	200	0 - 5
Dr John Hogan	Non-Executive Director	All Year	5 - 10	-	5 - 10	All Year	5 - 10	-	5 - 10
Helen Howe	Associate Non-Executive Director	All Year	5 - 10	1,400	5 - 10	11.06.18 - 31.03.19	0 - 5	300	5 - 10
Dr Helen Glenister	Non-Executive Director	All Year	5 - 10	1,000	5 - 10	All Year	5 - 10	1400	5 - 10
John Keddie	Non-Executive Director	01.07.19 - 31.03.20	5 - 10	300	5 - 10	-	-	-	-
George Wood	Non-Executive Director	01.07.19 - 31.03.20	5 - 10	-	5 - 10	-	-	-	-

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

Table of salaries - executive directors (subject to audit)

		2019/20				2018/19			
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	190 - 195	45 - 47.5	235 - 240	All Year	180 - 185	90 - 92.5	270 - 275
Sharon McNally	Director of Nursing and Midwifery	All Year	120 - 125	112.5 - 115	230 - 235	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
Dr. Andy Morris[1]	Chief Medical Officer	01.04.2020 - 30.03.2020	235 - 240	90 - 92.5	325 - 330	All Year	235 - 240	5 - 7.5	245 - 250
Marcelle Michail[2]	Interim Chief Medical Officer	30.03.2020 - 31.03.2020	0 - 5	-	0 - 5	-	-	-	-
Trevor Smith	Chief Financial Officer	All Year	145 - 150	7 - 7.5	150 - 155	All Year	140 - 145	-	140 - 145
Stephanie Lawton	Chief Operating Officer	All Year	130 - 135	0 - 2.5	135 - 140	All Year	130 - 135	20 - 22.5	150 - 155
James McLeish	Director of Quality Improvement	All Year	105 - 110	2.5 - 5	110 - 115	All Year	105 - 110	10 - 12.5	115 - 120
Michael Meredith	Director of Strategy	All Year	115 - 120	25 - 27.5	145 - 150	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

		2019/20				2018/19			
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**
Ogechi Emeadi	Director of People, Comms & OD	All Year	115 - 120	42.5 - 45	160 - 165	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

1. £130k of the salary within the total £235k-240k salary banding disclosed for Dr Andrew Morris, Chief Medical Officer, is for their clinical role. (2018-19 £128k of the total £235k-£240k salary of Dr Andrew Morris was for their clinical role).
2. Salary disclosed relates to secondment into CMO role, full salary for 19/20 falls into banding £165k - £170k.

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 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value (CETV)	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
Lance McCarthy[2]	2.5 - 5	0 - 2.5	60 - 65	130 - 135	950	70	1,020	0
Dr Andy Morris[2]	5 - 7.5	2.5 - 5	105 - 110	255 - 260	2022	142	2,164	0
Stephanie Lawton[1,2]	0 - 2.5	(5) - (2.5)	45 - 50	105 - 110	786	23	809	0
James McLeish	0 - 2.5	0 - 2.5	25 - 30	75 - 80	562	32	594	0
Michael Meredith[2]	0 - 2.5	0 - 2.5	10 - 15	20 - 25	161	31	192	0
Ogechi Emeadi[2]	2.5 - 5	0 - 2.5	40 - 45	95 - 100	745	59	804	0
Sharon McNally	5 - 7.5	15 - 17.5	45 - 50	145 - 150	902	143	1,045	0
Trevor Smith[2]	0 - 2.5	(5) - (2.5)	60 - 65	150 - 155	1207	39	1,246	0
Marcelle Michail	(2.5) - 0	(5) - (2.5)	50 - 55	125 - 130	1088	9	1,097	0

1. Member entered into lease car salary sacrifice arrangement during the year which reduced pensionable pay for benefit calculation
2. Real increase to lump sum may be low/zero or negative as now a member of 2008/2015 scheme which does not provide automatic lump sum.

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.

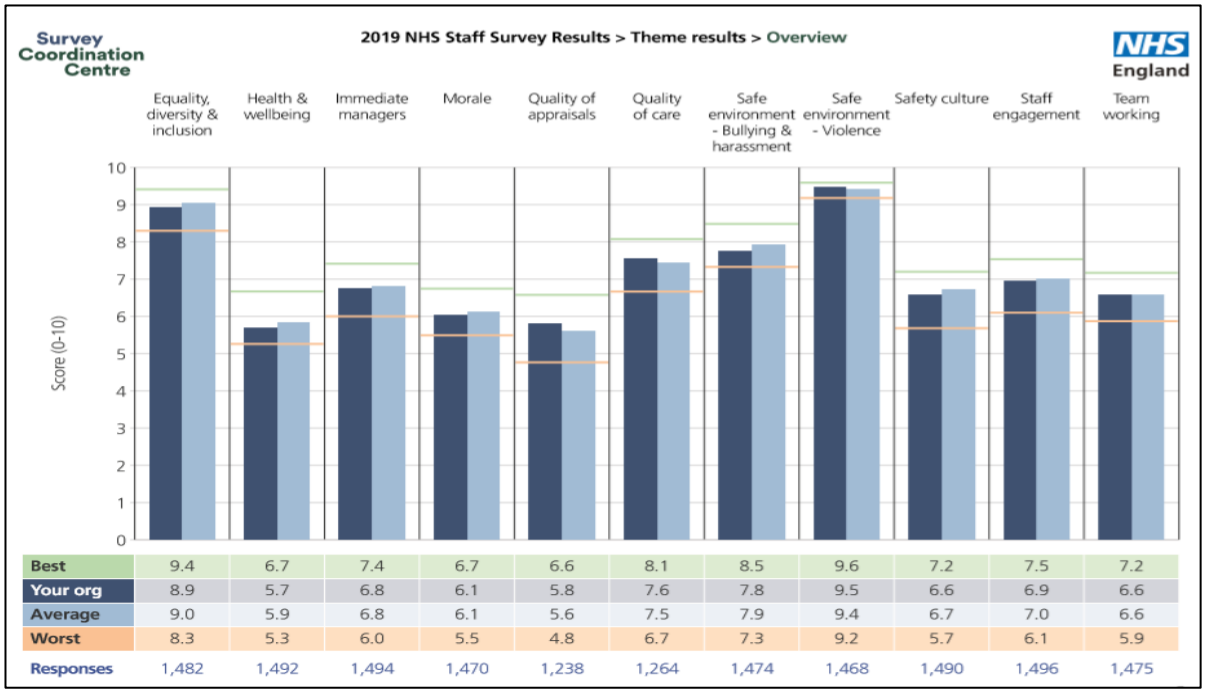
Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and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

The National NHS staff survey

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

A full census was held in the trust between October and November 2019 with all our people employed on 1 September 2019 having the opportunity to take part. In total 1520 (45%) completed and returned their survey questionnaire, which was 5% higher than 2018, and 2% lower than the average acute trust response rate (there are 85 acute trusts within the benchmark group).

The table below summarises the survey results by the key national themes, benchmarked against the 85 acute trusts.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.9	5.7	6.8	6.1	5.8	7.6	7.8	9.5	6.6	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	1,482	1,492	1,494	1,470	1,238	1,264	1,474	1,468	1,490	1,496	1,475

The full findings report of the 2019 NSS were presented to the workforce committee in March 2020 and to full trust board in April 2020. A series of action plans are being developed by each of the health care groups to address those areas most requiring improvement, which will align to three priority actions identified by the trust:

Priority one: Improving the physical and mental health and wellbeing of our people

Priority two: Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon (improving psychological safety)

Priority three: Improving the quality and effectiveness of line management skills

These are 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.

Staff friends and family test results

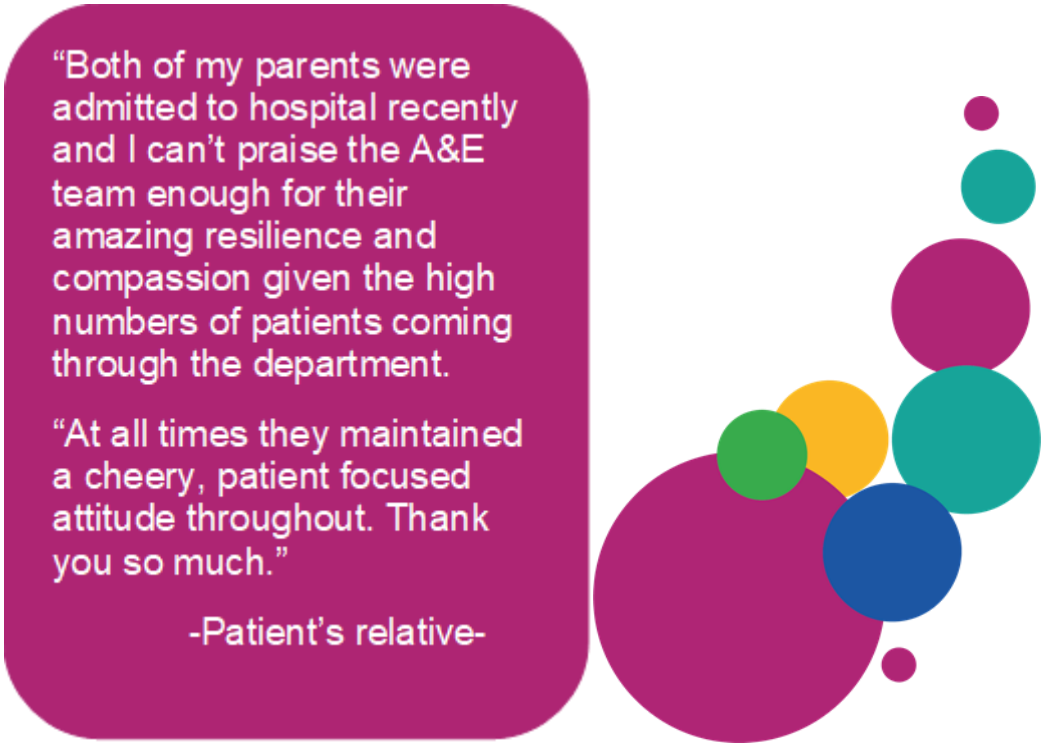
Since April 2014, the quarterly Staff Friends and Family Test (SFFT) has been carried out in all NHS trusts, and are seen as a crucial barometer of how our people view their workplaces. The SFFT is helping to promote a significant cultural shift across the NHS, encouraging our people to have both the opportunity and confidence to speak up, and ensuring their views are increasingly heard and then addressed.

Research has shown a clear relationship between staff engagement and both individual and organisational measures, such as staff absenteeism and turnover, patient satisfaction and mortality; and safety measures, including infection control rates. The more engaged our people are, the better the outcomes for our patients and the organisation generally. It is, therefore, important that the trust strengthens our people's voice, as well as our patients' voice.

On a quarterly basis (quarter 3 is included within the NSS and the questions are slightly different) our people are asked to respond to a short survey. The 2019 results to the two key national questions are shown below:

National SFFT Questions	National Target %	Q4 2019	Q1 2019	Q2 2019	Q4 2020
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	67%	75%	75%	78%	75%
How likely are you to recommend this organisation to friends and family as a place to work?	61%	62%	65%	65%	61%

Actions taken from the SFFT results are fed into the health care group NSS action plans.



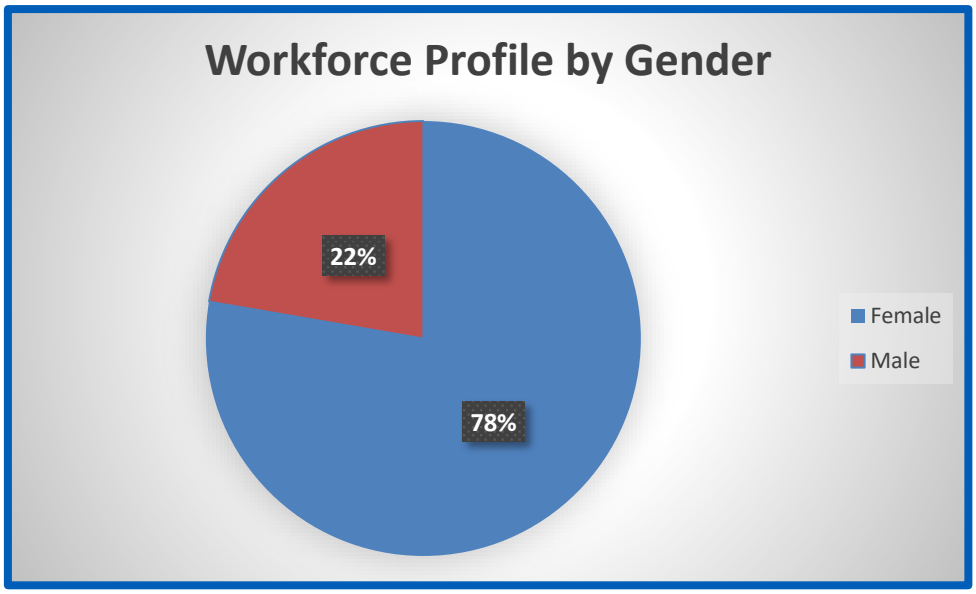
Our staff breakdown

2019-20 staff composition	Male	Female
Executive directors	5	3
Other employees	823	2884
Total	**828**	**2887**

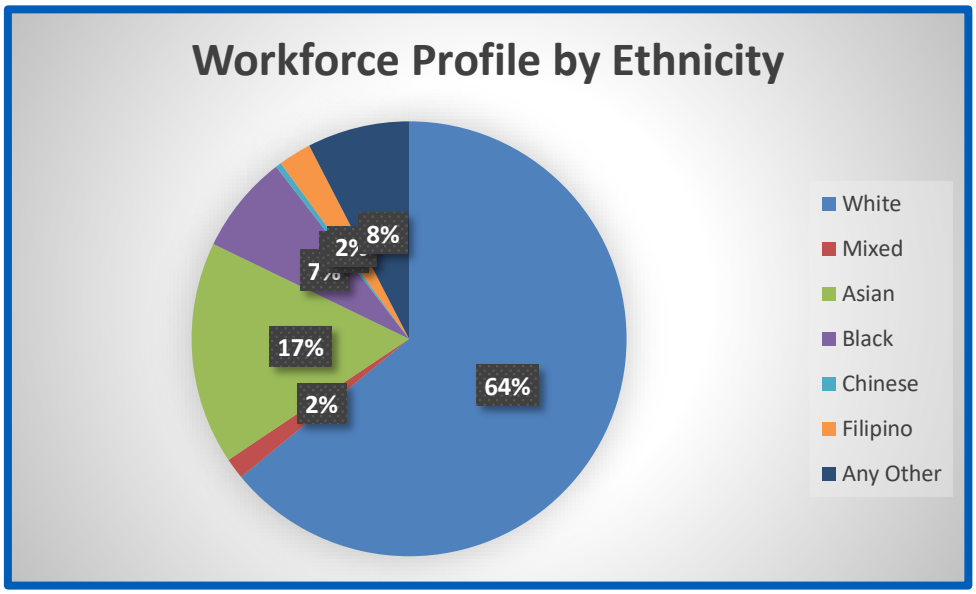
Turnover rate

Turnover rate	2018-19	2019-20
Overall staff turnover	16.82%	12.96%
Voluntary turnover	13.61%	10.74%

Our workforce – gender profile



Our workforce – ethnic profile



Equality and diversity: significant achievements during 2019-20

The equality, diversity and inclusion steering group meets monthly to review activities and initiatives to promote and support awareness and education of equality, diversity and inclusion within the trust. The group has widened its membership to ensure there is greater representation across healthcare groups and job roles. Diversity champions have been identified to be advocates of the nine protected characteristics identified in the Equality Act.

The group agreed a calendar of events for 2019-20, covering the 9 protected characteristics throughout the year. Some activities focussed on celebrations, others on awareness and education. These events have included:

- Highlighting disability issues with staff in a series of well attended interactive sessions held during the September staff event, Event in a Tent.
- Black History Month was celebrated in October 2019, involving a diversity event for each week of October.
- Celebration of International Men's Day in November 2019 and International Women's Day in March 2020, including social media campaigns.
- During January 2020, World Religion Day was celebrated with an awareness event for staff. The trust also facilitated an awareness event and memorial service on International Holocaust Memorial Day, in conjunction with Rabbi Irit from Harlow Synagogue.

Looking forward

As we reflect on our plans and ambitions for 2020-21 it is in the certain knowledge that our future will be significantly different. We anticipate that many of the changes that have been put in place to the way we deliver care as we face the current challenges of the COVID-19 pandemic will become our future standard.

It is evident that we will need to review and maximise the opportunities available to us to continue to transform the way that we organise and provide care. Together with our health, social care and community partners we can build on the improvements made and continue to enhance the difference we make to patients and the people we care for.

Recovery

However, we must, at the same time, provide health and wellbeing support and care to our people. As individuals and teams they are facing the toughest test of their clinical and professional careers and we will ensure that we have strong, tailored recovery plans to support both the care we provide and, importantly, the people providing the care.

Currently (April 2020) there is much that we do not yet have a clear sight of nor do we know fully what we have yet to face and in what additional ways COVID-19 will impact us all. What we do know is that our people are our strength and it is their ongoing commitment that will support the recovery plans and the successful implementation of our plans for PAHT2030.

PAHT 2030

Our vision to deliver outstanding healthcare to the community underpins our PAHT2030 improvement journey to achieve our three goals to be:

- ✓ Outstanding

- ✓ Integrated
- ✓ Modern

We have five key strategic priorities on which our PAHT2030 plans are based:

1. Technology and innovation
2. Integrated care development
3. New hospital
4. Organisational culture
5. Support services modernisation

Naturally, a significant focus for each of the next five years is the business case development, design and build of a new hospital for local people.

It is important that we balance this intense focus on planning and developing a hospital fit for the future with our core business priorities, which are enabled by our six supporting strategies and plans:

1. ICT strategy
2. Clinical strategy
3. Estates strategy
4. People strategy
5. Medium-term financial plan
6. Sustainability strategy

Our focus on our journey to outstanding delivered through the detailed plans in place for PAHT2030 remains clear. Our amazing people are our greatest asset and with their passion and energy we will continue to work together with our health and social care partners to make a difference to our patients and the people living and working in the communities we serve.

Lance McCarthy
Chief executive

The Princess Alexandra Hospital
NHS Trust

The Princess Alexandra Hospital NHS Trust

Annual Accounts for year ended 31 March 2020

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, other items of comprehensive income and cash flows for the year.

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

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

Chief Executive _____ **Date** 25 June 2020

Statement of Directors' responsibilities in respect of the Accounts

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

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

- make judgements and estimates which are reasonable and prudent;

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

- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board

Chief Executive _____ **Date** 25 June 2020

Chief Financial Officer _____ **Date** 25 June 2020

Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust

Qualified opinion

We have audited the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2020 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 35. 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 2019/20 HM Treasury's Financial Reporting Manual (the 2019/20 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2019/20 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, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as at 31 March 2020 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 qualified opinion

As a result of the COVID 19 pandemic, the Trust was only able to count certain locations where their stock is held and we were only able to attend one of those counts, where stock totalled £1 million. We were unable to satisfy ourselves by alternative means concerning the inventory quantities held at 31 March 2020, which are included in the balance sheet at £4.565 million, by using other audit procedures. Consequently, we were unable to determine whether any adjustment to this amount was necessary.

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 qualified opinion.

Material uncertainty related to going concern

We draw attention to Note 1.1.2 in the financial statements, which describes the Trust's trajectory in 2020/21 of £28.6 million deficit to be matched by FRF. This is dependent on meeting cost improvement plans to secure this funding in the next financial year and beyond. As stated in Note 1.1.2, these events or conditions, indicate that a material uncertainty exist that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

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

Emphasis of matter – Property, plant and equipment valuation

We draw attention to Note 1.7.2 Property, Plant and Equipment – Valuation - Impact of COVID-19 on valuation of the financial statements, which describes the valuation uncertainty the Trust is facing as a result of COVID-19 in relation to property valuations. 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.

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.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £4.565 million held at 31 March 2020. We have concluded that where the other information refers to the Inventory balance or related balances such as operating expenses, it may be materially misstated for the same reason.

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 2020.

We have nothing to report in these respects.

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

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 8 June 2020, we referred a matter to the Secretary of State under section 30(1)(b) of the Local Audit and Accountability Act 2014. At 31 March 2020, Princess Alexandra Hospital NHS Trust has achieved a surplus against its incoming resources for the financial year of £0.05 million but has failed to meet the break-even duty over a rolling 3 year period, with a cumulative deficit at 31 March 2020 of £144.344 million.

Under Paragraph 2 (1) of Schedule 5 of the 2006 Act, an NHS trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

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.

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

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 April 2020, 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 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of The Princess Alexandra 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
25 June 2020

Statement of Comprehensive Income

	Note	2019/20 £000's	2018/19 £000's
Operating income from patient care activities	3	**246,747**	211,910
Other operating income	4	**41,744**	24,790
Operating expenses	6	**(286,048)**	(251,680)
Operating surplus / (deficit) from continuing operations		**2,443**	**(14,980)**
Finance income	12	**85**	75
Finance expenses	13.1	**(2,032)**	(1,654)
Net finance costs		**(1,947)**	(1,579)
Surplus / (deficit) for the year from continuing operations		**496**	**(16,559)**
Other comprehensive income			
Revaluations	16	**613**	(284)
Other recognised gains and losses		**117**	(37)
Total comprehensive income / (expense) for the period		**730**	**(321)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		**496**	(16,559)
Adjustment in respect of capital grants and donations		**(78)**	17
Adjust for 2018/19 post audit PSF reallocation		**(368)**	0
Adjusted financial performance surplus / (deficit)		**50**	**(16,542)**

Statement of Financial Position

	Note	31 March 2020 £000's	31 March 2019 £000's
Non-current assets			
Intangible assets	15	**7,633**	9,021
Property, plant and equipment	16	**117,405**	107,377
Receivables	18.1	**692**	912
Total non-current assets		**125,730**	**117,310**
Current assets			
Inventories	17	**4,565**	4,515
Receivables	18.1	**49,837**	18,871
Cash and cash equivalents	19	**1,144**	1,197
Total current assets		**55,546**	**24,583**
Current liabilities			
Trade and other payables	20.1	**(27,068)**	(20,038)
Borrowings	22.1	**(150,958)**	(57,952)
Provisions	24	**(1,186)**	(151)
Other liabilities	21	**(1,158)**	(656)
Total current liabilities		**(180,370)**	**(78,797)**
Total assets less current liabilities		**906**	**63,096**
Non-current liabilities			
Borrowings	22.1	**(40)**	(66,383)
Provisions	24	**(767)**	(785)
Total non-current liabilities		**(807)**	**(67,168)**
Total assets employed		**99**	**(4,072)**
Financed by			
Public dividend capital		**133,863**	130,918
Revaluation reserve		**19,343**	18,626
Income and expenditure reserve		**(153,107)**	(153,616)
Total taxpayers' equity		**99**	**(4,072)**

The notes on pages 99 to 135 form part of these accounts.
The financial statements on pages 95 to 98 were approved by the Board on 19 June 2020 and signed on its behalf by :

25 June 2020

Chief Executive **Date**

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000's	Revaluation reserve £000's	Income and expenditure reserve £000's	Total £000's
Taxpayers' equity at 1 April 2019	**130,918**	**18,626**	**(153,616)**	**(4,072)**
Surplus for the year	0	0	496	**496**
Other transfers between reserves	0	(13)	13	**0**
Revaluations	0	613	0	**613**
Other recognised gains and losses	0	117	0	**117**
Public dividend capital received	2,945	0	0	**2,945**
Taxpayers' equity at 31 March 2020	**133,863**	**19,343**	**(153,107)**	**99**
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)**

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	2019/20 £000's	2018/19 £000's
Cash flows from operating activities			
Operating surplus / (deficit)		**2,443**	(14,980)
Non-cash income and expense:			
Depreciation and amortisation	6	**9,385**	9,082
Income recognised in respect of capital donations	4	**(98)**	(17)
Increase in receivables and other assets		**(30,746)**	(6,189)
Increase in inventories		**(50)**	(354)
Increase / (decrease) in payables and other liabilities		**3,989**	(4,495)
Increase / (decrease) in provisions		**1,015**	(759)
Net cash flows used in operating activities		**(14,062)**	**(17,712)**
Cash flows from investing activities			
Interest received		**85**	75
Purchase of intangible assets		**(522)**	(365)
Purchase of PPE and investment property		**(13,042)**	(13,407)
Net cash flows used in investing activities		**(13,479)**	**(13,697)**
Cash flows from financing activities			
Public dividend capital received		**2,945**	2,767
Movement on loans from DHSC		**26,511**	29,274
Capital element of finance lease rental payments		**(20)**	(18)
Interest on loans		**(1,937)**	(1,532)
PDC dividend paid		**0**	863
Cash flows used in other financing activities		**(11)**	(10)
Net cash flows from financing activities		**27,488**	**31,344**
Decrease in cash and cash equivalents		**(53)**	**(65)**
Cash and cash equivalents at 1 April		**1,197**	**1,262**
Cash and cash equivalents at 31 March	19	**1,144**	**1,197**

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 2019/20 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.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The Trust will therefore no longer be required to generate surpluses to eliminate its historic debt, and that total net assets will increase, thereby strengthening the Trust’s balance sheet. The affected loans totalling £150,928k (including interest accrual of £461k) are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

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:-

i) The Board considers the Trust operates a significant portfolio of clinical services. The Trust has signed a two year Allocative contract (expiring 31 March 2021) with its main Commissioner pre Covid-19. The contracting arrangements which were previously agreed for April to July have been replaced by the NHSE/I block contracts. The Trust has not been made aware of any plans from any Commissioner to disinvestment. The Trust is expanding and taking on lead responsibility for services e.g. MSK.

West Essex System partners aim to be an Integrated Care Trust (ICT) by 2022. The ICT will be made up of Primary Care, Community Care and Acute care providers. The development of ‘One Health and Care Partnership’ during 2020/21 will be a key transitional point towards the ICT.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

ii) In October 2019 the Trust received notification of financial improvement trajectories and Financial Recovery Fund (FRF) allocations for each year up to 2023/24. These trajectories outline a reduction in deficit with indicative FRF set to meet a breakeven position. Subsequent amendments to reflect policy changes and the debt write off regime were notified in January 2020 with the Trust's trajectory in 2020/21 of £28.6m deficit to be matched by FRF. It should be noted that due to Covid-19 operational planning guidance is currently suspended with the introduction of an adapted financial regime intended to cover the full costs of service delivery.

In March 2020 that NHSE&I announced revised arrangements for NHS contracting and payment to apply for the first four months of the 2020/21 year due to the Covid-19 pandemic. The contracting arrangements for the rest of 2020/21 and beyond have not yet been definitively announced

As part of the managing the Covid-19 emergency in March 20/21 details were released on the block contract and 'Top Up' arrangement for payments from April to July. This guidance establishes the principle that Providers will be funded at full cost recovery at least until July 2020. The contracting arrangements for the remainder of 20/21 have yet to be announced.

iii) The Trust has included an estimate of £40.9m of capital requirements in its 2020/21 operating plan. This plan includes £9.9m of internally generated funds, £9.5m for the development of a Medical Assessment Unit, £5m emergency capital and £9.2m to progress a Strategic Outline Business Case (SOC) for Hospital redevelopment. Support for the new Hospital Development has been received from senior Department of Health officials and the Prime Minister.

iv) The adapted financial regime provides certainty of financial flows associated with block and top-up payments has negated these concerns. While mechanisms for contracting and payment are not definitively in place beyond July 2020, it is clear that NHS services will continue to be funded, and government funding is in place for this, and cashflows have been revised to reflect the current information available. 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. This position has been confirmed by NHSI/E whereby Providers can expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. NHSI/E have further confirmed that temporary revenue support arrangements will continue, in order to support Providers with demonstrable needs and thon to the Accounts.

The Board of Directors has carefully considered the principle of 'going concern' and recognises that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Such uncertainties include delivery of a cost improvement programme for the following 12 months to levels that secure FRF funding in 2020/21 and beyond. The Board has considered this position and, although there remains uncertainty regarding the overarching financial regime beyond July 2020, assesses it is reasonable that identified savings will be delivered. This position is supported by existence of both a Transformational agenda, actions of the Recovery and Restoration cell as part of the response to Covid-19 and a continued track record of the Trust to delivery cost and efficiency improvements.

On that basis and for the reasons outlined above the Board of Directors considers it is appropriate to prepare the 2019/20 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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 term, the level of risk transfer, 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. As a result of COVID-19 the District Valuer has identified a material valuation uncertainty. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to 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:

Provisions (Note 24)

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

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

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

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

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.

Inventories

As a result of COVID-19 it was not possible to access all clinical areas and complete a full stocktake. The key areas where a count could not be completed were Theatres and Pathology, and in 2018/19 these locations accounted for £1.5m of stock. As the areas that were counted showed a minimal stock movement from prior year, the Trust has used the 2018/19 value as an estimate of the current level of stock held in Theatres and Pathology. Overall stock value in 2018/19 and 2020/21 total around £4.5m.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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).

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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.

NHS injury cost recovery scheme

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

Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.4.3 Other income

Grants and donations
Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on 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.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

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

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

- 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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Impact of COVID-19 on valuation

The valuation exercise was carried out through January 2020 to March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2017 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Notwithstanding the above, of the £79.6m of Building assets, £79m relates to the main Hospital site. This is classified as a Specialist Asset and valued on a Modern Equivalent Asset (MEA) basis. As per note 1.2, MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." The valuation as at 31 March 2020 used for the majority of the Trust's Building assets is on an MEA basis and the impact of COVID-19 has not changed the overall occupancy/services requirement. On this basis, and for the reasons outlined above, the Board of Directors are content that the valuation used is reasonable and materially valid.

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'.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the following criteria are met: The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Note 1.7.4 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.8 Intangible assets

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

	Min life Years	Max life Years
Buildings	0	28
Plant & machinery	2	15
Transport equipment	0	7
Information technology	0	5
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 1.8.1 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 when it meets the requirements set out in IAS 38.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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

	Min life Years	Max life Years
Information technology	0	5
Development expenditure	0	8

Note 1.9 Inventories

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

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of 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.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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).

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 21.79% 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.

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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.13.1 The Trust as lessee

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

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

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

Note 1.13.2 The Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust'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 minus 0.5% (2018/19 positive 0.29%).

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 24 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.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

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 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public Dividend Capital
Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital 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:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.19 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

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

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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

In light of COVID-19 pressures, HM Treasury and the Financial Reporting Advisory Board (FRAB) have decided that IFRS 16 implementation in the public sector will be deferred until 2021/22.

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for all leases. The standard also requires the remeasurement of lease liabilities after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

The trust has estimated impact of applying IFRS 16 in 2021/22 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2021 statement of financial position

	£000's
Additional right of use assets recognised for existing operating leases	18,203
Net impact on net assets on 1 April 2021	**18,203**

Estimated in-year impact in 2021/22

Additional depreciation on right of use assets	(1,433)
Additional finance costs on lease liabilities	(217)
Lease rentals no longer charged to operating expenditure	1,137
Estimated impact on surplus / deficit in 2021/22	**(513)**

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)	2019/20 £000's	2018/19 £000's
Acute services		
Elective income	28,132	27,977
Non elective income	87,816	79,807
First outpatient income	20,002	19,329
Follow up outpatient income	16,675	15,083
A & E income	18,388	15,147
High cost drugs income from commissioners (excluding pass-through costs)	14,077	14,927
Other NHS clinical income	52,298	35,758
All other services		
Private patient income	290	277
Agenda for Change pay award central funding*	0	2,606
Additional pension contribution central funding**	6,440	0
Other clinical income	2,628	999
Total income from activities	**246,747**	**211,910**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay contributions at the former rate with the additional amount being paid by NHS England on providers' behalf. The full cost and related funding have been recognised in these Accounts.

Note 3.2 Income from patient care activities (by source) Income from patient care activities received from:	2019/20 £000's	2018/19 £000's
NHS England	29,937	21,785
Clinical Commissioning Groups	215,150	185,544
Department of Health and Social Care	27	2,606
Other NHS providers	490	525
NHS other	103	110
Local authorities	19	64
Non-NHS: private patients	290	277
Non-NHS: overseas patients (chargeable to patient)	93	81
Injury cost recovery scheme	638	918
Total income from activities	**246,747**	**211,910**

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

	2019/20 £000's	2018/19 £000's
Income recognised this year	93	81
Cash payments received in-year	43	16
Amounts added to provision for impairment of receivables	38	7
Amounts written off in-year	1	4

Note 4 Other operating income	2019/20 £000's	2018/19 £000's
Other operating income from contracts with customers		
Research and development	632	713
Education and training	6,772	6,602
Non-patient care services to other bodies	2,706	2,675
Provider sustainability fund (PSF)	5,787	11,422
Financial recovery fund (FRF)	21,829	0
Marginal rate emergency tariff funding (MRET)	548	0
Other income	3,271	3,024
Other non-contract operating income		
Receipt of capital grants and donations	98	17
Charitable and other contributions to expenditure	0	0
Rental revenue from operating leases	101	337
Total other operating income	**41,744**	**24,790**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000's	2018/19 £000's
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	656	162

Note 6 Operating expenses

	2019/20 £000's	2018/19 £000's
Purchase of healthcare from NHS and DHSC bodies	6,655	1,990
Purchase of healthcare from non-NHS and non-DHSC bodies	3,880	1,950
Staff and executive directors costs	193,119	168,513
Remuneration of non-executive directors	94	75
Supplies and services - clinical (excluding drugs costs)	17,950	17,572
Supplies and services - general	3,395	3,190
Drug costs	20,189	20,550
Inventories written down	0	18
Consultancy and professional services	3,532	1,912
Establishment	1,618	1,601
Premises	10,328	9,122
Transport (including patient travel)	816	826
Depreciation on property, plant and equipment	7,494	7,242
Amortisation on intangible assets	1,891	1,840
Movement in credit loss allowance: contract receivables / contract assets	158	15
Change in provisions discount rate	7	(2)
Audit fees payable to the external auditor		
audit services - statutory audit	73	73
other auditor remuneration (external auditor only)	0	12
Internal audit costs	104	99
Clinical negligence	9,924	11,115
Legal fees	416	110
Insurance	117	141
Education and training	741	796
Rentals under operating leases	2,292	1,674
Redundancy	11	119
Car parking & security	459	408
Hospitality	1	12
Losses, ex gratia & special payments	73	76
Other external services	276	267
Other	435	364
Total	**286,048**	**251,680**

Note 7 Other auditor remuneration

Note 7.1 Other auditor remuneration

	2019/20 £000's	2018/19 £000's
Other auditor remuneration paid to the external auditor:		
Other assurance services	0	12
Total	0	**12**

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of assets

There were nil impairments in 2019/20 (nil in 2018/19).

Note 9 Employee benefits

	2019/20 £000's	2018/19 £000's
Salaries and wages	124,956	114,601
Social security costs	12,319	12,045
Apprenticeship levy	605	566
Employer's contributions to NHS pensions	21,144	13,467
Pension cost - other	35	21
Temporary staff (including agency)	35,865	29,182
Total gross staff costs	**194,924**	**169,882**
Recoveries in respect of seconded staff	0	0
Total staff costs	**194,924**	**169,882**
Of which		
Costs capitalised as part of assets	1,794	1,250

Note 9.1 Retirements due to ill-health

During 2019/20 there were three early retirements from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £151k (0k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

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 and Social Care 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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 Princess Alexandra Hospital NHS Trust as a lessor

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

	2019/20 £000's	2018/19 £000's
Operating lease revenue		
Minimum lease receipts	101	337
Total	**101**	**337**

	2019/20 £000's	2018/19 £000's
Future minimum lease receipts due:		
- not later than one year;	101	101
- later than one year and not later than five years;	247	247
- later than five years.	146	194
Total	**494**	**542**

Note 11.2 The Princess Alexandra Hospital NHS Trust as a lessee

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

	2019/20 £000's	2018/19 £000's
Operating lease expense		
Minimum lease payments	2,292	1,674
Total	**2,292**	**1,674**

	2019/20 £000's	2018/19 £000's
Future minimum lease payments due:		
- not later than one year;	2,089	1,291
- later than one year and not later than five years;	6,942	3,702
- later than five years.	9,320	4,955
Total	**18,351**	**9,948**

Note 12 Finance income

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

	2019/20 £000's	2018/19 £000's
Interest on bank accounts	85	75
Total finance income	**85**	**75**

Note 13.1 Finance expenditure

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

	2019/20 £000's	2018/19 £000's
Interest expense:		
Loans from the Department of Health and Social Care	2,019	1,643
Total interest expense	**2,019**	**1,643**
Unwinding of discount on provisions	2	1
Other finance costs	11	10
Total finance costs	**2,032**	**1,654**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract

There were nil interest charges on late payments in 2019/20 (nil in 2018/19)

Note 14 Other gains and losses

There were no gains or losses from disposals of assets in 2019/20 (nil in 2018/19)

Note 15 Intangible assets

	Internally generated IT £000's	Development expenditure £000's	Total £000's
15.1 Intangible assets - 2019/20			
Valuation / gross cost at 1 April 2019	**48**	**14,860**	**14,908**
Additions	68	435	**503**
Valuation / gross cost at 31 March 2020	**116**	**15,295**	**15,411**
Amortisation at 1 April 2019	**21**	**5,866**	**5,887**
Provided during the year	15	1,876	**1,891**
Amortisation at 31 March 2020	**36**	**7,742**	**7,778**
Net book value at 31 March 2020	**80**	**7,553**	**7,633**
Net book value at 1 April 2019	**27**	**8,994**	**9,021**
15.2 Intangible assets - 2018/19			
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 Property, plant and equipment - 2019/20	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 2019	**8,150**	**80,445**	**1,849**	**26,520**	**76**	**18,068**	**1,169**	**136,277**
Additions	0	1,772	9,854	1,739	132	3,412	0	16,909
Revaluations	0	(2,107)	0	0	0	0	0	(2,107)
Reclassifications	0	66	(66)	(71)	71	0	0	0
Disposals / derecognition	0	0	0	(160)	0	0	0	(160)
Valuation/gross cost at 31 March 2020	**8,150**	**80,176**	**11,637**	**28,028**	**279**	**21,480**	**1,169**	**150,919**
Accumulated depreciation at 1 April 2019	**0**	**535**	**0**	**17,783**	**28**	**9,440**	**1,114**	**28,900**
Provided during the year	0	2,754	0	2,149	10	2,571	10	7,494
Revaluations	0	(2,720)	0	0	0	0	0	(2,720)
Reclassifications	0	0	0	(71)	71	0	0	0
Disposals / derecognition	0	0	0	(160)	0	0	0	(160)
Accumulated depreciation at 31 March 2020	**0**	**569**	**0**	**19,701**	**109**	**12,011**	**1,124**	**33,514**
Net book value at 31 March 2020	**8,150**	**79,607**	**11,637**	**8,327**	**170**	**9,469**	**45**	**117,405**
Net book value at 1 April 2019	**8,150**	**79,910**	**1,849**	**8,737**	**48**	**8,628**	**55**	**107,377**

Note 16.1 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 16.2 Property, plant and equipment financing - 2019/20

	Land £000's	Buildings excluding dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2020								
Owned - purchased	8,150	79,607	11,637	8,110	170	9,469	45	**117,188**
Finance leased	0	0	0	83	0	0	0	**83**
Owned - donated	0	0	0	134	0	0	0	**134**
NBV total at 31 March 2020	**8,150**	**79,607**	**11,637**	**8,327**	**170**	**9,469**	**45**	**117,405**

Note 16.3 Property, plant and equipment financing - 2018/19

	Land £000's	Buildings excluding dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2019								
Owned - purchased	8,150	79,910	1,849	8,681	48	8,628	55	**107,321**
Finance leased	0	0	0	0	0	0	0	**0**
Owned - donated	0	0	0	56	0	0	0	**56**
NBV total at 31 March 2019	**8,150**	**79,910**	**1849**	**8,737**	**48**	**8,628**	**55**	**107,377**

Note 16.4 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 £98k (2018/19

Note 16.5 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 Valuation 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 theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

Note 17 Inventories

	31 March 2020 £000's	31 March 2019 £000's
Drugs	1,451	1,395
Consumables	3,046	3,004
Energy	32	80
Other	36	36
Total inventories	**4,565**	**4,515**

Inventories recognised in expenses for the year were £31,347k (2018/19: £30,816k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £18k).

Note 18.1 Receivables

	31 March 2020 £000's	31 March 2019 £000's
Current		
Contract receivables	47,666	17,365
Allowance for impaired contract receivables / assets	(1,193)	(1,066)
Prepayments (non-PFI)	1,241	1,514
Interest receivable	4	4
VAT receivable	1,406	882
Other receivables	713	172
Total current receivables	**49,837**	**18,871**
Non-current		
Contract assets	692	912
Total non-current receivables	**692**	**912**
Of which receivable from NHS and DHSC group bodies:		
Current	45,164	14,300
Non-current	0	0

Note 18.2 Allowances for credit losses

	2019/20 £000's	2018/19 £000's
Allowances as at 1 April - brought forward	1,066	0
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	0	1,058
New allowances arising	175	211
Changes in existing allowances	0	(9)
Reversals of allowances	(17)	(187)
Utilisation of allowances (write offs)	(31)	(7)
Allowances as at 31 March 2020	**1,193**	**1,066**

Note 19 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.

	2019/20 £000's	2018/19 £000's
At 1 April	**1,197**	**1,262**
Net change in year	(53)	(65)
At 31 March	**1,144**	**1,197**
Broken down into:		
Cash at commercial banks and in hand	22	46
Cash with the Government Banking Service	1,122	1,151
Total cash and cash equivalents as in SoFP / SoCF	**1,144**	**1,197**

Note 19.1 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 and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000's	31 March 2019 £000's
Bank balances	16	15
Total third party assets	**16**	**15**

Note 20.1 Trade and other payables

	31 March 2020 £000's	31 March 2019 £000's
Current		
Trade payables	8,598	4,434
Capital payables	6,757	3,214
Accruals	7,667	9,140
Social security costs	1,863	1,661
Other taxes payable	347	1,487
Other payables	1,836	102
Total current trade and other payables	**27,068**	**20,038**
Of which payables from NHS and DHSC group bodies:	4,663	2,447

Note 20.2 Early retirements in NHS payables above

There are no early retirements included in NHS payables (nil in 2018/19)

Note 21 Other liabilities

	31 March 2020 £000's	31 March 2019 £000's
Current		
Deferred income: contract liabilities	1,158	656
Total other current liabilities	**1,158**	**656**

Note 22.1 Borrowings

	31 March 2020 £000's	31 March 2019 £000's
Current		
Loans from DHSC	150,928	57,952
Obligations under finance leases	30	0
Total current borrowings	**150,958**	**57,952**
Non-current		
Loans from DHSC	0	66,383
Obligations under finance leases	40	0
Total non-current borrowings	**40**	**66,383**

Note 22.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000's	Finance leases £000's	Total £000's
Carrying value at 1 April 2019	**124,335**	**0**	**124,335**
Cash movements:			
Payments and receipts of principal	26,511	(20)	**26,491**
Payments of interest	(1,937)	0	**(1,937)**
Non-cash movements:			
Application of effective interest rate	2,019	0	**2,019**
Other changes	0	90	**90**
Carrying value at 31 March 2020	**150,928**	**70**	**150,998**

Note 22.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC £000's	Finance leases £000's	Total £000's
Carrying value at 1 April 2018	**94,682**	**18**	**94,700**
Cash movements:			
Payments and receipts of principal	29,274	(18)	**29,256**
Payments of 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 23 Finance leases

Note 23.1 The Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020 £000's	31 March 2019 £000's
Gross lease liabilities	**71**	**0**
of which liabilities are due:		
not later than one year;	30	0
than five years;	41	0
later than five years.	0	0
Finance charges allocated to future periods	(1)	0
Net lease liabilities	**70**	**0**
of which payable:		
not later than one year;	30	0
later than one year and not later than five years;	40	0
later than five years.	0	0

Note 24 Provisions for liabilities and charges analysis

	Pensions: early departure £000's	Legal claims £000's	Other £000's	Total £000's
At 1 April 2019	**858**	**78**	**0**	**936**
Change in the discount rate	7	0	0	**7**
Arising during the year	50	282	809	**1,141**
Utilised during the year	(75)	0	0	**(75)**
Reversed unused	0	(58)	0	**(58)**
Unwinding of discount	2	0	0	**2**
At 31 March 2020	**842**	**302**	**809**	**1,953**
Expected timing of cash flows:				
not later than one year;	**75**	**302**	**809**	**1,186**
later than one year and not later than five years;	300	0	0	**300**
later than five years.	467	0	0	**467**
Total	**842**	**302**	**809**	**1,953**

Note 24.1 Clinical negligence liabilities

At 31 March 2020 £107.9m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2019: £125.4m).

Note 25 Contingent assets and liabilities

	31 March 2020 £000's	31 March 2019 £000's
Value of contingent liabilities		
NHS Resolution legal claims	(38)	(16)
Employment tribunal and other employee related litigation	(128)	(127)
Gross value of contingent liabilities	**(166)**	**(143)**

Note 26 Contractual capital commitments

	31 March 2020 £000's	31 March 2019 £000's
Property, plant and equipment	8,265	3,766
Total	**8,265**	**3,766**

Note 27. Financial instruments

Note 27.1 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 27.1 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 27.2 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 held at amortised cost	**31 March 2020 £000's**	**31 March 2019 £000's**
Trade and other receivables excluding non financial assets	47,377	17,387
Cash and cash equivalents	1,144	1,197
Total at 31 March 2020	**48,521**	**18,584**

Note 27.3 Carrying values of financial liabilities

Carrying values of financial liabilities held at amortised cost	**31 March 2020 £000's**	**31 March 2019 £000's**
Loans from the Department of Health and Social Care	150,928	124,335
Obligations under finance leases	70	0
Trade and other payables excluding non financial liabilities	24,858	16,890
Total at 31 March 2020	**175,856**	**141,225**

Carrying values of financial liabilities as at 31 March 2019	**Total book value £000's**
Loans from the Department of Health and Social Care	**124,335**
Obligations under finance leases	0
Trade and other payables excluding non financial liabilities	**16,890**
Total at 31 March 2019	**141,225**

Note 27.4 Maturity of financial liabilities

	31 March 2020 £000's	31 March 2019 £000's
In one year or less	175,856	74,842
In more than one year but not more than two years	0	25,663
In more than two years but not more than five years	0	40,720
Total	**175,856**	**141,225**

Note 27.5 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 28 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000's	Total number of cases Number	Total value of cases £000's
Losses				
Cash losses	2	4	2	4
Bad debts and claims abandoned	31	32	4	6
Stores losses and damage to property	3	33	9	64
Total losses	**36**	**69**	**15**	**74**
Special payments				
Compensation under court order or legally binding arbitration award	4	9	5	31
Ex-gratia payments	5	3	10	1
Total special payments	**9**	**12**	**15**	**32**
Total losses and special payments	**45**	**81**	**30**	**106**
Compensation payments received		0		0

Note 29 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 England and 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 29 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	4,314	0	11	0
Addenbrooke's Charitable Trust	Helen Howe	Associate Non-Executive Director	Trustee	2	0	0	0
Anglia Ruskin University	John Keddie	Non-Executive Director	Governor	24	46	11	0
Anglia Ruskin University	James McLeish	Director of Quality Improvement	Family member an employee	24	46	11	0
Care Quality Commission	Ahmed Soliman	Associate Medical Director - Urgent Care	Specialist Clinical Advisor	151	0	0	0
East of England Ambulance Service	James McLeish	Director of Quality Improvement	Family member an employee	45	0	2	0
Holly House Hospital	John Hogan	Non-Executive Director	Private Practice	63	1	29	0
St Clare Hospice	Monica Bose	Consultant Gastroenterologist AMD CCCS	Trustee	22	0	3	0
University of Suffolk	Steve Clarke	Chairman	Independent Director	1	0	0	2
Barts Health NHS Trust	John Hogan	Non-Executive Director	Consultant Cardiologist	386	425	301	343

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 £286k (unaudited) to the Trust (2018/19 £278k).

Note 30. 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

Note 31. Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £150,928k (including interest accrual of £461k) as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The Trust has no other adjusting events after the end of the reporting period. The Accounts were approved by the Board of Directors on 28 May 2020.

Note 32 Better Payment Practice code

	2019/20 Number	2019/20 £000's	2018/19 Number	2018/19 £000's
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	49,002	76,083	51,665	67,947
Total non-NHS trade invoices paid within target	43,722	64,320	36,583	49,942
Percentage of non-NHS trade invoices paid within target	**89.2%**	**84.5%**	**70.8%**	**73.5%**
NHS Payables				
Total NHS trade invoices paid in the year	2,227	56,446	2,553	42,033
Total NHS trade invoices paid within target	1,805	47,379	1,810	36,631
Percentage of NHS trade invoices paid within target	**81.1%**	**83.9%**	**70.9%**	**87.1%**

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.

Note 33 External financing limit

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

	2019/20 £000's	2018/19 £000's
External financing limit (EFL)	30,083	32,286
Cashflow financing	29,489	32,088
Unadjusted EFL	**594**	**198**
Adjusted financial performance (management control total basis):		
CT Scanner funding deferred to 20/21 included in 19/20 limit	(447)	0
Underspend against EFL	**147**	**198**

Note 34 Capital Resource Limit (CRL)

	2019/20 £000's	2018/19 £000's
Gross capital expenditure	17,412	11,934
Less: Donated and granted capital additions	(98)	(17)
Charge against Capital Resource Limit	**17,314**	**11,917**
Capital Resource Limit	17,721	12,102
Unadjusted CRL	**407**	**185**
Adjusted financial performance (management control total		
CT Scanner funding deferred to 20/21 included in 19/20 limit	(447)	0
COVID CRL Support for 2019/20 to be adjusted in 20/21	509	0
Underspend against CRL	**469**	**185**

Note 35. Breakeven duty and financial performance

Note 35.1 Breakeven duty by Control Total

	Control Target £000's	Actual Outturn £000's	Under-spend £000's
Net Control Total - 2019/20	(6,168)	50	**6,218**
Net Control Total - 2018/19	(20,436)	(16,542)	**3,894**

Note 35.2 Breakeven duty financial performance

	2019/20 £000's
Adjusted financial performance surplus / (deficit) (control total basis)	50
Add back income for impact of 2018/19 post-accounts PSF reallocation	368
Breakeven duty financial performance surplus	**418**

Note 35.3 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	2019/20 £000's
Breakeven duty in-year financial performance		511	415	461	122	(16,403)	(21,998)	(37,714)	(26,715)	(28,435)	(16,542)	418
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)	(144,344)
Operating income		172,171	179,388	180,790	184,568	177,739	190,478	196,124	209,742	213,231	236,700	288,491
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%**	**-50.03%**

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.

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