# Annual Report 2020 - 2021

The Princess Alexandra Hospital NHS Trust

Your future • Our hospital

# The performance report 2020-21

## 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

A year ago as we sat down to write the foreword for our annual report we had just come out of the intense first wave of the COVID-19 pandemic. We were facing the unprecedented challenges, having cared for hundreds of COVID-19 positive patients, of how we were going to support our colleagues through the impact that the previous few months had had on them and how we were going to continue to support our local community with the much needed ongoing care for COVID-19 and non-COVID-19 conditions that they required.

One year on, and we could not have predicted the severity of the second wave of the COVID-19 pandemic and the significant and profound impact this would have on all of us and all of our community.

It is vital that we keep our focus on managing the virus and its variants as we look to the future and we are in no doubt that our PAHT people will continue to meet the challenge and provide compassionate care to all of our patients and all of the people they work alongside.

With the pandemic as our backdrop, we are incredibly proud of the hard work and commitment of our people in their response and of the significant changes that our people have put in place and the many ways they have responded to and adapted the ways that patient care is delivered. Just one of these changes, which we will continue to enhance and provide to our patients are virtual appointments. Many of our patients have told us how helpful they find virtual appointments in terms of fitting them around their work and family commitments without the need to travel. As technology extends, we will be able to offer more video call appointments and bring the benefits of a virtual face-to-face appointment to a wider range of patients.

During the pandemic, in-line with national guidance, we had to pause visitors coming to the hospital. We recognise that this was a difficult change for many people and we thank our patients' friends, family and loved-ones for their understanding and support. To enable contact beyond a phone call, we introduced a new initiative, *Message to a loved one*, where colleagues have volunteered to ensure messages and cards have been delivered across the hospital and, additionally, that patients could connect with their loved ones through a video call on a PC tablet – enabling people to see each other too.

Throughout the last year, the improvement action plans within our PAHT 2030 strategy have continued. Aligned to the *NHS Ten Year Plan*, the strategy sets out five key areas of focus and the objectives that, together, we are striving to achieve. Many of the initial actions are set alongside the new hospital project and will put us in a position to provide improved levels of high quality care, implement changes and be ready to

transition into a new hospital. It is good to be part of the conversations and to see our people working collaboratively to ensure that the needs of all patients are considered and included in the changes and plans for the future.

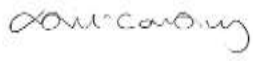
The new Princess Alexandra Hospital project is also continuing at pace as the PAHT team bring together a very detailed and extensive outline business case that will be submitted to the national New Hospital Programme at the end of the year. Creating a plan to build a new hospital for the 21st century is a huge project to bring together and, as with any project, the progress is thanks to our team of skilled specialists who are working behind the scenes to ensure that every detail is being considered and included. It is fantastic to know that the outline business case continues to progress at pace and that we have many exciting stages ahead of us as we work towards building and welcoming our people and patients to our new hospital.

The past year has been a year unlike any other and a year of unprecedented demand on all of us. It is thanks to the hard work, compassion and commitment to patient care of each and every member of the PAHT team that we have achieved all that we have in the last twelve months. We have also been honoured to receive the generous support and kindness from local people from the very start of the pandemic to the present day, culminating in the award of a civic award from Harlow District Council to all of the staff at PAHT for their continuous commitment and contribution to the community of Harlow. The award was thanks to the nominations of many members of the local community and their appreciation, touching comments and positive feedback has meant so much to us.

The COVID-19 pandemic continues and we remain mindful of the impact on our people and making sure they have the help and support they need in terms of their health and wellbeing as, every day, they continue to high quality care to our patients and support their colleagues too. They are amazing.

Best wishes

**Steve Clarke**
Chair



**Lance McCarthy**
Chief executive

A final change to update you about is that I will be stepping down from his role and leaving PAHT. I took on the role of chair in December 2018 and will be leaving in June 2021. I have thoroughly enjoyed my time at PAHT and want to thank everyone for their hard work that they continue to give to patient care.

**Steve Clarke**
Chair

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The year 2020-21 has been an unprecedented time, we are pleased to share with you a message from Lance McCarthy, chief executive, shared with all our people to mark the first 12 months of the COVID-19 pandemic.

## Our year of COVID-19...

Dear all

The 29 January 2021 marked a year since the first COVID-19 patient was admitted to a UK hospital. We didn't admit our first patient until 15 March, but what a year. An unprecedented year in our lifetimes, an extraordinary year, an exhausting year, a sad year and a truly remarkable year in terms of what we have all done.

We have swabbed more than 23,000 patients for COVID; we have treated more than 1,800 positive patients; we have seen 1,200 of them discharged; but sadly we have seen nearly 500 die; too soon and from a virus we knew nothing about a year ago.

We have made hundreds of decisions about issues we would never have thought about a year ago; we have changed and transformed buildings, clinical pathways, teams and ways of working at a phenomenal pace; we have built things, moved things, lent things, borrowed things and procured things that we would never have dreamed of. We all now think differently.

We have a 'red ED' and a 'red ITU'; we have run at more than 600% critical care capacity; we have turned wards to COVID-19 wards, back to non-COVID-19 and back to COVID-19 again; we have rolled out 1,000s of laptops for virtual outpatient appointments and home working; we have moved colleagues off site; we have built a temporary mortuary; we have installed screens between bed spaces; we have run loads of new assays; we have set up a health and wellbeing hub and an absence line. We have all done things differently.

We have worked extra hours, in different teams, in different roles; used different drugs, in different ways; measured, monitored and tracked numbers like never before and we have developed a new vocabulary - COVID, lockdown, tiers, lateral flow test, PCR test, Samba, social distancing, hands face and space, stay safe, SIREN, furlough, shielding, clinically extremely vulnerable, surge levels.

We have experienced more anxiety, adrenaline and pride than usual but we have also been more scared, exhausted and traumatised than usual.

We've experienced the strangest Christmas and New Year in most of our lives; we've home schooled; we've worked from home and we've transitioned in to a virtual world; for families to speak to their loved ones in our care, for outpatient appointments, for meetings, or to speak to our family and friends. Zoom, Teams, WebEx..."you're on mute!"

We have made new friends with colleagues that we never really knew a year ago and, sadly, we have lost old friends. Colleagues, family members, personal friends, gone too soon and leaving holes in our hearts.

We have also embraced diversity, equality and inclusion; George Floyd's death in Minneapolis and the realisation in the first wave of the increased vulnerability of our BAME colleagues and friends to COVID-19, affected us all. We have done and will always work together regardless of age, sex, sexual orientation, race, religion, disability and ethnicity.

Through all of this, we have built a new two-storey adult assessment unit, a sanctuary space and prayer room, a junior doctors' mess, a refurbished paediatric ward, a new fracture clinic and an EBME workshop. We have looked out for each other and others less fortunate and we have been looked out for by others and seen the generosity of many.

Infection prevention and control is more centre stage than ever, PPE guidance at the front of our minds, scrubs (raspberry especially) worn almost everywhere and face masks part of everyday life. We've celebrated, we've thanked, we've been kind and we've been recognised, with scientists, technicians, nurses and doctors all receiving national awards, including an MBE.

And as we welcomed in the new year, some of our amazing colleagues were busy setting up a vaccination hub in record time; administering more than 6,500 doses to local health and care workers in just four weeks, giving us all some hope and hopefully some immunity.

It has been a year of huge change and huge emotion. We've been tested and pushed to our limits and beyond. We've had good days and great days, bad days and terrible days.

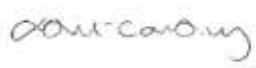
It has been a year of huge contrasts, a year of opposites and a year that we wouldn't want to see the likes of again. Through it we have treated 1,000s of patients, cared for them, put their minds at rest and made them better.

The pandemic, the battle against COVID-19, is not over, but we're slowly winning it. We will all need more health and well-being and psychological support than ever and being civil and kind has never been more important; but we will get back to 'normal', we will stop wearing masks everywhere, we will get to go out again and we will keep caring for sick members of the community.

Thank you. Thank you to all the doctors, nurses, midwives, pharmacists, scientists, technicians, radiographers, physios, dieticians, OTs, SALTs, ODPs, all other AHPs, HCSWs, MCAs, MLSOs, PAs, optometrists, audiologists, phlebotomists, domestics, porters, caterers, housekeepers, drivers, estates team, librarians, chaplains, assistants, associates, students, volunteers and all our administrative and corporate colleagues from all professions. You have all been amazing.

**#TeamPAHT**

Best wishes



**Lance McCarthy**
Chief executive

## The purpose and activities of the organisation

PAHT is a 414 bedded hospital with a full range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), plus an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU). During 2021 the Trust opened a new building on the main site that holds the Adult Assessment Unit & Same Day Emergency Care unit, both are services that improve patient experience for those patients requiring urgent care.

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

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

The trust operates over forty different services to meet the needs of its patients (see service portfolio below):

| **Directory of our services** | | | |
|---|---|---|---|
| Adult assessment services incorporating ambulatory care and same day emergency care. | Endocrinology | Maxillo-facial surgery | Radiology |
| Audiology | Ear Nose & Throat | Medical Oncology | Respiratory Medicine |
| Breast screening | Frailty service | Neonatal critical care – special care baby unit and neonatal community nurses | Rheumatology |

| | | | |
|---|---|---|---|
| Breast surgery | Gastroenterology | New-born Hearing Screening | Specialist palliative care |
| Cardiology | General medicine | Neurology | Speech and language therapy |
| Chemotherapy | General surgery | Obstetrics | Surgery – in-patients |
| Clinical Haematology | Genito-urinary medicine | Ophthalmology | Transfusion services |
| Clinical Oncology | Geriatrics | Oral surgery | Tongue tie service |
| Colposcopy and hysteroscopy services | Gynaecology:<br>Including Termination of Pregnancy Services<br>Gynaecology ambulatory service | Oncology services | Trauma and orthopaedics |
| Community midwifery | High Dependency Unit | Paediatrics – in-patients, out-patients, ambulatory care | Urology |
| Colorectal services | Intensive Care unit | Paediatric diabetic Medicine | Vascular services |
| Day surgery | Infection prevention & control services | Paediatric Emergency Department | Blood tests |
| Dermatology | Interventional radiology | | End of life care |
| Diabetic medicine | Maternity comprising:<br>• Antenatal clinic<br>• Ultrasound scanning<br>• Labour Ward<br>• Antenatal Ward<br>• Postnatal Ward<br>• Maternal Foetal | Pathology | Mortuary & Bereavement services |
| Dietetics | | Patient appliances | Patient at home |
| Early Pregnancy Unit | | Pharmacy services | Research & Development |
| Emergency Department | | Physiotherapy and occupational therapy | Tissue viability |
| Endoscopy services | | Perioperative Medicine (Anaesthetics and ICU) | |

| | | | |
|---|---|---|---|
| | Assessment Unit<br>• Breast feeding support<br>• Birthing Unit<br>• Community midwifery services | | |

## Strategic objectives

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

Over the course of 2020-2021 the trust has been working towards the launch of PAHT2030. PAHT2030 provides our roadmap to 'outstanding' and delivery of services from a modern, fit for purpose new hospital through five strategic priorities:


Underpinning our five priorities and the way in which we achieve these ambitions are our trust goals, objectives and values.


The development of PAHT2030 over 2020-2021 has been set against a challenging and changing NHS landscape which has emphasised the importance of a strong organisational strategy to provide our communities, staff and partners with the assurance that we can deliver our ambitions. PAHT2030 has been developed from the ground up, with input from over 300 members of our staff to understand where real change is required to deliver outstanding care.

The NHS Long Term Plan is an ambitious 10 year plan focussed on new service models; prevention and health inequalities; significant improvements in the quality of care and patient outcomes; strengthened workforce; digital transformation; financial efficiency and value for money for the taxpayer. The trust's one vision, three goals and five 'P's together with the strategic priorities all bring together our ambition and closely align it to the NHS Long Term Plan.

Our ambition was strengthened further in February 2021 when the Department of Health and Social Care published the White Paper 'Integration and innovation: working together to improve health and social care for all'. The paper proposes greater flexibility for local health and care organisations to work in partnership through Integrated Care Systems (ICS) to deliver localised models of care to support their populations which is exactly what we want to achieve with our partners for our local community.

## Models of Care

Although integrated care has been a focus for the trust since 2015, in 2020-2021 we have worked in partnership with the newly formed Hertfordshire and West Essex Integrated Care System and more localised One Health & Care Partnership to develop new models of care and begin holding joint accountability for delivery of these models across our local health and care system. We are doing this because

we believe working together is the only way we can truly meet the holistic needs of our population.

Our ambitious care development programme took place over June-September 2020, working with a range of health and care professionals from across the trust and wider health and care system to develop models of care which push the boundaries of how healthcare is planned and delivered. Underpinned by place based planning and developed through innovative challenge sessions to understand how we and our system partners can collaborate and deliver real, evidence based integrated care and population health management.

## Integrated Care Systems

Developed with and supported by our ICS and local One Health & Care Partnership our new models of care have provided a foundation to design our new hospital. 2020-2021 saw the trust and wider system partners set out a new and innovative approach to care delivery: the development of a Learning Health System culture, which will champion and develop a patient-centric and data driven health system that continually strives to improve with a relentless focus on outcomes.

Using the new Hospital Programme as a springboard we have developed a comprehensive Digital Strategy keeping us relentlessly focused on our ambition of becoming the most technological and digitally enabled hospital in the UK, allowing us to transform the care we deliver and the experience of our people.

This Digital Strategy outlines how PAHT will deliver world class care, in a paperless world supported and transformed through a digital culture that is right at our core.

## New Hospital

Never before has the reality of a new hospital been so close having submitted our Pre-Consultation Business Case in September 2019, coinciding with the launch of the government's Health Infrastructure Plan (HIP) Programme. In October 2019 the Department of Health announced that PAHT would be one of 6 trusts in the first wave of the HIP Programme giving the go ahead for PAHT to develop its Outline Business Case, with a new hospital build on a greenfield site as the preferred way forward. With the development of a national New Hospital Programme we are one of the frontrunner 8 organisations working closely with the national team to deliver a new hospital for Harlow and surrounding areas.

Between January- March 2020 the trust built its New Hospital Programme Team consisting of a clinical leadership team, full PMO, health planners, and design team. Over 2020-2021 the New Hospital Programme Team have worked tirelessly to deliver the following elements of the Outline Business Case:

- A full demand & capacity modelling exercise determining the predicted population growth and capacity required over the next 20+ years,

- A fully developed integrated and innovative model of care fit for the next 20+ years
- An ambitious Digital Strategy illustrating how the trust will become the most technically advanced hospital in the country
- A net zero carbon strategy for the new hospital
- A set of clinically designed 1:200 layouts for each department in the hospital that will support the delivery of care for the foreseeable future
- In support of our commitment to continual public engagement, a series of 'Virtual Town Hall' events with local communities outlining our vision for the new hospital and collecting feedback on a number of design ideas
- A staff engagement programme providing space for over 250 members of staff to influence the design of the new hospital

The Outline Business Case will be submitted to national regulators in autumn 2021.

## 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 2020-21 were variation in clinical outcomes, 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. The BAF is published within the Board papers on the trust's website.

## Going concern

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual. Consequently, as in previous years, the Trust has prepared its 2020-21 Annual Accounts on a going concern basis.

In approving the trust's annual accounts the Board of Directors has satisfied itself that the Trust has prepared the accounts on the basis of going concern.

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Strategic Delivery Plan and NHS Long Term Plan response for the five year period 2020-21 to 2024-25 and this plan includes the continued provision of services by the Trust. In addition, the Trust continues to

develop an Outline Business Case to build a new hospital, which is being supported by a variety of stakeholders. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

For the 2020-21 financial year, the Trust achieved a surplus of £1.8m against a planned deficit of £0.4m. Income from our local Clinical Commissioning Groups was largely based on the adapted finance regime introduced in response to the COVID-19 pandemic and this provided predictability and improved cash flow with the Trust finishing the year with a £65.2m cash balance. Additional costs arising from the pandemic were reimbursed in the first half the year and incorporated into a block payment basis for the second half of the year.

In April 2020, the DHSC and NHS England and NHS Improvement (NHSE/I) announced reforms to the NHS cash regime for the 2020-21 financial year. During 2020-21 existing DHSC interim revenue loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. Consequently, the Trust received PDC of £146.2m to repay these loans which had accumulated from prior year deficits. In addition, capital loans of £4.3m were also extinguished and replaced with PDC and therefore total net assets increased by £150.5m. This strengthened the value of the Trust's Statement of Financial Position and means that the Trust is no longer required to generate surpluses to service this historic debt.

For 2021-22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding to support elective recovery post COVID.

The national financial arrangements for the second half of the year are not fully known at this stage and while the implications of COVID-19 should be greatly reduced, there is likely to be some ongoing effect and, potentially, additional funding for this. The Trust's income is largely based on commissioner block contracts which will continue throughout the second half of the year. Reducing the Trust's underlying cost base and increasing efficiencies is essential with the focus on delivering a cost-improvement programme of £6.7m (or 2.2%). In 2019-20, the Trust achieved £9.9m (or 3.4%) of cost improvements and therefore is reasonably assured of being able to achieve this target.

The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period to 30 June 2022. The cash forecast shows sufficient liquidity for the Trust to continue to operate during that period with no need to borrow. In addition, the Trust has access to working capital arrangements should the need for this arise. In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

## Performance Analysis

### Financial Performance

As part of the national response to COVID-19, operational planning arrangements for 2020-21 were suspended. Operational planning was replaced with an 'adapted financial regime'. As part of these arrangements all NHS organisations were required to deliver financial balance over the first half of the financial year. This was achieved by a move away from commissioner contracts based on activity payments mechanism (Payment by Results) and replaced with block/fixed contract arrangements. In addition to block contract payments NHS providers received 'top-up' payments. These payments, along with a reimbursement process to recover costs associated with the response to COVID-19 ensured Trust's delivered financial balance. From 1 April to 30 September 2020 the Trust therefore delivered a breakeven position.

From September 2020 the block contract arrangements continued but the 'top up' payment mechanism ceased. For the second half of the financial year, September 2020 to March 2021, a control total was agreed with our Integrated Care System (ICS). Our financial plan was set at a £391k deficit. This became the basis on which our financial performance was measured.

The Trust delivered a £1.8m surplus against our deficit plan (a £2.2m improvement). This improved financial performance can be attributed to non-recurrent transactions.

### Operating and Financial Review

The key financial results for 2020-21 are that the Trust delivered a surplus of £1,816k. This was an improvement on the 2019-20 financial performance.

### Cost improvement

Even during the course of the pandemic, the Trust made efficiency savings of £6.2m during the year through our Cost Improvement Programme (CIP) without impacting the quality or safety of the care we provide.

### Capital investment

As the Trust has been in deficit for a number of years, this had previously led to significant constraints on being able to generate sufficient internally funded capital to be able to invest in our estate and facilities.

In 2020-21 we secured additional capital funding. We had a strategic capital investment plan and associated cash management plan in line with our local investment priorities. As a result we have been able to make investments that improved our estate which has helped us to be able to deliver high quality care to our patients and provide a better working environment for our people.

The Trust has made capital investments of £47.7m. In 2020-21 our key capital projects have included

- the Adult Assessment Unit
- the Fracture Clinic Unit
- the mortuary and staff facilities
- a new training facility
- equipment to support the NHS COVID-19 response
- critical infrastructure developments
- ICT investment including further rollout of wireless technology
- new CT and MRI equipment
- continued investment in backlog maintenance to ensure our estate is safe
- the development of our New Hospital Outline Business Case

Looking forward to 2021-22 we are planning major capital investment projects which will continue to transform the care that we are able to provide with the purchase of a further CT scanner and other medical equipment. We will continue to seek more capital investment to provide the best possible care to our local population now and into the future.

## Looking ahead

Looking ahead to 2021-22, the current national guidance is to continue the principles of the 'Adapted Financial Regime' into the first half of 2021-22. Block contract arrangements with commissioners will continue and will be uplifted for national inflationary uplifts offset by efficiency requirement. The ICS will receive additional funding allocations e.g. Growth and COVID-19 which will be distributed to ICS partners.

During the first half of the financial year the Trust will be eligible to receive additional funding from an 'Elective Recovery Fund'. This fund will be available to support the Trust in performing additional activity and accelerate the restoration of activity following COVID-19.

The Trust has also developed its capital plan for 2021-22. The plan is risk based inclusive of the continuation and the completion of capital commitments entered into during 2020-21. The plan also includes planned new strategic investments and continuation of progression towards our New Hospital. Our capital programme for next year is circa £49m which is funded by a combination of internal and external funding.

## Key Financial Results

The following table shows a range of financial performance values taken from the accounts.

| Accounts Highlights | 2020-21 £000's | 2019-20 £000's |
|---|---|---|
| Surplus for year | 1,816 | 50 |
| Public Dividend Capital Dividend Payable | 3,034 | 0 |
| Value of Property, Plant and Equipment | 137,845 | 117,405 |

| | | |
|---|---|---|
| Value of borrowings (including loans) | 40 | 150,998 |
| Cash at 31 March | 65,242 | 1,144 |
| Creditors – trade and other | 49,070 | 27,068 |
| Debtors – trade and others | 8,381 | 49,837 |
| Revenue from patient care activities | 267,835 | 246,747 |
| Clinical negligence costs | 13,010 | 9,924 |
| Gross employee benefits | 203,722 | 193,119 |

## 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

During the COVID-19 pandemic, and where possible and appropriate the Trust accelerated payments to suppliers recognising its responsibility to support all businesses in sustaining cash flow. As such performance in 2020-21 was an improvement on 2019-20. Performance is summarised as follows:

| **Non-NHS Payables** | **2020/21 Number** | **2020/21 £000's** | **2019/20 Number** | **2019/20 £000's** |
|---|---|---|---|---|
| Total non-NHS trade invoices paid in the year | 45,928 | 109,532 | 49,002 | 76,083 |
| Total non-NHS trade invoices paid within target | 39,957 | 92,948 | 43,722 | 64,320 |
| Percentage of non-NHS trade invoices paid within target | **87.0%** | **84.9%** | **89.2%** | **84.5%** |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 2,296 | 53,313 | 2,227 | 56,446 |
| Total NHS trade invoices paid within target | 1,912 | 48,878 | 1,805 | 47,379 |
| Percentage of NHS trade invoices paid within target | **83.3%** | **91.7%** | **81.1%** | **83.9%** |

## Anti-Fraud and Bribery

The Trust continues to work to maintain an anti-fraud, bribery and corruption culture and has 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.

## Operational performance

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

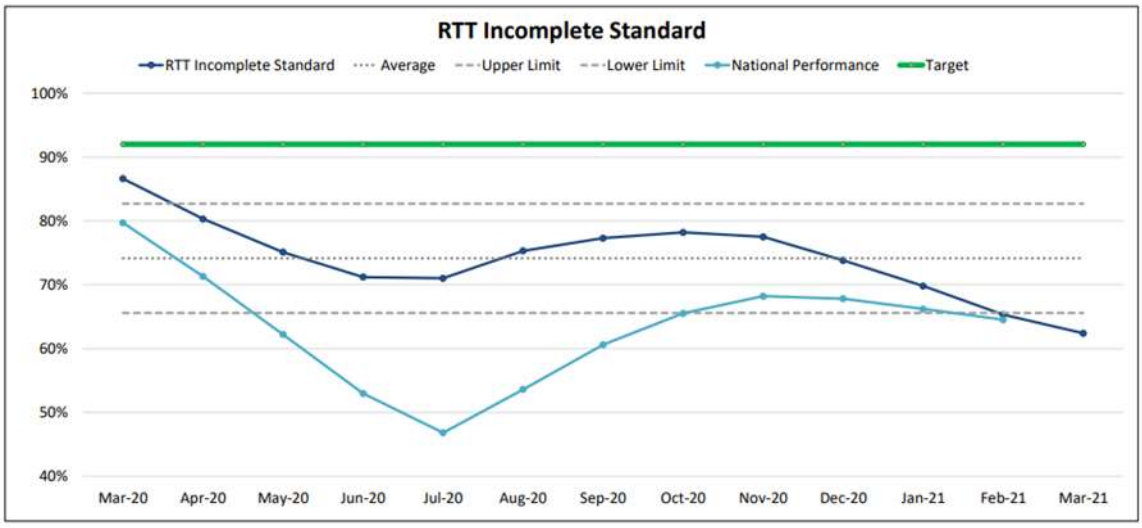
- Regular Performance Review Meetings between members of the executive team and each health care group
- The Urgent Care Board
- The Elective Access Board
- The Cancer Board
- Senior Management Team meetings
- The Performance and Finance Committee
- Trust board meetings

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

### Targets and national standards

Delivery of all national standards has been significantly impacted by COVID-19 and the increased volume of emergency patients requiring care. The requirement to maintain separate urgent COVID-19 and non-covid pathways and flows through the hospital, the change of many wards to focus on emergency care and the transfer of theatre staff to critical care significantly reduced the volume of elective activity that could be delivered.

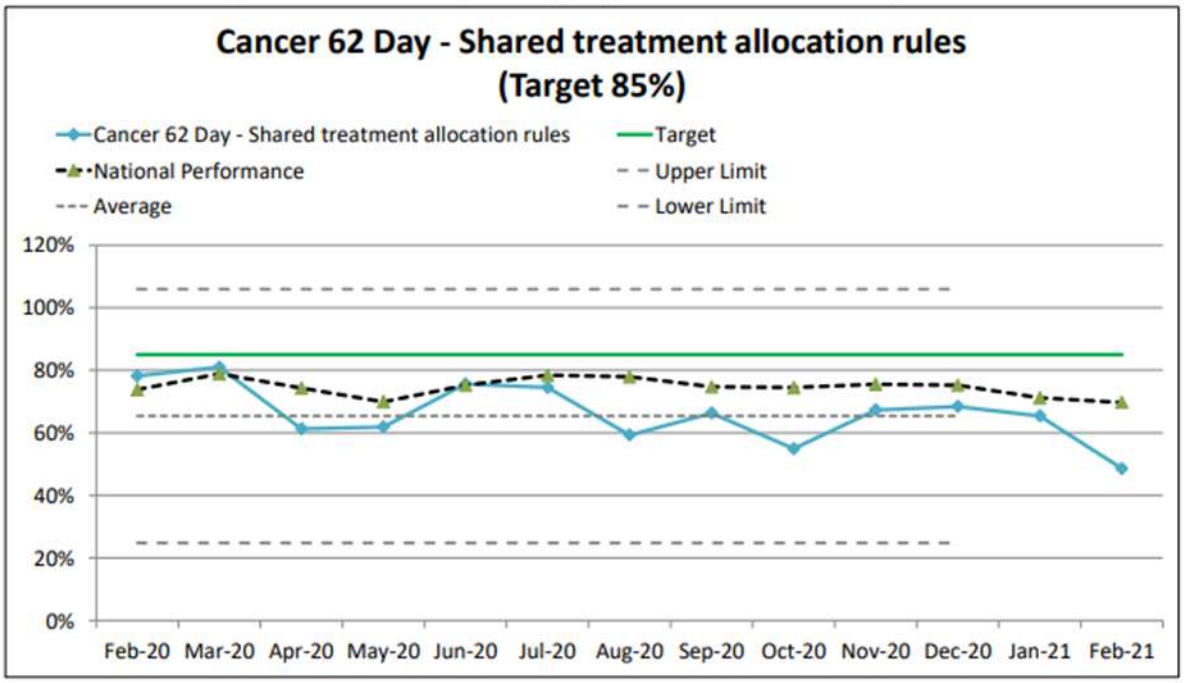
Full elective operating was paused on the PAH main site in March 2020 and did not recommence until July 2020. The local Independent Sector Provider hospital supported PAH by allowing activity to be carried out at their location which allowed PAH to continue cancer and urgent elective surgery, along with associated diagnostics.




The consequent impact on the 18 week RTT standard has been dramatic, although the trust has continued to deliver performance higher than the national average.

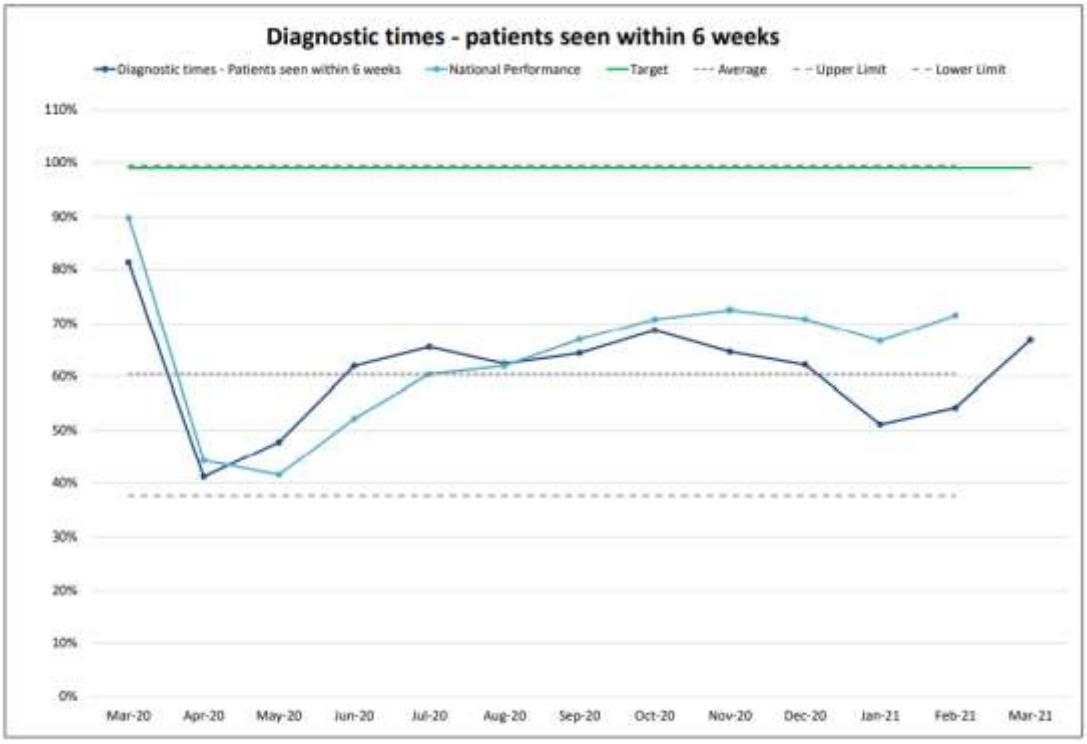
Delivery of the national cancer standards was also impacted by COVID-19, however the trust prioritised the maintenance of cancer services by transferring activity to the independent sector. After both waves of COVID-19, cancer recovery plans were implemented across all specialties and these led to sustained improvements in clearing the backlog of long waiting patients in the autumn which is reflected in the low 62 day performance seen as we treated more patients over 62 days than in previous years. The Trust's cancer performance was below the national average as it was more impacted by COVID-19 than other providers that had more flexible facilities to maintain elective activity during COVID-19 waves.

The trust continues to be committed to the delivery of all national cancer standards and plans are now in place to reduce the backlog from the first wave. The new 28 day faster diagnosis standard is coming into effect during 2021 and the trust has implemented a number of pathway changes in response to COVID-19 that sets up the achievement of the 28 day standard in 2021-22.



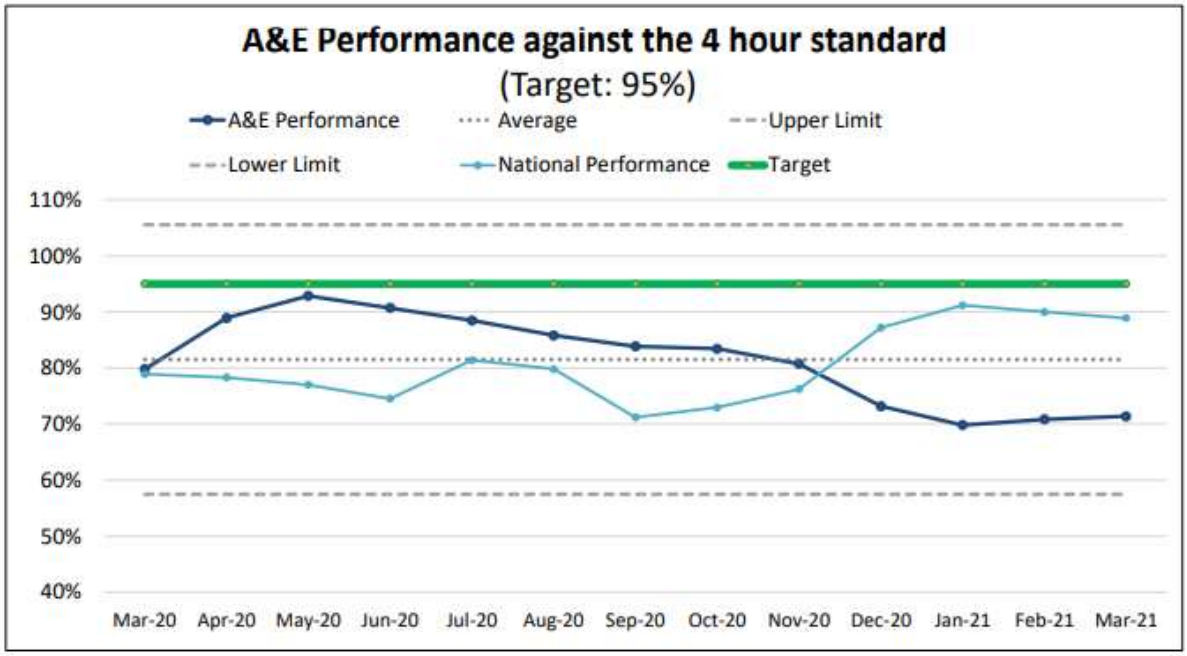

**Diagnostic performance**

Diagnostic performance was also impacted by COVID-19 demand as routine appointments were paused twice during 2020-21. Cancer and urgent diagnostics continued and despite considerable staff absence levels the diagnostics department delivered additional support to the emergency departments for COVID-19 patients. In between each wave of COVID-19 the diagnostic services recommenced routine work and increased capacity as far as possible with the use of CT vans on site, offsite additional working and patients travelling to independent providers for their diagnostic. The graph below shows clearly the drop in performance during COVID-19 and the rapid improvements in between.

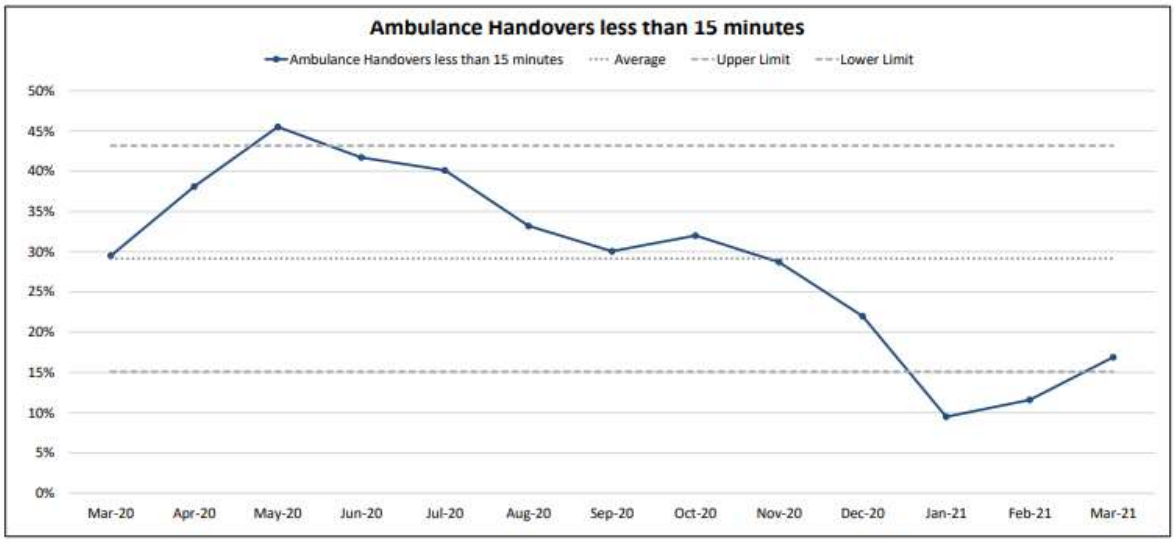



**Urgent Care and ED performance**

The urgent care attendances during the year have been untypical of an average year, with the waves of COVID-19 reducing non COVID-19 attendances, however attendances in March 2021 have shown an increase to pre-COVID-19 winter levels. The Emergency Department rapidly created a Respiratory Emergency Department to take COVID-19 attendances and ensure segregated non COVID-19 urgent care services. During the majority of 2020 the trust maintained performance against the 4 hour standard ahead of the national average however in the winter and early 2021

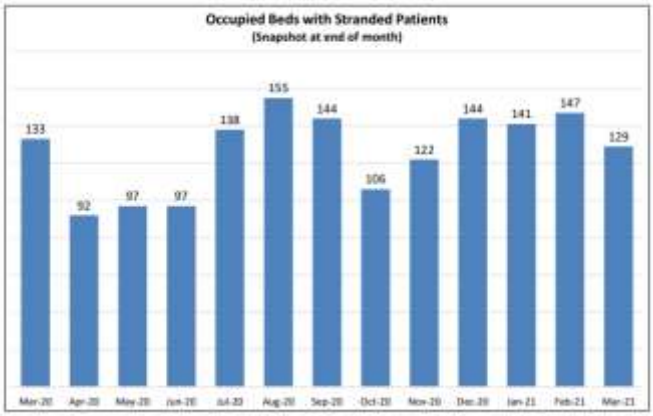


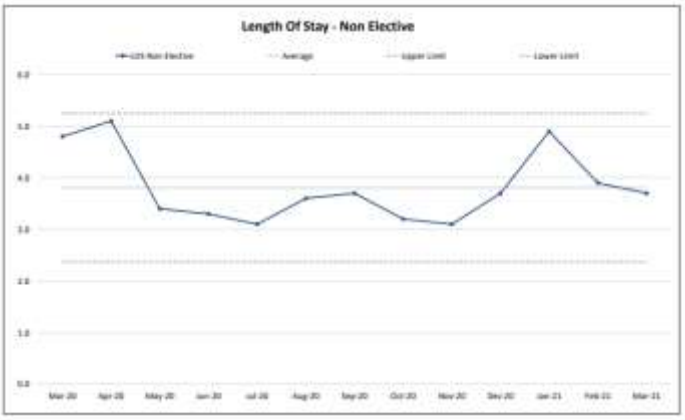
the increased COVID-19 admissions created huge pressure on bed capacity and the urgent care departments were unable to place patients on wards quickly to maintain the 4 hour standard. This also then impacted the ambulance handover performance and patients waited longer for handover to the emergency departments. The Rapid Assessment Treatment (RAT) pathways continued to be in place over the year but staff absence due to COVID-19 impacted the number of RAT teams available for this pathway.




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 Board 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 the opening of the Adult Assessment Unit and Same Day Emergency Care in addition to improvements in the Frailty unit.

The trust has continued to focus on reducing long length of stays for patients through collaborative work with the community across the ICS. The length of stay of COVID-19 patients directly impacted the overall non elective length of stay, particularly as each wave of COVID-19 showed different average lengths of stay.




## Responding in an emergency

Throughout 2020-21 the resilience team focused predominantly on supporting colleagues across the organisation with the response to the COVID-19 pandemic.

The response to COVID-19 has not been without its challenges, however, our people have gone above and beyond to demonstrate their ability to respond to challenges in a safe, coordinated and effective manner to ensure that our patients receive the best possible care.

From the end of January 2020 a full ‘command and control’ structure was implemented to ensure a robust response to what has been at times a rapidly changing situation. This structure comprised a Strategic Command Cell, with tactical cells managing operational response, clinical response, infection prevention and control, supporting our people, communications response and the management of our estate and infrastructure.

Along with our internal work we recognise the importance of multi-agency working, and continue to actively engage in the work of the local health resilience partnership, the Essex resilience forum and local organisations within out care system to provide a coordinated approach to emergency preparedness, resilience and response.

As required nationally we undertook an assessment against the NHS England emergency preparedness, 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 continued challenges posed by the COVID-19 pandemic, and our work to recover, identify learning, and restore our services, in a way that reflects a dramatically different way of working. Further detail on how the Trust is managing this virus is included in the infection prevention and control section below.

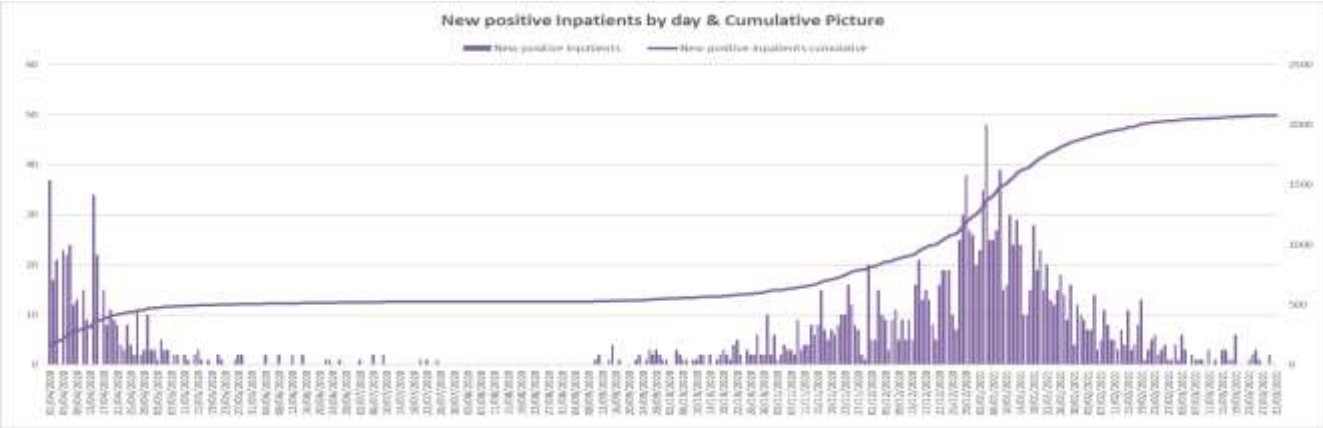
## Clinical performance

## Infection Prevention & Control

## COVID-19:

The trust's Infection and Prevention Control (IPC) programme was in place well before our first COVID-19 admission on 15 March 2020. The IPC programme was supported and escalated using the Trust's 'command and control' structure, as the pandemic evolved. Numbers of COVID-19 positive inpatients are listed in the table below from the dates stated until 31 March 2021:

| Table 1 **– Data up to 31 03 21** | Inpatient Spells since: | |
|---|---|---|
| | 01 02 20 :First wave | 01 09 20 : Second wave |
| TOTAL Inpatient Spells (with a Positive Swab): | 2069 | 1542 |
| Inpatients (Positive) - on 31 03 21: | 5 | 5 |
| Inpatients (Previously Positive)- on 31 03 21: | 7 | 7 |
| Discharged Home (with a positive Swab in Spell): | 1249 | 1018 |
| Discharged Other (with Positive Swab in Spell): | 69 | 47 |
| Inpatient deaths (with Positive Swab in Spell): | 529 | 330 |
| Transferred (with Positive Swab in Spell): | 210 | 135 |




The above graph shows the number of new positive inpatients by day, and also the total cumulative number of positive patients admitted.

The table below shows numbers of nosocomial COVID-19 at PAHT, using national definitions:

| 01/04/20 – 31/03/21 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Patients testing positive for the first time 3-7 days after admission (Indeterminate cases) | 31 | 1 | 84 | 76 |
| Patients positive for the first time 8-14 days after admission (Probable nosocomial infection) | 19 | 0 | 57 | 56 |
| Patients positive for the first time ≥15 days after admission (Definite nosocomial infection) | 12 | 0 | 40 | 38 |

- Cases are 'indeterminate' as it is possible these are community acquired and not hospital associated cases.

- It is likely patients had the more transmissible Kent variant in Q3 and 4, as nosocomial infection rose steeply despite outbreak control measures

A variety of strategies were put in place to manage patients admitted with SARS CoV2 and control COVID-19 infections at PAHT. This was supported by the Trust Board.

- The Executive team had access to national and regional support and feedback, provided visible leadership and chaired all Trust meetings.
- There was acceleration of coordination, planning, monitoring, training including IPC training, staff resource and finance.
- Risk communication, Operational support and logistics, and supply chains were optimised.
- CCG and Public Health (Essex Health Protection Unit) engagement with the IPC team and Executive team occurred on a regular basis.
- Data management (COVID-19 data, mortality, and operational data), IT support and remote working was facilitated throughout the year.
- Constant review of national guidance took place with adherence in all aspects of IPC including uniform policy, linen and waste disposal.
- 27 COVID-19 associated outbreaks were noted at PAHT from 01 April 2020 to 31 March 2021; 22 associated with clinical areas and five with non-clinical areas. Regular reporting to East of England Regional leads took place.
- In order to reduce staff sickness and staff outbreaks, close contact between staff was minimised at work stations, ward rounds and handover sessions, moving to 'virtual' multi-disciplinary meetings, and staggering staff breaks.
- Mortality reviews of all probable and definite nosocomial COVID-19 cases took place. This helped us learn lessons and implement improvements in practice such as minimal ward transfers.

Changes made in March 2020 to the way the organisation and the IPC team functioned continued throughout 2020-21. The IPC cell, Clinical cell, People cell, and Strategic cell shared decisions with the Incident Management Team for onward action. Ten PPE safety marshals were appointed to work alongside the IPC team to support and monitor the PPE programme.

Other IPC measures continued including:

- ✓ Respiratory segregation and respiratory etiquette.
- ✓ PCR testing of in-patients every 48 hours for COVID-19, to detect cases early.
- ✓ Ward cleaning up to four times daily, using a neutral detergent and a chlorine-based disinfectant.
- ✓ Single use items were used where possible, including allocations for side rooms.
- ✓ Social distancing when possible, in-patients wearing masks (FRSM IIR) when possible, any visitors to wear masks.
- ✓ All staff in PPE appropriate to their assessed risk (FRSM IIR or FFP3, gloves, scrubs, aprons/ gowns, goggles/ visors), including in non-clinical areas.
- ✓ Staff support up to seven days a week, by Staff Health and Wellbeing and The People team.
- ✓ Robust IPC risk assessment processes and control practices including for non COVID-19 infections and pathogens.

The following measures were also implemented and escalated at the Trust:

- Epidemiological investigation and contact tracing within the hospital and via public health links in the community
- Adherence to all mandatory reporting systems, risk registers, board assurance framework.
- Individual risk assessments for all staff, redeployment and COVID-19 secure settings.
- Ventilation reviews, system modifications, and introducing air cleaning and disinfection devices to reduce airborne transmission.
- Isolation of immuno-compromised patients using a side room priority isolation list stratified by pathogen and infection risk.
- PPE supply and compliance monitoring, for low risk (green), medium risk (amber) and high risk (red) patient pathways.
- A significant expansion in Microbiology laboratory capacity and diagnostics: In-house PCR testing capacity increased to 252 tests per day on weekdays, with 126 tests per day during weekends.
- The introduction of Point of care (POC) tests, mainly Samba II nucleic acid amplification units with ED testing capacity of 72 samples a day, increasing to 96 samples per day.
- Daily meeting of the Infection Prevention and Control (IPC) cell including weekends when required, with roll out and monitoring of all IPC methods.
- Protection of the health workforce including monitoring of staff sickness, database of COVID-19 related staff illness, lateral flow testing and participation in the national PHE run Siren study.
- Case management, and improvements in therapeutics managed by the PAHT Clinical cell.
- Introduction of the COVID-19 care bundle at the Trust, which included protocols on use of antibiotics only for concurrent bacterial infections.
- A well-publicised vaccine programme made available to all staff from December 2020 with booster doses in March - April 2021.
- In line with national guidance, monitoring for Variants of Concern by isolating any patients with a travel history, and providing positive isolates for genome sequencing. Only the UK Kent variant B.1.1.7 has been detected at PAHT to date.
- Monitoring patients for COVID-19 re-infections, and more recently also being vigilant for COVID-19 infections post vaccination.

## Alert Organisms

***Clostridium difficile* (C.*difficile*) -** There were a total of 43 hospital-onset and 11 community-onset healthcare associated (i.e. these patients were in-patients in the previous four weeks) *C.difficile* cases at the Trust during the year 2020-2021 (first two categories in table one below). This compares with 17 hospital-onset and five community-onset healthcare associated cases last year. The rise in cases is likely to be associated with the COVID-19 pandemic and the increase in broad spectrum antibiotic prescribing. Of the C.*difficile* cases in January to March 2021, at least half were known to have had COVID-19.

Community cases have also risen, and *C.difficile* in the whole population of West

Essex CCG are higher; 73% compared to around 60% in the other two CCGs in the Integrated Care System (ICS).

Table 1: *C.difficile* – cases by month

| Clostridium difficile (C.difficile) | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital onset healthcare associated: | 0 | 2 | 1 | 4 | 6 | 4 | 2 | 1 | 5 | 7 | 3 | 8 |
| Community onset healthcare associated: | 1 | 0 | 0 | 0 | 2 | 0 | 1 | 1 | 0 | 2 | 2 | 2 |
| Community onset indeterminate association: | 1 | 1 | 1 | 2 | 2 | 2 | 5 | 1 | 1 | 1 | 0 | 0 |
| Community onset community association: | 0 | 2 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 1 |

Control of *C.difficile* will be a top priority for our clinical teams, the IPC Committee, and the Antimicrobial Stewardship Group in the months to come.

**MRSA Bacteraemia -** There have been no Trust-attributable MRSA bacteraemia cases this year, which means the organisation remains in an excellent position nationally. Community cases have increased (four in 2020-2021) and are being investigated by the CCG.

**MSSA Bacteraemia -** There is no trajectory in place for MSSA bacteraemia. There were seven Trust-apportioned cases during the year which is a low number of cases. Case numbers are the same this year as for the previous year.

**Gram Negative Blood Stream Infections (GNBSIs) -** There is a whole health-care economy ambition for reducing healthcare associated GNBSIs by 50% by 2023-2024. Cases during 2020-21 were comparable with the number seen in 2019-20.

Total number of cases during the year 2020 - 2021

| Gram Negative Blood Stream Infections | Pre 48 hour cases | Post 48 hour cases |
|---|---|---|
| *E.coli* bacteraemia | 156 | 12 |
| *Klebsiella spp*. bacteraemia | 33 | 8 |
| *Pseudomonas Aeruginosa* bacteraemia | 14 | 3 |

## Infection Incidents and Outbreaks

**Norovirus.** There were no outbreaks of norovirus.

**Influenza and other respiratory viruses.** From 28 September 2020 influenza A and B, and RSV testing was undertaken routinely. Just six of 20,000 patients tested were positive for Influenza A, nine were positive for Influenza B and ten were positive for RSV throughout the six month period. These are extra-ordinarily low numbers, showing the predominant role of SARS CoV 2, and the success of the influenza vaccination.

## Audits and Surveillance

PPE compliance and hand hygiene audits continued throughout the year with actions plans implemented by Health Care Groups and monitored by the IPC cell/IPC Committee.

## Conclusion

Together with our colleagues across the UK, we are reviewing lessons learned from the COVID-19 virus and our response, identifying gaps in our knowledge and anticipating potential challenges that may lie ahead. With global travel stopping and starting depending on the evolving epidemiological situation around the world, the COVID-19 vaccination programme and emergence of SARS-CoV-2 variants of concern, the virus is currently still being monitored very closely.

## Learning from incidents

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

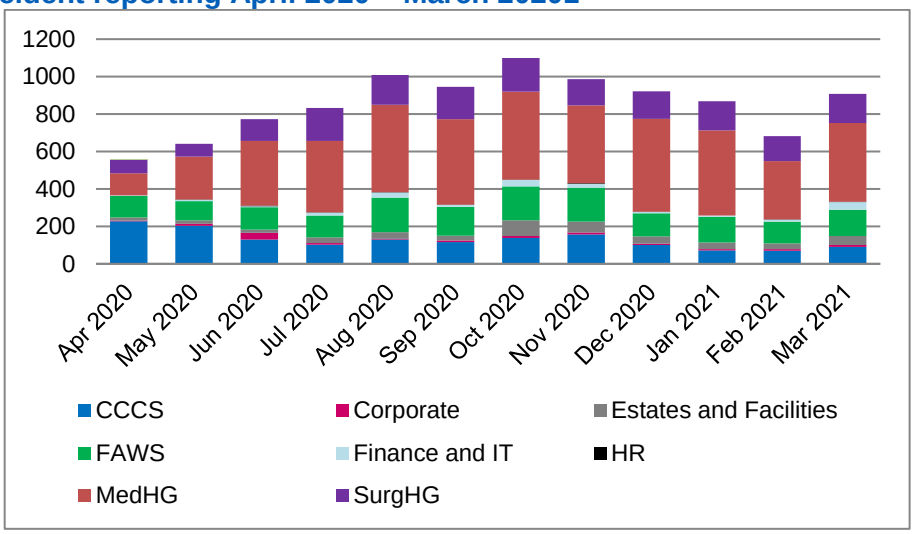
A patient safety incident or adverse incident is defined as ‘any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS funded care’. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised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

This year saw changes in the incident management process in response to the impact of the pandemic. Twice weekly Incident Management Group meetings (IMG) took over from the historical daily oversight and serious incident group meetings. IMG reviews all incidents graded as moderate and above and makes a decision on the appropriate harm grading and the level of investigation. All moderate, severe and death graded harms were reviewed through this process.

IMG is chaired by the Director of Clinical Quality Governance, deputised by the Associate Director of Quality Governance. There is executive oversight of the incident management process through quality briefings and reports submitted to the Patient Safety Group and Quality and Safety Committee.

For the year 1 April 2020 to 31 March 2021, a total of 10,226 incidents were reported on the trust’s Datix incident management system; this is a 0.8% increase from 2019/20.

## Incident reporting April 2020 – March 20201




10,226 incidents were reported during 2020-21, 0.8% increase from 2019-20.
6902 were patient safety incidents (67%) reported this year, a decrease from 72% last year. Other incident reporting types were:

- 738 staffing shortage (7.4%)
- 652 staff related (6.4%)
- 564 equipment related (5.6%)
- 485 Security (4.8%)
- 463 environmental (4.6%)
- 369 monitoring (3.7%) not incidents but recorded on Datix for monitoring purposes
- 53 visitor related (0.5%)

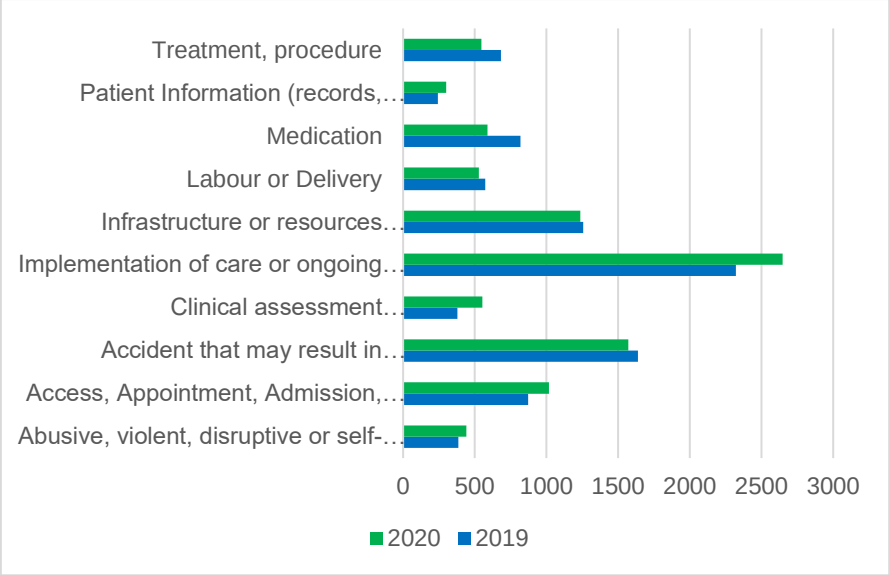
In comparison with last year there has been a rise in:

- Security incidents from 2% to 4.8%
- Staffing shortage from 5.8% to 7.4%

Both of these incident types saw an increase related to the social and organisational pressure of the pandemic. Other incident types have either seen congruent or decreased reporting numbers.

## Top 10 Patient safety incidents

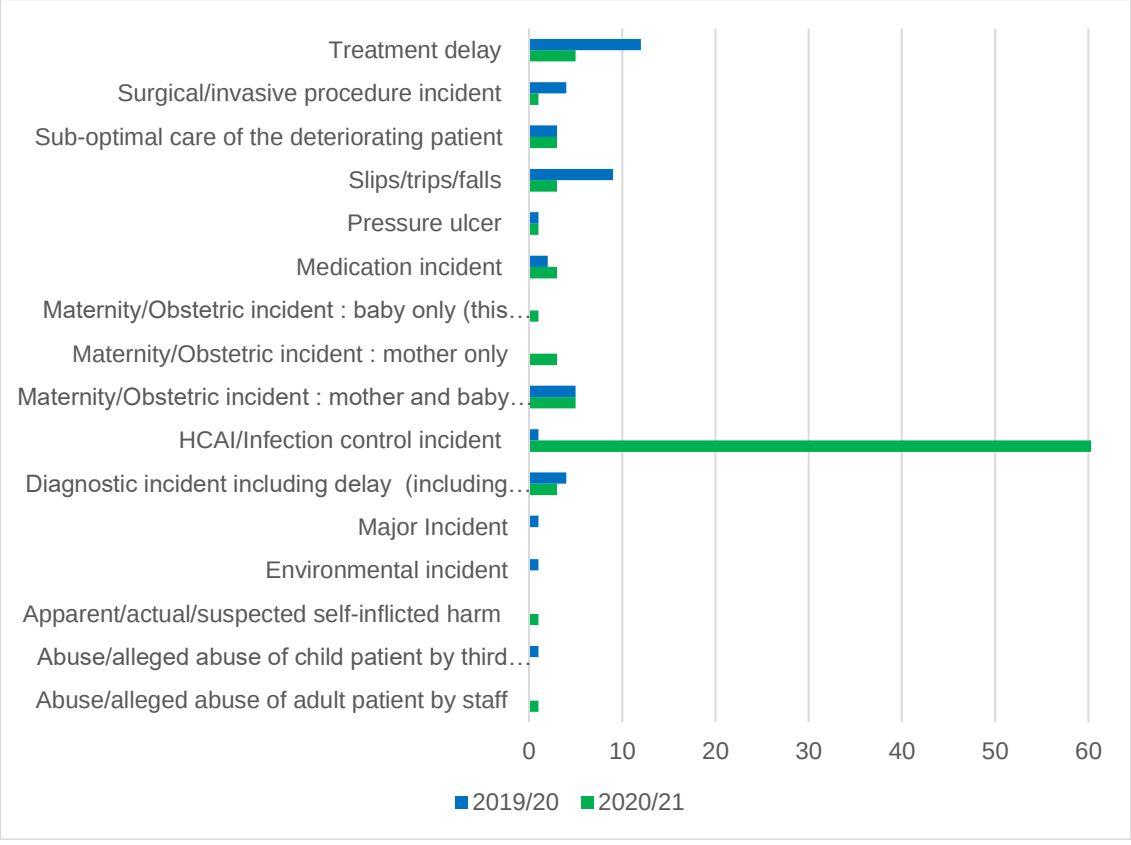
The top 10 categories of patient safety incidents reported in year are summarised in the table below. These are reported to the National Reporting and Learning System (NRLS) now part of NHS England to enable learning and comparison with similar sized organisations to occur.




## Serious Incidents

94 serious incidents (SIs) were reported by the trust in 2020-21. In comparing the last two years with 2020-21, there has been a reduction in incidents for falls, treatment delays, surgical procedure, and diagnostic incidents meeting the criteria for SI. There was an increase in maternity incidents from 4 to 9, and an increase in health care associated infections related to the COVID-19 pandemic.

### Serious incidents reported in year



## Never Events

The trust reported one Never Event in 2020-21.

## Friends and Family Test (FFT)

The use of the Friends and Family test was suspended at PAHT as the approach to gathering data presented a risk of infection for patients and staff. National returns of this data were also suspended for much of 2020-21 due to the pandemic. As a result, although some evidence was gathered electronically this section of the report focusses on the wider patient experience metrics.

## The year in patient experience

We closed 2020-21 with 204 complaints received, the first increase in complaints year on year since 2011 (176 in 2019-20) and 3112 PALS cases received (vs. 3462 2019-20).

The top trending theme is medical care expectations and communication issues which continue to be the most significant issue.

## A richer picture of communication issues

As we develop plans to renew our patient safety, experience and quality strategy we have been taking a closer look at the issues underlying our communication challenges. As a result of this analysis we now have a richer, more complex picture of the people who are most concerned about communication.

We see that caregivers and relatives play the most significant role in raising concerns about the quality of care and communication, confusion about the correct information from professionals to both patients and relatives appears to be a systemic issue and in addition to this telephone contact with relatives is significant issue.

## Some examples of our operational response to these issues:

Existing support projects continue with 1542 family video calls completed through our 7 day service in the last year, over 1533 carers messages distributed and 128 ITU patients' carers and relatives provided with ITU information.

- The team developed new inpatient visiting guidance which has restarted based on the national guidance, supports open visiting for high risk groups as well as visiting at the ward managers discretion for those for whom this would 'enhance the care experience' so that family carers are fully supported.
- Repatriated patient property for over 200 families who may otherwise not have received their family member's belongings, refreshing our policy in the process, introducing securely tagged, colour coded bags for elements of property, a night safe and centralised control.
- New communication channels for carers with a group operating the first and third Monday of the month, being publicised through local voluntary sector groups and Trust communications.

- Work on health inequalities as a result of funding from the East of England Cancer Alliance who funded a cancer information film from a patient perspective translated into five community languages on video and information card. The languages are Polish, Romanian, Italian, Urdu and Punjabi.

## Mortality

Some of the statistical markers for mortality have been higher than expected for 2020-21. This year a change in requirements for the configuration of the data submitted to HES has led to incomplete data submission affecting the HSMR and SHMI from September 2020-November 2020. Resolution is expected by May 2021 and a data bundle will be submitted which will enable correction of the SHMI and HSMR for that period.

## 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 2019 to November 2020 (including a time lag of one month) the trust's HSMR was 116 (higher than expected) but improved from 2018-2019 (122).

It is anticipated that the HSMR will continue to improve.

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)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the Trust.

SHMI for the period December 2019 to November 2020 is 101.85 (as expected).

## Progress over the past year

Mortality governance is a key priority for the trust board. The medical director 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 are 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 the actual and the expected number of deaths both nationally and at PAHT. The first COVID-19 death at PAHT was reported on 18 March 2020. All deaths related to COVID-19 are included in the structured judgement review process with the learning shared rapidly through the IPC reporting infrastructure.

Going forward a new software system (SMART) is being implemented to enable a 'live' and 'visible to all staff' view of the trust status in terms of learning from deaths. Go Live is anticipated to be May 2021 and the benefits expected include more timely insights in to the effectiveness of the care we give.

The healthcare groups will be appointing medical patient safety and quality leads who will work with all the clinical specialties to ensure learning from deaths across the organisation and support a continuing improvement in mortality indices.

## Quality improvement

The trust is registered with the Care Quality Commission (CQC) and our current status is 'registered without condition'.

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

The last full trust inspection conducted by the CQC was completed in March and April 2019 with the report published in July 2019, this showed 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 at **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 current CQC ratings received in July 2019:

| 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

During the 2019 inspection, the CQC identified areas where the trust was performing well and had made improvements from previous inspection in 2017, these were:

- Safety incidents reported well
- Pain management regularly monitored
- Patients treated with compassion, kindness, privacy and dignity.
- Services were inclusive and complaints treated seriously
- Positive culture where staff felt respected, supported and valued
- Clear vision for the trust and embedding of large amounts of change over the last 3 years
- 72% of all ratings are now ‘good’ or ‘outstanding’
- Caring rated as ‘good’ for the third consecutive inspection

Within this inspection report, the CQC identified areas where the trust needed to improve performance and these were:

- Mandatory training not completed (doctors) and insufficient nursing staff
- Poor and incomplete record keeping
- Limited audit activity (national and local)
- 4-hour standard for urgent and emergency care not achieved
- Slow response to issues of risk and poor performance

The report detailed 42 recommendations for the trust;

- 22 MUST do actions
- 20 SHOULD do actions.

The recommendations were collated into 14 individual projects based on themes, using our Quality Improvement methodology to enable a consistent and sustained approach to the achievement of these objectives. Each project has a designated executive, a senior responsible officer (SRO) and may have a small project team appointed.

The trust is using the quality improvement plan as a dynamic document; with additional topics added over time, as we identify areas that require further improvement. The quality improvement plan is monitored monthly through the Clinical Quality Improvement Group and reports into the Trust Compliance group and Quality and Safety Committee.

### 2020

The CQC undertook an unannounced winter assurance visit to the Urgent and Emergency care department on 3 February 2020. Their report was published in April 2020 and rated the service **Requires Improvement** with two areas receiving a regulation notice:

- The trust must ensure sufficient provision of out of hours endoscopy service to minimise risk of treatment delay to patients who require to access the service
- The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of reflective of each patient's full clinical pathway and include actions taken in response to individual risks.

The Trust implemented a quality improvement plan to address recommendations raised and strengthen the leadership team with the service areas.

### 2021

The CQC conducted an unannounced inspection of the emergency and urgent care department on 14 February 2021. Their report was published on 27 April 2021, giving the department a rating of inadequate and the trust received a section 29A warning notice.

The concerns identified by the CQC from their inspection was-

- Risk assessments were not being completed for all patients within the emergency department.
- Not assured that patients presenting with acute mental health illness were receiving timely assessments.
- There was a lack of adherence to infection, prevention and control procedures.
- The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded.

Immediate actions were implemented following receipt of the warning notice, with further actions underway. We have undertaken a review of these findings across the trust, for all core services to ensure the learning is shared widely and improve services across the whole trust.

The trust is confident that the actions undertaken and planned in the coming weeks will ensure we continue to improve the safety of patients in our emergency department.

The CQC will complete a further unannounced inspection of the emergency department after 1 June 2021 to monitor our progress against the action plan and we look forward to the opportunity to show them the improvements we have made.

## 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 past year has been a very different year for everyone especially those working and receiving care in the NHS.

The Trust's and NHS's response to the COVID-19 pandemic has seen some quality improvement initiatives and transformation projects not progress at the pace that had been hoped for or anticipated. However, in other areas our response to the pandemic has seen some changes occurring at an exponentially increased pace, due to the necessity to keep patients safe. This is evidenced by the ability of our teams to introduce non face to face outpatient services within two weeks. Our learning from such changes has supported the ability to sustain and enhance this change for the benefits of our patients, people, performance, places and pounds.

The Quality First team responded at pace to the necessary changes to activity the pandemic has necessitated. This included redeployment of members of the team to high risk areas such as critical care, introduction and delivery of the lateral flow tests for staff and key patient groups and leading the COVID-19 vaccination service to circa 7000 local health and social care staff.

## 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.

We continue to develop our people with quality improvement skills, knowledge and capability with a focus on leading change and leading projects. 385 staff members have completed Leading Change, with 198 completing Leading Projects. We now have 52 Improvement Partners at PAHT.

## Improving patient outcomes

Our work to improve outcomes (mortality rates) for our patients has continued throughout the COVID-19 pandemic. Original plans were amended as many of the clinical and operational leads had to prioritise supporting our response to the pandemic; however here are some notable achievements from the previous year.

We have significantly improved our learning from death processes and standardised the mortality and morbidity meetings that happen in our speciality teams giving us greater ability to address lessons learnt as well as celebrate our successes. Our focus will continue to be on the areas where we know we have an opportunity to improve, namely the following diagnosis areas, sepsis, acute kidney injury (AKI), acute respiratory (COPD, Pneumonia and Aspiration Pneumonia), fracture of neck of femur and our end of life pathways, which will continue to do in partnership with our wider health and care system colleagues.

Every specialty has a clear clinical strategy in place and a big part of delivering these will address unwarranted variation in care and ultimately improve patient outcomes.

A significant milestone achievement for PAHT was being able to provide non-invasive positive pressure ventilation in our respiratory ward in addition to critical care. We know beginning non-invasive positive pressure ventilation quickly can improve patient outcomes, reduce length of stay in hospital and reduce the need for admission to critical care. Thank you to the respiratory, Locke Ward, critical care, emergency department and clinical site teams for their support with developing the pathway.

## Theatre utilisation

The development of a QlikView dashboard to show performance in theatres to help identify opportunity for improvement was completed and went live on 15th September 2020. This development will support focus for the surgical teams to improve theatre utilisation to achieve 85% utilisation by March 2022. The focus is now on improving utilisation within three clinical specialties, Ophthalmology, ENT and Maxillofacial. If we reach 85% within these specialties it will increase the trust's utilisation by 10%.

## Outpatients

Patient initiated follow up (PIFU) allows patients to determine whether their condition requires clinical intervention and allows access to the specialist when it is needed. In turn this reduces the number of follow up appointments needed. The first pilot for Fracture went live on 22nd February 2021 and as at 25th March 2021 38 patients have been discharged onto this pathway. Prior to PIFU these patients would have been booked for a follow up appointment.  Plans are in place for a pilot in Neurology to go live on 12th April 2021. We will be working with specialties to determine the roll out plan for PIFU across the Trust.

“Doctor Dr” was introduced and enabled paperless communication for patients. A text message generates a link for correspondence to be viewed. This is in place for all appointments in outpatients with outcome letters due to go live in April 2021. There has been a 71% uptake in patients choosing to view their letters electronically which has both cost savings, due to reduction in postage, and environmental saving, as less paper is used.

We moved away from a one-way messaging flow provider to a new provider enabling two way messaging with our patients. We have gone live with Paediatric and Paediatric diabetes as a two way messaging flow for appointments. Other main outpatient services will be live by October 2021 and pilots are due to commence for gynaecology elective activity in April 2021 before roll out to all elective activity.

Telemedicine was rolled out rapidly, using the Attend Anywhere platform, as part of the national response to COVID-19 in April 2020 with 70% of specialties trained to use the system. Template letters and processes have been established to support the delivery of telemedicine. We are now engaging with operational teams to identify opportunities to increase non-face to face capacity in line with new hospital ambitions.

## National Careers Week

Over 150 students took part in virtual work experience as part of National Careers week, where they looked at 3 of the NHS’s wicked problems (recruitment and retention, patient flow and patient experience) they then presented their ideas on how these problems could be solved to the board of directors during national careers week.

## Strategic realisation and system partnership

The Quality First Team works in partnership with PAHT’s Strategy Team to support the facilitation of Clinical Strategy workshops and the quality improvement methodology is embedded into each of specialty level strategies ensuring that our plans have clear aims, measurable deliverables and achievable actions (tests of change).

We also work with system partners in the development and delivery of the ICP/S and transformation plans and support expert oversight groups (EOGs) in the delivery of quality improvement.

## People performance

In 2020-21 our people faced many challenges in response to the COVID-19 pandemic. Staff were required to work in significantly different ways through skill development and redeployment in management of unprecedented levels acute patients as well as COVID-19 related staff absences. The trust has continued to recruit throughout the year to both substantive posts and temporary recruitment to support is increase and pressure in the services.

The key workforce indicators are reflected in the table below:

| People KPI | 2019-20 target | Year to date performance |
|---|---|---|
| **Vacancy rate** | 8.6% | 8% |
| **Sickness absence** | 4.3% | 3.6% |
| **Voluntary turnover** | 10.7% | 9.7% |
| **Statutory and mandatory training** | 92% | 87% |
| **Appraisal** | 89% | 71% |
| **Flu** | 80.1% | 81% |
| **Time to hire** | 31 days | Average 41 days |

The below key themes highlight the outputs that form our people framework and clarifies the five key pillars of the people strategy:

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

It is acknowledged that the last year has been a challenge for our workforce, in addition to PAHT's people strategy the NHS 2020-21 people plan also set out practical actions for employers and systems in light of the challenges faced by organisations in their response to COVID-19, as outlined below:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

The trust focused on how we continue to look after each other and foster a culture of inclusion and belonging, as well as taking action to grow and develop our workforce, and work together differently to deliver patient care.

## Health and Wellbeing

One of the key priorities during 2020-21 was to implement and embed a sustainable health and wellbeing offer to our staff in response to the impact of COVID-19 and the challenges that have been faced.

The trust had 160 staff who were required to shield under government rules. Laptops were distributed to enable staff to work from home where possible. This included some redeployment into roles that could continue to provide support remotely from home.

A seven day week first line absence reporting service was set up during the peak of the pandemic to take calls from staff reporting their absence either through their own sickness or a requirement to self-isolate. This captured live absence data throughout the day and enabled clinical staff to reviewing staffing levels on an ongoing basis.

Individual risk assessments were carried out on staff working on all hospital sites which assessed any underlying conditions that may affect the level of risk of becoming seriously unwell if tested positive for COVID-19. Advice and coaching was provided to staff and managers on undertaking the risk assessment and managing outputs. Where required, action plans were then agreed between the staff member, their manager and the trusts staff health and wellbeing service (SHaW).

Project wingman was a national initiative resourced voluntarily by pilots and cabin crew who were grounded at the time of the pandemic. The purpose of the initiative was to provide a first class style socially distanced breakout area where drinks and refreshments were served to staff. An additional key element of this initiative was that all of the cabin crew were mental health first aiders. This was well received by staff.

The winter flu campaign saw 81% of staff vaccinated, a slight increase on 19/20 figures.

Webinars took place within the trust to provide staff with updated information and advice about the virus, a number of these were facilitated specifically for our BAME staff to address emerging themes and concerns.

The trust has developed a range of health and wellbeing support initiatives for our staff whether at the front line or in supporting services. A number of these services have been developed on a national and ICS level and additional support implemented locally in partnership with SHaW (staff health and wellbeing) - our occupational health service, the trust's employee assistance programme, the Red Cross and Essex partnership university NHS foundation trust (EPUT).

Work was undertaken to support both shielding staff and their managers in returning to work and psychological and physical support was made available. The trust

delivered an ongoing series of webinars for both staff and managers throughout the COVID-19 period.

Lateral flow testing was implemented across the trust in October 2020, initially to frontline staff and in December this was rolled out to all staff.

January 2021 saw the first dose of the COVID-19 vaccination delivered to staff, students and volunteers working within the trust. This programme was led by the trusts occupational health department with the support of the quality first team. The second vaccination dose programme commenced in March and completed in April. 85% of staff received their first vaccination through the trust, those staff who were unable to receive their vaccinations were supported to book their vaccination through the community provider in Harlow.

The trust introduced a peer support initiative called “time to talk”. This initiative is supported by substantive staff from within the trust who are trained as either mental health first aiders or are trauma and risk management practitioners. The concept is to provide immediate intervention with face to face drop in support to staff across the trust at designated times and places such as at the end of each shift. This support has been well received by staff and will continue as part of the trust’s recovery plan going forward

A 12 week “back to better” people focused campaign was launched by the trust with the aim of supporting our people to develop and drive refreshed approaches to delivering services following the significant challenges that have been faced over the last 12 month and will continue to face going forward. There are four themes underpinning this campaign:

- Health and Wellbeing
- Compassionate and inclusive leadership
- Civility
- Operational leadership

The trusts intranet ALEX, has a page dedicated to the health and wellbeing offer available to our staff. This includes signposting staff to the services which offer both psychological and physical wellbeing and support, as well as online resources, toolkits and self assessments.

In line with the NHS people plan the trust has appointed a non-executive director as a health and wellbeing guardian. This role will work closely with the people division and wellbeing leads across the organisation to encourage a model of wellbeing leadership.

## Workforce, resourcing and planning

The trust implemented agile working across the organisation including working from home. The wide use of laptops and digital telephone systems enabled the trust to implement social distancing rules and decrease footfall across our working sites. The impact of agile working/ working from home has enabled greater productivity efficiencies though re-evaluation of current processes and systems and has enabled specific objectives and targets to be set and measured more efficiently.

- We continued to welcome international nursing staff into the trust, facilitating the required isolation period with designated hospital accommodation. The nursing staff group now has a vacancy rate of 7.8%. The overall trust vacancy rate is less than 10%

- There were a number of national initiatives to support staff groups with staff deployed across the NHS in response to the pandemic. These included medical students, aspirant nurses and staff deployed from other organisations, both private and public sector

- The trust has continued to support NHS management graduates placed within the organisation

- Following a pause during the pandemic, pre-registration students restarted placements with the trust in March 2020

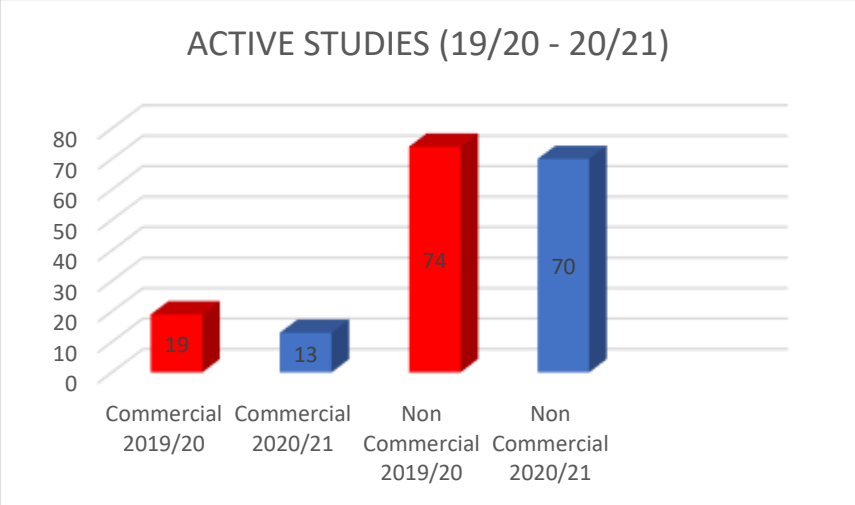
- Whilst apprenticeships were paused in a number of areas during wave 1 and wave 2 of the COVID-19 pandemic, we continued to support this scheme where possible and currently have 65 apprentices working across the trust

- The trust management and leadership development programmes were paused for most of 2020-21 however the ward managers leadership programme commenced in March 2020

- Non statutory training was paused during the pandemic to maximise availability of staff. All training was reinstated in March 2021, the majority of which is either online or visa MS teams

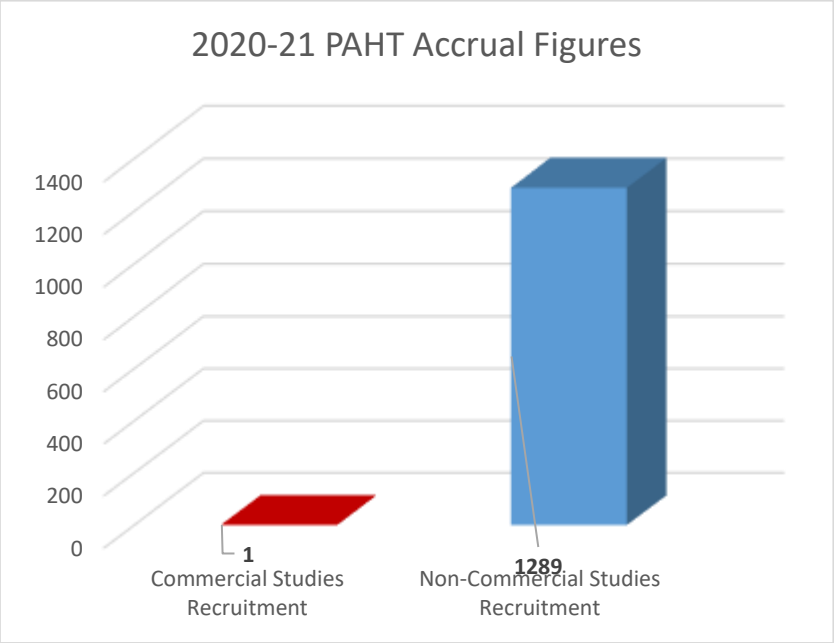
- Appraisals were also paused during the pandemic and reinstated in March 2021

## Research, development and innovation



There were 13 Commercial Portfolio studies throughout 2020-21. 5 were open with 1 having a significant delay/suspension due to the COVID-19 Pandemic (Diamond Study). 8 of the studies were In Follow Up.

We had 70 Non Commercial Portfolio studies in 2020-21. Out of the 50 Open studies, 15 were significantly suspended or delayed due to the COVID-19 Pandemic. There was 1 COVID-19 Non UPH study and 9 COVID-19 UPH studies. 17 were closed to recruitment and had moved to In Follow up only and 3 were closed following the conclusion of Follow Up.




## Recruitment per Speciality

| Recruitment | Speciality | Directorate | Commercial/Non Commercial |
|---|---|---|---|
| **Portfolio Activity** | | | |
| 777 | Cancer | C,C & CSS | Non-Commercial |
| 5 | Gastroenterology | Medical | Non-Commercial |
| 3 | Emergency Dept. | Urgent & Ambu | Non-Commercial |
| 16 | Critical Care | Surgery | Non-Commercial |
| 369 | People | Corporate | Non-Commercial |
| 64 | Respiratory | Medical | Non-Commercial |
| 10 | Maternity | F & W,S | Non-Commercial |
| 3 | Ophthalmology | Medical | Non-Commercial |

| | | | |
|---|---|---|---|
| 35 | Musculoskeletal | Medical | Non-Commercial |
| 6 | Diabetes | Medical | Non-Commercial |
| 1 | Cancer | C,C & CSS | Commercial |

## Improving our estate

The trust has invested substantially in remodelling and maintaining the estate with the following initiatives and priorities progressing at pace over 2020-21.

- Improving the management of buildings and engineering systems.
- Providing excellent facilities.
- Ensuring safety and security.

The approved capital programme was significant including £7.7m backlog maintenance and £17m investment in improving the estate. The programme was made up of three elements, these include:

- Emergency backlog and critical infrastructure maintenance schemes (£7.7m).
- Capacity schemes (£11.3m).
- Development schemes (£5.7m).

2020-21 saw the Trust implementing agile working, reducing office accommodation onsite to enable maximising the availability for clinical space in line with the emerging demand from increased patient activity.

Completed schemes include:

- Fracture Clinic.
- Kao Park (administrative hub)
- Adult Assessment Unit (AAU).
- Multi-faith facility
- Alex Study (Consultants Office)
- Dolphin Ward upgrade.
- Drammen House upgrade
- Kalmar House upgrade

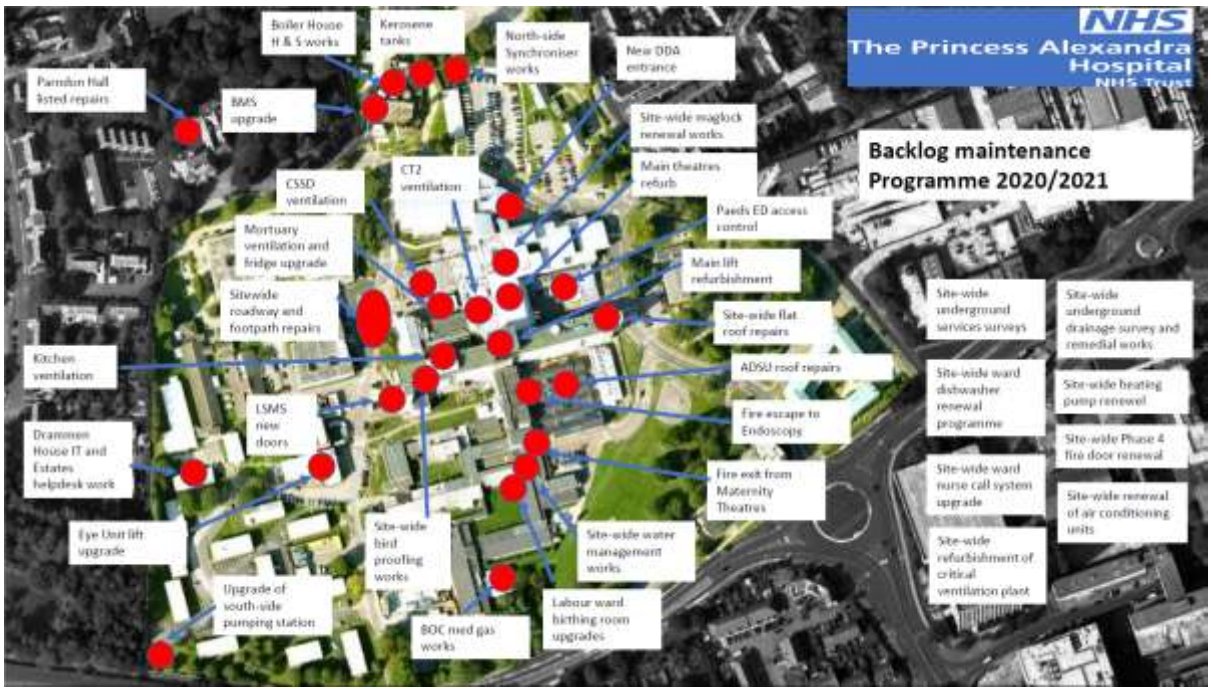
The locations of the projects are shown on the site plan below. Included are schemes initiated in 2020-21 but due for completion in early 2021-22.


In addition we completed a total of 54 schemes (90 individual projects) ranging from £10k to £500k to manage maintenance backlog and the Trust's critical infrastructural risks. These included:

- Asbestos - encapsulation/removal works.
- Fire damper remedial works - Trust wide.
- Replacement of kerosene tanks located in Boiler house compound.
- Water Management remedial works from audit.
- Labour ward corridor and room upgrade.
- Upgrade of Bereavement Suite.
- Bird proofing to roof mounted AHU/Chiller plant.
- Site underground services survey update and required remedial works.
- New external door sets to meet LSMS audit report.
- Upgrade of main block (3No.) and Eye Unit lift
- Obsolete switchgear replacement - North and south side.
- Medical gas plant remedial works identified in BOC audit.
- CSSD - ventilation replacement.

- New UPS/IPS to ED, theatres and ITU dept. on critical equipment.
- Basement fabric, electrical, mechanical repairs required for compliance and business continuity.
- Refurbishment of main sewerage stack.
- Site-wide Roadway and Footpath Repairs.

The locations of the projects are shown on the site plan below.




## Sustainability

The Clinical Senate Council (South West) acknowledged that climate change should be treated as a healthcare emergency and that there is much that can be done both in the short and medium term to make the NHS more sustainable, at provider, organisational, procurement, estates and individual levels. In light of this the trust has continued to pursue its commitment to ensure delivery of high quality health care service with minimal negative impact on the environment.

We reported significant progress on our Sustainable Development Management Plan (SDMP) for 2019-20 financial year; where we achieved 28% energy related carbon footprint reduction in compliance with set regulatory target by the Environmental Agency on our Carbon Reduction Commitment (CRC) on 2013 baseline figures. This success was replicated in our waste management practices where we laid emphasis on processes and methodology to support waste hierarchy and circular economy and in water management with reduction in water usage.

Despite the impact of COVID-19 pandemic in 2020-21 financial year, the Trust continued to embark on environment and sustainability driven projects to realise set

actions on its SDMP and to comply with requirements set by the Sustainable Development Unit (SDU), NHSI and the government. The projects focused on include:

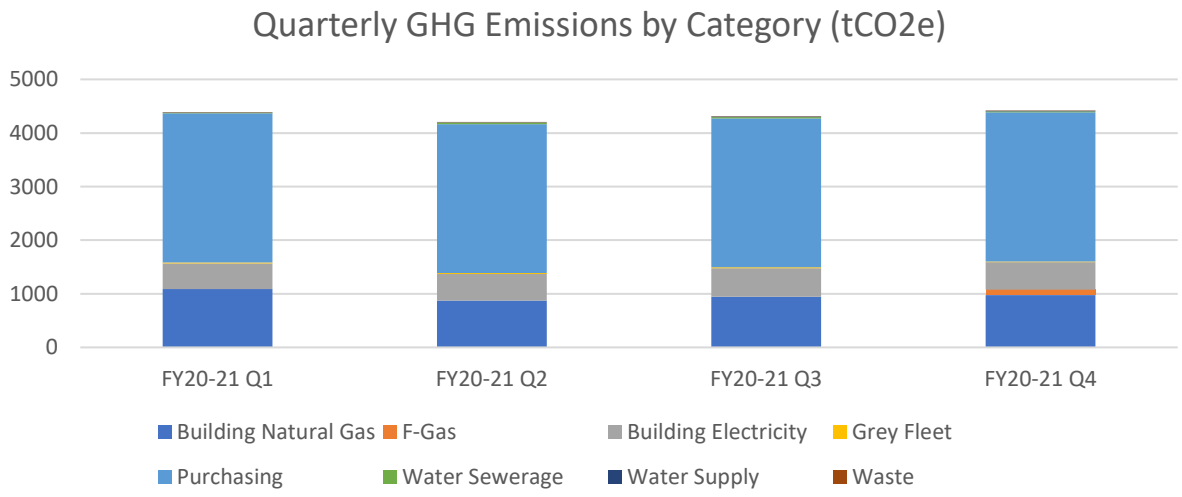
- Completion of the LED lighting project to actualise the projected carbon and cost savings.
- The 'Green Zone' project:
    - Implementing the 'Green Travel Plan' – installation of Electric Vehicle (EV) charging infrastructure.
    - Cycle rack installation
    - Changing facilities for cyclists and runners
    - Waste recycling area
- 'Green Plan' requirement – review of SDMP activities and timelines to align them to the new Green Plan guideline introduced by the SDU, NHS England and NHSI
- Delivering net zero by 2045

## Carbon Footprint Statement

To refresh our SDMP in line with new SDU guidance the Trust is working with a Net Zero consultancy firm to establish our baseline emission data and to set measurable targets and a pathway to achieve net zero by 2045. The analytics method is based on the tools proposed by the Intergovernmental Panel on Climate Change (IPCC) for compilation of Greenhouse Gas (GHG) emissions. The data stream includes limited emissions under Scope 1 and 2 (purchased electricity, gas & fuel used in transport) and limited emissions under Scope 3 (fuel used in personal/hire cars for business purposes, purchasing, generated waste and water supply/sewerage).

The interim report (using data available as at February 2021) shows total carbon emission of 17,321.77tCO2e and the following percentage breakdown by category:

- Purchasing (scope 3) – 64.21%
- Natural Gas (scope 1) – 22.42%
- Electricity (scope 2) – 11.65%
- Others (scope 1&3) – 1.72%




The 2020-21 GHG emissions data indicates that a high percentage of our carbon footprint is from purchasing i.e. supply chain contributors, so key action of the

updated SDMP (Green Plan) will be to collaboratively work with our supply chain partners to fully integrate sustainable and ethical procurement practices into our procurement strategy/processes for all goods and services.

## Sustainability Activities Update

### Light-Emitting Diode (LED) lighting project

The Estates & Facilities team along with the installation contractor worked through the challenges of COVID-19 pandemic to deliver the first and second phases of the LED project to programme in December 2020.

The total number of installations across the site and the benefits are listed below:

- Total number of LED luminaires / lamps installed – 4,144 units
- Annual cost savings – £150,068.74
- Annual energy savings – 1,005,016.35 kWh
- Annual carbon savings – 384.18 Tonnes of CO2

### Green Zone Project

The green zone construction phase works started in February 2021 (delayed due to COVID-19 pandemic). The scheme is split into two major elements – the installation of Electric Vehicle (EV) charging points and the cyclist and runners welfare scheme. In addition to the reduction of travel related carbon footprint, these projects also support staff welfare and travel modal shift as indicated in staff response to travel survey conducted in 2019.

### Electric Vehicle (EV) charging point

The EV charging point works have completed. This scheme will enhance modal shift to use of electric vehicles rather than fossil fuelled vehicles. The installation provides the following:

- Capability to charge up to 22kW (“Fast charging”) to ensure the system is future proofed ready for improvements in vehicle battery
- Load-balancing between multiple vehicles to optimise available supply capacity
- MID-approved (Measuring Instrument Directive) compliant meters fitted to each charge point connection ensures accurate consumption monitoring
- Integrated Wi-Fi to enable remote monitoring and fault resolution

### Changing facilities for cyclist and runners

The planned completion date for this work is May 2021. Deliverables from this element of the green zone scheme are:

- Fully refurbished changing facilities with external cladding
- Installation of cycle storage facilities
- Improved landscape around the changing facilities, providing outdoor garden space for staff
- Improved lighting and footpath with benches.

## Provision of waste recycling area and receptacles

The provision of recycling area and receptacles will enable the Trust to embark on recycling more domestic waste streams as well as supporting the local community with recycling of clothing and glass bottles.

## Net Zero strategy project scope

The trust is undertaking this project to align its carbon emission reduction commitments to NHS and UK government goal of achieving net zero by 2050. The output will be a defined and measurable Net Zero Strategy to be adopted by the trust and will include high-level cost-benefit analysis and action plan pathway to Net Zero carbon emission. This project involves:

- Comprehensive assessment of the current major greenhouse gas (GHG) emission sources and emissions across the Trust aligning to the NHS Carbon Footprint guidance including access to the Net Zero Hub for ongoing carbon reporting
- Baseline and technical audits including data capture, assessment of the energy performance of the hospital to inform the strategy and behavioural surveys to understand employee influence
- Assessment of climate-related risks and opportunities available to the Trust including PESTLE analysis of climate change relating to Operation and Value Chain carbon and assessment of the Trust's strengths, weaknesses, opportunities and threats
- Assessment of existing and known potential climate-related legislation and compliance schemes that the Trust are to be aware of
- Scenario modelling using government, national and local data sets to assess various technical and financials approaches to Net Zero and informing other works, namely objective settings workshop
- Objective setting workshop to collaborate with the Trust to set reasonable and achievable target for the Net Zero journey
- Production of a Net Zero Strategy in line with the NHS's Green Plan guidance bringing together all data sources and work completed to compile an adoptable document supported by various technical workbooks.

## Low Carbon Skill Fund (LCSF) and Public sector decarbonisation scheme (PSDS)

The Trust's application for the public sector LCSF grant was successful. We received a grant of £19,140 through Salix and the department of Business Energy & Industrial Strategy (BESI). The funding enabled the Trust to carry out surveys for applicable sustainability technologies to reduce its carbon footprint and deliver an effective PSDS grant scheme application, however the £1bn fund made available by the government was oversubscribed and the Trust's £450k grant application was not successful. The trust is in a better position to put in another application once the government provides further funding opportunities; this is deemed to be imminent due to government's commitment to sustainability.

## Waste management

Due to the pandemic, clinical waste generated across all healthcare settings had increased significantly; PAHT produced 608 tonnes in 2020, an increase of 128 tonnes over 2019 data. This unprecedented increase in waste generation happened across the country and impacted on the national clinical waste treatment infrastructure leading to regular service disruptions and the cabinet office established a national emergency logistic cell to manage the situation.

The trust managed to remain compliant with the 'COVID-19 waste management standard operating procedure (SOP) issued by the NHSE/I for the management of waste during the pandemic. We have implemented the guidance to ensure our waste is managed in a safe manner using appropriate receptacles and waste bags for infectious and non-infectious waste consignments so that our activities do not negatively affect critical national waste disposal resources during the emergency response period.

## Procurement (Supply Chain)

Through working collaboratively with our supply chain partners we currently have 75% of our electricity supply from renewable sources (not fossil) that are REGOS certified. The aim is to fully integrate sustainable and ethical procurement practices into our procurement strategies and processes for all goods and services. This is being incorporated into the procurement of our environment and sustainability related contract agreements.We will continue to specify environmentally friendly practises to our supply chain partners to ensure that our contract arrangements for services that have direct or indirect impact on the environment are managed with climate risk elements mitigated

## Look-ahead

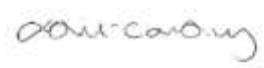
In addition to making visible the Trusts commitment to work towards the national goal of keeping the global average temperature increase below 2°C and achieving 'Net Zero' by 2050. We will continue to review the carbon footprint of our estates and its impact on the environment, our staff, patients and our finances in line with our strategy to decarbonise our facilities.
To achieve this we will:

- Produce achievable and measurable Green Plan (SDMP) from established site specific baseline data, pestle analysis and defined net zero pathway scenarios i.e. with outlined programme of goals where we can keep track of planned actions and progress. The actions will include:
    - Proposal to change fleet and estate vans to electric vehicles
    - Further removal of single use plastic from our restaurant
    - Switch over to low power laptops where reasonably practical
    - Collaboration to positively influence our supply chain partners.
- Drive further energy, water and carbon reductions in owned buildings and rented buildings.
- Achieving the BREEAM (Building Research Establishment Environmental Assessment Method) standard for all our capital projects and new builds.

- Maintain comprehensive measurement and reporting systems with external verification and publish our annual report.
- Challenge building contractors to propose cost-effective, low carbon solutions when undertaking refurbishment projects and monitor the benefits.
- Work with waste contractors to implement the waste hierarchy, achieve zero waste to landfill and turn residual waste into a resource opportunity wherever possible.
- Aim to increase the amount of electricity we purchase from the national grid is generated from renewable energy sources.
- Produce a Net Zero Strategy alongside partners to understand the Trust's current position and actions required to work towards Net Zero within the NHS's timeframe no later than 2045.
- Implementation of the trusts green travel plan to ensure that all travel options and impacts are taken into consideration when planning new premises and for off-site/local community healthcare services.

## Conclusion – Sustainable Development Goals

The Trust is constantly striving to understand fully and reduce the environmental impact created through delivering quality healthcare services. We are also looking at how sustainable principles can help provide a better environment for our staff, patients and the local and global community. We will continue to analyse the environmental, social and economic impacts of our activities; covering the three approved global Greenhouse Gas (GHG) emission scope protocols (scopes 1, 2 & 3) with the aim of fully embedding sustainability themes throughout the whole organisation in compliance with the target set by the Climate Change Act (2008), Net Zero by the year 2045 and to fulfil our moral responsibilities of ensuring better environment for future generations.



**Lance McCarthy**
Chief executive officer

# The Accountability Report 2020-21

## 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.

| 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 | 31.08.20 |
| Simon Covill | Acting Chief Financial Officer | Y | 01.09.20 | 13.12.20 |
| Saba Sadiq | Director of Finance | Y | 14.12.20 | Current |
| 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 & 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 | 31.10.20 |
| Fay Gilder | Medical Director | Y | 01.11.20 | Current |
| Phil Holland | Chief Information Officer | N | 01.02.21 | Current |

| Non-Executive Directors: | | | | |
|---|---|---|---|---|
| Steve Clarke | Chairman | Y | 03.12.18 | Current |
| 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 Chair of Strategy Committee from 01.01.20) | Y | 01.08.17 | 03.07.23 |
| 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 | 31.03.23 |
| Helen Howe | Non-executive director (Chair of Workforce Committee from 01.04.20) | Y | 11.06.18 | 31.03.23 |
| John Keddie | Associate non-executive director (Chair of Charitable Funds Committee from 01.01.20) | N | 01.07.19 | 30.06.21 |
| Darrel Arjoon | NExT NED | N | 04.01.21 | 6-12 month placement |
| Darshana Bawa | NExT NED | N | 11.01.21 | 6-12 month placement |
| Anne Wafula-Strike | Associate NED | N | 15.02.21 | 14.02.23 |

## Attendance at board meetings

Number of board members present at board meetings in 2020-21:

| | 02.04.20 | 07.05.20 | 04.06.20 | 19.06.20 | 02.07.20 | 06.08.20 | 03.09.20 | 01.10.20 | 05.11.20 | 03.12.20 | 05.01.21 | 14.01.21 | 11.02.21 | 04.03.21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Public** | **Private Board** | **Public & Private** | **Extraordinary** | **Private Board** | **Public & Private** | **Private Board** | **Public & Private** | **Private Board** | **Public & Private** | **Extraordinary** | **Private Board** | **Public & Private** | **Private Board** |
| **Public** | 14/15 | 15/15 | 15/15 | 5/5 | 13/15 | 15/15 | 14/15 | 15/15 | 15/15 | 15/15 | 14/16 | 16/17 | 17/17 | 18/19 |
| **Private** | No private meeting held due to COVID-19 | | 15/15 | | | 15/15 | | 15/15 | | 15/15 | | | 17/17 | |

## 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

## New Hospital Committee

The PAHT New Hospital Committee is established under delegated authority from the Trust Board to oversee the strategic direction and progress of the new build and provide a forum to monitor progress of the new hospital programme, including mitigation of risks and management of financial elements.

## 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 2020-21

| Name | Title | Interests/Memberships declared |
|---|---|---|
| Steve Clarke | Chairman | • Trustee and honorary treasurer of Dementia UK<br>• Independent director, University of Suffolk<br>• Trustee and honorary treasurer of Young Dementia UK<br>• Wife employed by NHS England (EoE Regional Office) |
| Pam Court | Non-executive director | • Chief executive officer of Saint Francis Hospice<br>• Daughter employed by Princess Alexandra Hospital Trust |
| Helen Glenister | Non-executive director | • Chair of Accelerate CIC Limited<br>• Chief Executive of Isabel Hospice<br>• Chair of Saffron Walden Orchestral Society |
| Helen Howe | Non-executive director | • Trustee of Addenbrooke's Charitable Trust<br>• Honorary professor pharmacy/chairman of pharmacy pre-registration training advisory group (HEE funded) for East of England<br>• Member UEA undergraduate Pharmacy advisory group<br>• Chair of Governors at Great Abington Primary School |

| | | |
|---|---|---|
| John Hogan | Non-executive director | • Consultant cardiologist at Barts Health NHS Trust<br>• Non-Executive Director Whitfield Academy Trust |
| George Wood | Non-executive director | • Chairman of the King George's Hospital Charity<br>• Associate Non-Executive Director BHRUT |
| John Keddie | Associate non-executive director | • Governor, Anglia Ruskin University<br>• Trustee, Anglia Trust<br>• Chair, Harlow Growth Board<br>• Chair, Discover Harlow Board<br>• Deputy Chair, London Stansted Cambridge Consortium<br>• Chair, ARU Direct Ltd |
| Darrel Arjoon | NExT Non-executive director | • Executive Chair for Reuse Technology Group Ltd |
| Darshana Bawa | NExT Non-executive director | • Finance Director for Micro Scooter Ltd<br>• Company Secretary at Kit Imports Ltd |
| Anne Wafula-Strike | Associate non-executive director | • Founder of Olympia-Wafula Foundation<br>• Non-Executive Director for UK Athletics<br>• Non-Executive Director for British Paralympic Association<br>• Non-Executive Director for Dimensions UK<br>• Non-Executive Director for Active Essex |
| Lance McCarthy | Chief executive officer | • Trustee, NHS Providers |

| | | |
|---|---|---|
| Saba Sadiq | Director of Finance | • No Interests Declared |
| Ogechi Emeadi | Director of people, organisational development and communications | • No Interests Declared |
| Michael Meredith | Director of strategy and estates | • No interests declared |
| Sharon McNally | Director of nursing, midwifery and allied health professionals | • No interests declared |
| Stephanie Lawton | Chief operating officer | • No interests declared |
| James McLeish | Director of quality improvement | • Spouse is a paramedic for East of England Ambulance Service<br>• Daughter is student nurse, Anglia Ruskin University |
| Fay Gilder | Chief medical officer | • Director, Gilder Medical Ltd |
| Phil Holland | Chief Information 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.

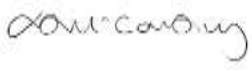
## The statement of accounting officer's responsibilities

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 2021

## The Princess Alexandra Hospital Annual Governance Statement 2020-21

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the Trust during 2020-21. During the year, we continued to review and strengthen our governance arrangements and took into account the findings of our CQC inspections together with continuing feedback and support from NHS England and Improvement.

At the same time, we have taken a full and active role within the Hertfordshire and West Essex Integrated Care System (ICS) 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 ICS 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 2020-21 financial year.

The key financial results for 2020-21 are that the Trust delivered a surplus of £1,816k.

## 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 2021 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
- two non-voting NExT Non-Executive Directors (NHSEI placement scheme)
- five voting Executive Directors (Chief Executive Officer, Director of Finance, Medical Director, Chief Operating Officer and Director of Nursing, Midwifery and AHPs) and four further Executive Directors without voting rights; the Director of People, OD and Communications, the Director of Strategy and Estates, the Director of Quality Improvement and the Chief Information Officer .

The following Non-Executive Director appointments were made in the year:

- Helen Howe, previously an Associate Non-Executive Director was appointed as a substantive Non-Executive Director in Andrew Holden's vacant post; Andrew Holden's term of appointment ended on 31 March 2020.
- Two NExT Non-Executive Directors, Darshana Bawa and Darrel Arjoon joined the Board in January 2021.
- Anne Wafula-Strike joined the Board as an Associate Non-Executive Director in February 2021.

The following executive appointments were made in the year:

- The Chief Medical Officer, Andy Morris was seconded to NHSEI to support COVID-19-19 planning and the deputy Chief Medical Officer (strategy), Marcelle Michail was appointed as the Acting Chief Medical Officer, with effect from 30 March 2020 until 31 October 2020.
- The Medical Director, Fay Gilder was appointed on 1 November 2020.
- The Chief Financial Officer, Trevor Smith left the Trust on 31 August 2020 and Simon Covill was appointed as acting Chief Financial Officer from 1 September to 13 December 2020.
- The Director of Finance, Saba Sadiq was appointed on 14 December 2020.
- The Chief Information Officer, Phil Holland was appointed on 1 February 2021. This was a new role.

Attendance at Board and Committee meetings throughout 2020-21 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 & Safety Committee
- Performance and Finance Committee
- Workforce Committee
- New Hospital Committee
- Remuneration & Nominations Committee
- Charitable Funds Committee
- Senior Management Team Meeting.

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

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

In response to the pandemic a full 'command and control' structure was implemented from the end of January 2020. This consisted of a Strategic Command Cell, with tactical cells managing operational response, clinical response, infection prevention and control, supporting our people, communications response and the management of our estate and infrastructure. In the peak of the pandemic, the cells met daily and as the number of COVID-19 patients reduced, the frequency of the meetings also reduced.

## 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 2020-21:

- The Director of Finance has delegated responsibility for co-ordinating the management of financial and business related risk and assisted me in ensuring that the Trust's resources were managed efficiently, economically and effectively.
- The Director of Nursing, Midwifery and AHPs has delegated authority and responsibility for the professional leadership of the Nursing, Midwifery and Allied Health Professions. The role is also the executive lead for infection prevention and control with the Director of Infection Prevention and Control reporting to them. The role has delegated responsibility for reporting to the Trust Board on medicines

management, the achievement of quality and patient experience standards and complaints and claims management and is the Trust's Safeguarding Lead.

- The Medical Director has overall accountability for operational and clinical risk and incident management. This includes the establishment and monitoring of assurance mechanisms and provision of associated risk reports to the Trust Board. The Medical Director also has delegated responsibility for co-ordinating and monitoring the Trust's revalidation programme for Medical Staff in line with the 'Maintaining High Professional Standards' system for the NHS. The Medical Director is also the Caldicott Guardian for the Trust.
- The Chief Operating Officer has delegated authority for managing the Trust's performance delivery both against national operating standards and key performance indicators together with local contractual standards set by the Clinical Commissioning Groups (CCGs).
- The Director of People, OD and Communications has delegated responsibility for overseeing all People functions across the Trust including recruitment, staff training and managing absence as well as embedding the Trust's People Strategy and OD and Culture programme.
- The Director of Quality Improvement has delegated responsibility for managing the Trust's transformation and modernisation programme as well as the Quality 1st 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.
- The Chief Information Officer has delegated responsibility for ensuring that Information Governance arrangements at the Trust are suitable, is the Trust's Senior Information Risk Owner (SIRO) and is responsible for the development and implementation of the Digital Strategy for the Trust.

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

## The Risk and Control Framework

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

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

- A Risk Management Strategy (for the effective management of clinical and non-clinical risk)
- A Board Committee structure with clear reporting lines to the Trust Board
- A Risk Management Group reporting to the Trust Board via Senior Management Team Meetings
- A Significant Risk Register and Board Assurance Framework, both of which are reviewed by the Risk Management Group and Trust Board.
- Monitoring systems for incidents and complaints.

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

The Risk Management Group meets on a monthly basis to review risks across all Health Care Groups as well as corporate departments. The Group's objectives are:

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

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

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

The highest scoring BAF risks throughout 2020-21 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 Trust's risk management processes and BAF by the Trust's Internal Auditors an overall assessment of reasonable 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 AHPs who, with the Medical Director ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. For any transformational change required, they are supported by the Trust's Quality 1st Team.

Each of the Trust's four Health Care Groups has a Patient Safety and Quality group where themes and trends from reviews of incidents and complaints and learning are reported. Performance is reviewed at monthly performance review meetings and at the Quality & Safety Committee each Health Care Group presents a quarterly overview of its performance on a rolling programme, in line with the CQC key lines of enquiry. Throughout 2020-21, the Quality & Safety Committee continued to receive updates on progress against the Quality Improvement Plan developed to address concerns raised by CQC during their inspection. Regular 'Sharing the Learning' reports providing an overview of themes, trends and learning arising from incidents, serious incidents and on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers are also received. The Chief Pharmacist provides regular reports to the committee on medicines management. Following a review of the quality governance framework in quarter 4 of 2019-20 a new structure for the meeting groups reporting to the Quality and Safety Committee was agreed and 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 2020-21. The Trust's rolling HSMR for the last 12 months has been 'higher than expected'. The SHMI has been 'as expected'. For the period December 2019 to November 2020 (including a time lag of one month) the Trust's HSMR was 116 (higher than expected) but improved from 2018-2019 (122). It is anticipated that the HSMR will continue to improve. PAHT is 1 of 6 trusts within the peer group of 15 that sit within the 'higher than expected' range.

A Trust-wide Mortality improvement programme was established which utilised QI 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. The 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.

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

In October 2020 the Trust reported its first Never Event since 2016. It related to unintentional connection of a patient requiring oxygen to an air flowmeter. This was

reported as a serious incident and a full root cause analysis was undertaken with immediate learning noted and actions taken.

## Well-Led Reviews

The Board commissioned an external review of the Well-led framework in March 2021 and the outcome of that review will be reported to the Board in June 2021. The Board's own self-assessment against the CQC's well-led framework resulted in an overall rating of 'Good' being assigned. The CQC rated the Trust as 'good' for well-led at its last inspection.

## Compliance with NHS Provider Licence

The Trust is compliant with 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 reported to the Workforce Committee.

## 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 2020-21, 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 ICS partners we will continue to explore opportunities for joint roles as we identify workforce models that support integrated working and the implementation of our new models of care.

## Managing Conflicts of Interest

The Trust has published an up-to-date register of interests, 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).

The last full inspection conducted by the CQC was completed in March and April 2019 with the report published in July 2019. This showed 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 at '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.

Following the CQC Winter Assurance visit on 14th February 2021, the CQC issued a Section 29a warning notice in relation to a lack of effective governance processes including:
1. Risk assessments were not being completed for all patients within the emergency department.
2. A lack of assurance that patients presenting with acute mental health illness were receiving timely assessments.
3. A lack of adherence to infection, prevention and control procedures.
4. The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded

Immediate actions were implemented following receipt of the warning notice, with further actions underway. Formal progress against these concerns is due to be reported to the CQC by 1 June 2021. A review of all core services across the Trust is being undertaken to ensure this learning is shared widely and improves the safety and quality of care our patients receive.

## 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 Trust Board. The Performance and Finance Committee reviews productivity, operational and financial performance and use of resources both at Trust and Health Care Group level.

The Trust 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 2020-21 and both have been closed.

The first breach related to a member of bank staff accessing a patient record inappropriately in breach of Trust policy. The ICO has investigated and closed this incident with no further action taken.

The second breach occurred due to human error, where documents from a vacated room were left unsecured in a space outside the back of a building for a limited time. The ICO has investigated and closed this 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 and the national addendum relating to COVID-19. These pathways are reviewed at weekly Patient Tracker List (PTL) meetings, chaired by the Performance Manager 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 & Planning. 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 the Data Quality Steering Group report to the Senior Management Team and then onto Performance & 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 report received a limited assurance rating:

- Supply Chain and EROS – Authorisation Controls

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 Trustor were not yet due for implementation.

Action plans are in place to address Internal Audit's recommendations for all audits undertaken. The Internal Auditors provide a progress report to the Executive Management Team, Senior Management Team and Audit Committee. The Executive Team as well as the Audit Committee continues to focus on the implementation of recommendations to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed.

## Head of Internal Audit Opinion (HoIA) on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2021:

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

My opinion is set out as follows:

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

1. My overall opinion is that **Reasonable** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
2. The basis for forming my opinion is as follows:
   i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
   ii. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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

## Significant Issues

The following is a summary of significant issues which were and will continue to be the focus of the Trust Board's attention and direct the Trust's management efforts during 2021 (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 83.2% for all attendances. The urgent care attendances during the year have been untypical of an average year, with the pandemic reducing non COVID-19 attendances. During most of 2020 the Trust maintained the 4 hour standard ahead of the national average however in the winter and early 2021 the increase in

COVID-19 attendances and admissions created pressure on bed capacity across the Trust and the urgent care department was unable to place patients on wards quickly enough to maintain the 4 hour standard. The Rapid Assessment Treatment (RAT) pathways continued to be in place over the year but staff absence due to COVID-19 impacted the number of RAT teams available for this pathway. Patient experience and the flow of patients in to and through the hospital has been enhanced by the opening of the Adult Assessment Unit and Same Day Emergency Care in addition to improvements in the Frailty unit.

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. The Urgent Care Board and governance structure beneath has been enhanced following the CQC unannounced Winter Assurance visit on 14 February 2021.

## COVID-19: Recovery and Restoration

The impact of the COVID-19 pandemic on the Trust's services has been significant. As elective procedures were reduced during the pandemic, there has been an increase in the number of patients waiting for more than 52 weeks for routine surgery and a rise in demand for diagnostic services. The intensity of the response to the pandemic has had a marked impact on the Trust's people. The same group of staff who worked through the pandemic are stepping up to recover elective backlogs and the Trust has launched a number of health and well-being initiatives to support colleagues. The Trust has expanded endoscopy, CT and MRI capacity to support the management of cancer patients and has continued to work closely with independent sector colleagues to maximise access to key services and maintain timely services for patients. All patients who have been waiting for longer than they would do normally continue to be reviewed by the relevant clinical team and reprioritised where relevant.

The Trust acknowledges the scale of the challenge that lies ahead and continues to work with partners across the local health and care system to bring waiting lists down in a way that is transparent and equitable, that provides equity for patients and looks after the workforce. Despite a huge amount of hard work from everyone it will be some time before the Trust's services are restored to pre-pandemic levels.

## Estate

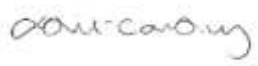
The quality and safety of the estate remain significant challenges for us at a time of financial constraint. It has been well communicated that the current hospital estate has reached its limit in terms of capacity and development. A significant portion of the hospital site is more than 60 years old and falls short of modern day expectations 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 long term estate strategy which includes building a new hospital to address these challenges and enable the Trust to be successful in delivering integrated care as part of an Integrated Care Partnership.

However we still need to deliver high quality, efficient services from the current estate for at least the next 5 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 2021)

## Remuneration and staff report

## Background

This report includes details regarding “senior managers” remuneration in accordance with paragraphs 3.31 to 3.78 of the DHSC (Department of Health and Social Care) Group Accounting Manual 2020-21. The Remuneration Report set out below is subject to audit by our external auditors.

The Trust has established a Remuneration and Nominations Committee to advise and assist the Board in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief executive officer, executive directors and very senior managers. The Remuneration Committee is chaired by the Trust’s 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 2020-21 was £185k-£190k (£235k- £240k in 2019-20). This was 5.7 times the median remuneration of the workforce which was £33.1k (in 2019-20 the ratio was 7.5 times with the median remuneration being £31.8k)

- In 2020-21, 19 employees received remuneration in excess of the highest paid director (this was 2 employees in 2019-20). Remuneration ranged from the bands £0k-£5k to £270k-£275k (in 2019-20 these were £0k-£5k to £255k-£260k).

- 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

2020-21 total expenditure on consultancy and professional services was £3,419k (2019-20 £3,532k).

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

### Employee benefits

| Gross expenditure | Permanently employed | Other | 2020-21 Total | 2019-20 Total |
|---|---|---|---|---|
| | £000's | £000's | £000's | £000's |
| Salaries and wages | 136,406 | 544 | **136,950** | **124,956** |
| Social security costs | 12,456 | - | **12,456** | **12,319** |
| Apprenticeship levy | 606 | - | **606** | **605** |
| Employer's contributions to NHS pensions | 23,171 | - | **23,171** | **21,144** |
| Pension costs - other | 36 | - | **36** | **35** |
| Temporary Staff | - | 33,141 | **33,141** | **35,865** |
| **Total employee benefits** | **172,675** | **33,685** | **206,360** | **194,924** |
| Less: Employee costs capitalised | 1,197 | 1,406 | **2,603** | 1,794 |
| Redundancy | 35 | - | **35** | 11 |

| | | | | |
|---|---|---|---|---|
| **Gross employee benefits excluding capitalised costs** | **171,444** | **32,279** | **203,722** | **193,119** |

## Average staff numbers

| | Permanent Number | Other Number | 2020-21 Total | 2019-20 Total |
|---|---|---|---|---|
| Medical and dental | 507 | 60 | 567 | 563 |
| Ambulance staff | 0 | 0 | 0 | 0 |
| Administration and estates | 591 | 46 | 637 | 617 |
| Healthcare assistants and other support staff | 354 | 58 | 412 | 422 |
| Nursing, midwifery and health visiting staff | 976 | 123 | 1,099 | 1,029 |
| Nursing, midwifery and health visiting learners | 403 | 63 | 466 | 510 |
| Scientific, therapeutic and technical staff | 239 | 0 | 239 | 240 |
| Healthcare science staff | 79 | 0 | 79 | 0 |
| Social care staff | 0 | 0 | 0 | 80 |
| Other | 147 | 0 | 147 | 139 |
| **Total** | **3,296** | **350** | **3,646** | **3,600** |
| Staff engaged on capital projects (included in above) | 21 | 25 | 46 | 34 |

## Staff sickness and ill health retirements

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

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

| Ill Health Retirements | 2020-21 | 2019-20 |
|---|---|---|
| | **Number** | **Number** |
| Number of persons retired early on ill health grounds | 3 | 3 |
| | **£000's** | **£000's** |
| Total additional pensions liabilities accrued in the year | 147 | 151 |

## Reporting of compensation schemes - exit packages 2020-21 (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 | 0 | 0 | **0** |
| £50,001 - £100,000 | 0 | 0 | **0** |
| £100,001- £150,000 | 0 | 0 | **0** |
| £150,001 - £200,000 | 0 | 0 | **0** |
| > £200,000 | 0 | 0 | **0** |
| **Total** | **0** | **0** | **0** |
| Total resource cost (£) | £0 | £0 | **£0** |

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 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 | 1 | **2** |
| £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** | **1** | **2** |
| Total resource cost (£) | £44,000 | £27,000 | **£71,000** |

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

| | 2020-21 | | 2019-20 | |
|---|---|---|---|---|
| | **Agreements** | **Total value of agreements** | Agreements | Total value of agreements |
| | **Number** | **£000's** | Number | £000's |
| Contractual payments in lieu of notice | - | - | 1 | 27 |
| Exit payments following Employment Tribunals or court orders | - | - | - | - |
| **Total** | **-** | **-** | 1 | 27 |

Note: the prior year exit packages figure has been restated for 1 case ("other" £27k) identified during 20/21 as relating to 19/20.

## Off payroll arrangements

No individual holding a Board position was paid directly through an associated limited company. During 2020-21 there were no executive posts covered by off-payroll arrangements.

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

| | | 2020/21 | | | | | | | 2019/20 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Period** | **Salary (bands of £5,000)** | **Expense payments (taxable) to nearest £100** | **Performance pay and bonuses (bands of £5,000)** | **Long term performance pay and bonuses (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **TOTAL (bands of £5,000)** | **Period** | **Salary (bands of £5,000)** | **Expense payments (taxable) to nearest £100** | **Performance pay and bonuses (bands of £5,000)** | **Long term performance pay and bonuses (bands of £5,000)** | **All pension related benefits (bands of £2,500)** | **TOTAL (bands of £5,000)** |
| | | | **£000's** | **£'s** | **£000's** | **£000's** | **£000's** | **£000's** | | **£000's** | **£'s** | **£000's** | **£000's** | **£000's** | **£000's** |
| Steve Clarke | Chairman | All Year | 35 - 40 | - | - | - | - | 35 - 40 | All Year | 35 - 40 | 4,500 | - | - | - | 35 - 40 |
| Andrew Holden | Non-Executive Director | - | - | - | - | - | - | - | All Year | 5 - 10 | 1,900 | - | - | - | 5 - 10 |
| Pam Court | Non-Executive Director | All Year | 10 - 15 | - | - | - | - | 10 - 15 | All Year | 5 - 10 | 200 | - | - | - | 5 - 10 |
| Dr John Hogan | Non-Executive Director | All Year | 10 - 15 | - | - | - | - | 10 - 15 | All Year | 5 - 10 | - | - | - | - | 5 - 10 |
| Helen Howe | Non-Executive Director | All Year | 10 - 15 | 300 | - | - | - | 10 - 15 | All Year | 5 - 10 | 1,400 | - | - | - | 5 - 10 |
| Dr Helen Glenister | Non-Executive Director | All Year | 10 - 15 | - | - | - | - | 10 - 15 | All Year | 5 - 10 | 1,000 | - | - | - | 5 - 10 |
| John Keddie | Associate Non-Executive Director | All Year | 10 - 15 | - | - | - | - | 10 - 15 | 01.07.19 - 31.03.20 | 5 - 10 | 300 | - | - | - | 5 - 10 |
| George Wood | Non-Executive Director | All Year | 10 - 15 | - | - | - | - | 10 - 15 | 01.07.19 - 31.03.20 | 5 - 10 | - | - | - | - | 5 - 10 |
| Darrel Arjoon | NExT NED | 04.01.21 - 31.03.21 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Darshana Bawa | NExT NED | 11.01.21 - 31.03.21 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Anne Wafula-Strike | Associate Non-Executive Director | 15.02.21 - 31.03.21 | 0-5 | - | - | - | - | 0-5 | - | - | - | - | - | - | - |

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

| | | 2020/21 | | | | | | | 2019/20 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Title | Period | Salary (bands of £5,000) | Expense payments (taxable) to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5,000) | All pension related benefits (bands of £2,500) | TOTAL (bands of £5,000) | Period | Salary (bands of £5,000) | Expense payments (taxable) to nearest £100 | Performance pay and bonuses (bands of £5,000) | Long term performance pay and bonuses (bands of £5,000) | All pension related benefits (bands of £2,500) | TOTAL (bands of £5,000) |
| | | | £000's | £'s | £000's | £000's | £000's | £000's | | £000's | £'s | £000's | £000's | £000's | £000's |
| Lance McCarthy | Chief Executive | All Year | 185 - 190 | - | - | - | 50 - 52.5 | 240 - 245 | All Year | 190 - 195 | - | - | - | 45 - 47.5 | 235 - 240 |
| Sharon McNally | Director of Nursing and Midwifery | All Year | 125 - 130 | - | - | - | 65 - 67.5 | 190 - 195 | All Year | 120 - 125 | - | - | - | 112.5 - 115 | 230 - 235 |
| Dr. Andy Morris[2] | Chief Medical Officer | 01.04.20 - 30.06.20 | 50 - 55 | - | - | - | - | 50 - 55 | 01.04.19 - 30.03.20 | 235 - 240 | - | - | - | 90 - 92.5 | 325 - 330 |
| Marcelle Michail[2] | Interim Chief Medical Officer | 01.04.20 - 31.10.20 | 115 - 120 | - | - | - | - | 115 - 120 | 30.03.20 - 31.03.20 | 0 - 5 | - | - | - | - | 0 - 5 |
| Trevor Smith | Chief Financial Officer | 01.04.20 - 31.08.20 | 65 - 70 | - | - | - | 25.5 - 27.5 | 90 - 95 | All Year | 145 - 150 | - | - | - | 7 - 7.5 | 150 - 155 |
| Stephanie Lawton | Chief Operating Officer | All Year | 135 - 140 | - | - | - | 42.5 - 45 | 175 - 180 | All Year | 130 - 135 | - | - | - | 0 - 2.5 | 135 - 140 |
| James McLeish | Director of Quality Improvement | All Year | 110 - 115 | - | - | - | 12.5 - 15 | 125 - 130 | All Year | 105 - 110 | - | - | - | 2.5 - 5 | 110 - 115 |
| Michael Meredith | Director of Strategy | All Year | 120 -125 | - | - | - | 27.5 - 30 | 150 - 155 | All Year | 115 - 120 | - | - | - | 25 - 27.5 | 145 - 150 |
| Ogechi Emeadi | Director of People, Comms & OD | All Year | 120 - 125 | - | - | - | 25 - 27.5 | 145 - 150 | All Year | 115 - 120 | - | - | - | 42.5 - 45 | 160 - 165 |
| Saba Sadiq | Director of Finance | 14.12.20 - 31.03.21 | 35 - 40 | - | - | - | 5 - 7.5 | 45 - 50 | - | - | - | - | - | - | - |
| Fay Gilder[1] | Medical Director | 01.11.20 - 31.03.21 | 70 - 75 | - | - | - | - | 70 - 75 | - | - | - | - | - | - | - |
| Phil Holland | Chief Information Officer | 01.02.21 - 31.03.21 | 15 - 20 | - | - | - | 2.5 - 5 | 20 - 25 | - | - | - | - | - | - | - |
| Simon Covill | Acting Chief Financial Officer | 01.09.20 - 13.12.20 | 35 - 40 | - | - | - | 15 - 17.5 | 50 - 55 | - | - | - | - | - | - | - |

1. Not a member of the NHS Pension Scheme
2. Where calculations of pension related benefits returns a negative figure, this has been replaced with a zero as per national guidance. Negative balances can be returned where a member retires, or leaves the pension scheme, during the year.

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

| Name | Title | Real increase / (decrease) in pension at pension age (bands of £2,500) | Real increase / (decrease) in pension lump sum at pension age (bands of £2,500) | Total accrued pension at pension age at 31 March 2021 (bands of £5,000) | Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) | Cash Equivalent Transfer Value at 1 April 2020 (£000's) | Real increase in Cash Equivalent Transfer Value (CETV) (£000's) | Cash Equivalent Transfer Value at 31 March 2021 (£000's) | Employer's contribution to stakeholder pension (£000's) |
|---|---|---|---|---|---|---|---|---|---|
| Lance McCarthy[1] | Chief Executive | 2.5 - 5 | 0 - 2.5 | 65 - 70 | 135 - 140 | 1,036 | 72 | 1,108 | 0 |
| Sharon McNally | Director of Nursing and Midwifery | 2.5 - 5 | 10 - 12.5 | 50 - 55 | 155 - 160 | 1,063 | 104 | 1,167 | 0 |
| Dr Andy Morris [1 2] | Chief Medical Officer | (42.5) - (40) | (62.5) - (60) | 65 - 70 | 200 -205 | 2,200 | (2,200) | 0 | 0 |
| Marcelle Michail [2 3] | Acting Chief Medical Officer | (57.5) - (55) | (132.5) - (130) | - | - | 1,115 | (1,115) | 0 | 0 |
| Trevor Smith | Chief Financial Officer | 2.5 - 5 | 2.5 - 5 | 70 - 75 | 155 - 160 | 1,267 | 94 | 1,361 | 0 |
| Stephanie Lawton[1] | Chief Operating Officer | 2.5 - 5 | 0 - 2.5 | 50 - 55 | 110 - 115 | 823 | 56 | 879 | 0 |
| James McLeish | Director of Quality Improvement | 0 - 2.5 | 2.5 - 5 | 25 - 30 | 80 - 85 | 604 | 47 | 651 | 0 |
| Michael Meredith[1] | Director of Quality Improvement | 0 - 2.5 | 0 - 2.5 | 10 - 15 | 20 - 25 | 195 | 34 | 229 | 0 |
| Ogechi Emeadi[1] | Director of People, Comms & OD | 0 - 2.5 | (2.5) - 0 | 45 - 50 | 95 - 100 | 817 | 47 | 864 | 0 |
| Saba Sadiq[1] | Director of Finance | 0 - 2.5 | - | 10 - 15 | - | 103 | 30 | 133 | 0 |
| Fay Gilder[3] | Medical Director | - | - | - | - | 0 | 0 | 0 | 0 |
| Phil Holland[1] | Chief Information Officer | 0 - 2.5 | 0 - 2.5 | 20 - 25 | 35 - 40 | 314 | 33 | 347 | 0 |
| Simon Covill | Acting Chief Financial Officer | 2.5 - 5 | 0 - 2.5 | 45 - 50 | 100 -105 | 767 | 66 | 833 | 0 |

1. 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.
2. Member retired in 2020-21.
3. Information for the Medical Director and Acting Chief Medical Officer is incorrectly excluded from the above table disclosing individual pensions benefits for 2020/2021. This information for the Acting Chief Medical Officer is also incorrectly excluded from the table of benefits for 2019/20. This is because the NHS Business Services Authority did not request the necessary information to allow for full pensions benefit disclosures to be made. This was on the basis that their understanding was that Greenbury reporting applied only for members who had been contributing to the scheme during the current year. The Acting Chief Medical Officer stopped contributing to the NHS Pension Scheme in 2019 and the Medical Director stopped contributing in 2020. Information for the Medical Director is correctly not included in the above table for 2019/2020 as the individual was not in post during 2019/20.

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.

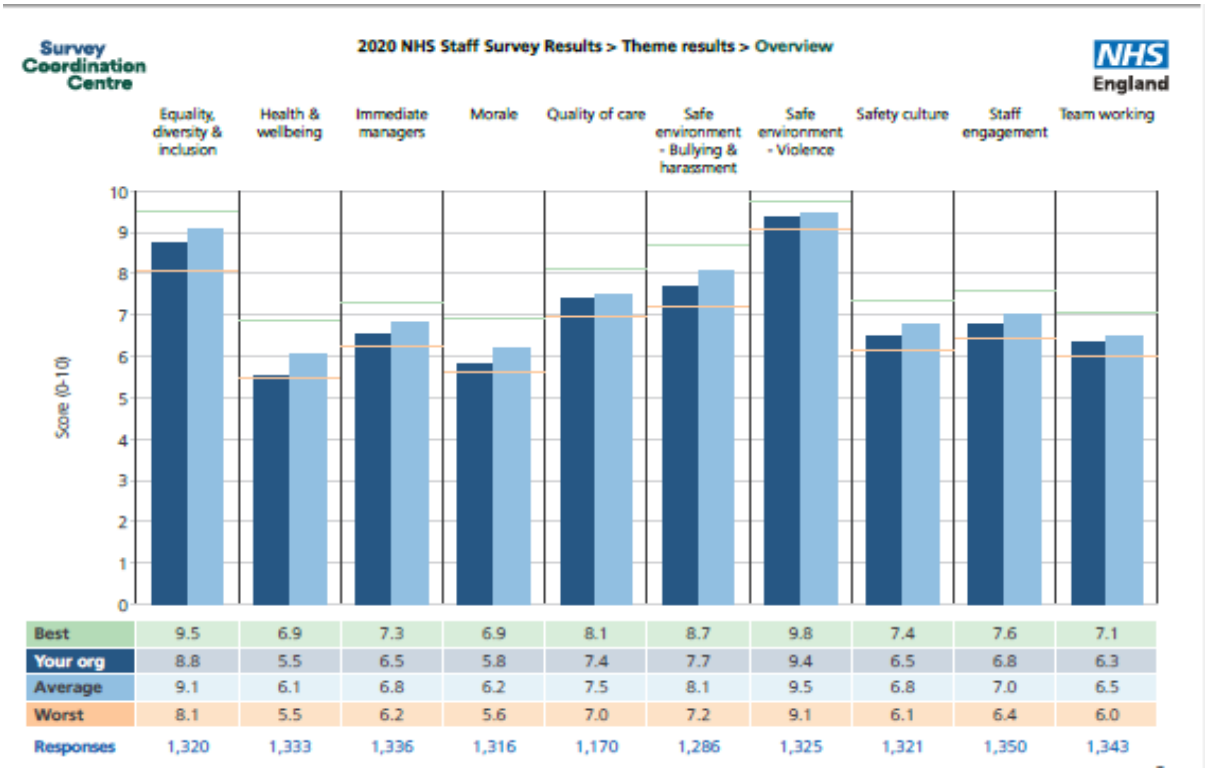
Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and 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 determine improvements that will make the hospital a better place to both work and be treated.

A full census was held in the Trust between 28th September and 27 November 2020 with all our people employed on 1 September 2020 having the opportunity to take part. In total 1368 (38.2%) completed and returned their survey questionnaire, which was 6.8% lower than 2019, and 6.8% lower than the average 2020 response rate (there are 128 acute and acute and community trusts within our benchmarking group).

The table below summarises the survey results by the key national themes, benchmarked against the 128 other trusts.




| | Equality, diversity & inclusion | Health & wellbeing | Immediate managers | Morale | Quality of care | Safe environment - Bullying & harassment | Safe environment - Violence | Safety culture | Staff engagement | Team working |
|---|---|---|---|---|---|---|---|---|---|---|
| Best | 9.5 | 6.9 | 7.3 | 6.9 | 8.1 | 8.7 | 9.8 | 7.4 | 7.6 | 7.1 |
| Your org | 8.8 | 5.5 | 6.5 | 5.8 | 7.4 | 7.7 | 9.4 | 6.5 | 6.8 | 6.3 |
| Average | 9.1 | 6.1 | 6.8 | 6.2 | 7.5 | 8.1 | 9.5 | 6.8 | 7.0 | 6.5 |
| Worst | 8.1 | 5.5 | 6.2 | 5.6 | 7.0 | 7.2 | 9.1 | 6.1 | 6.4 | 6.0 |
| Responses | 1,320 | 1,333 | 1,336 | 1,316 | 1,170 | 1,286 | 1,325 | 1,321 | 1,350 | 1,343 |

The full findings report of the 2020 NSS were presented to the Workforce Committee in March 2021 and to the full Trust Board in April 2021. 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 1: Improving the physical and mental health and wellbeing of our people*

*Priority 2: Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon (improving psychological safety)*

*Priority 3: Improving the effectiveness of line managers*

Action plan progress will be monitored by the Executive team at monthly performance review meetings, with bi-monthly assurance reporting to the Workforce Committee and updates to Trust Board. 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.

**2020-21 Staff Friends and Family Test**

Due to the pandemic, NHSE/I issued new guidance pausing the quarterly Staff Friends and Family Test (SFFT) survey's from quarter 1 (April to June 2020) to quarter 4 (January to March 2021).

**PAHT COVID-19 Staff Survey**

Following a recommendation from the PAHT COVID-19 People Cell a decision was taken by the Strategic Cell to replace the formal SFFT quarter 1 survey with a specifically designed COVID-19 survey. The survey ran from 26 May to 21 June 2020, and a total of 3529 questionnaires were issued (via e-mail and QR codes). PAHT received 739 full completions and 387 partial completions, with an overall response rate (full and partial) of 31.91%.

A full report was made available to all PAHT staff, and a summary of the findings was presented to Workforce Committee in September 2020. Responses ranged from issues initially with PPE supply and the impact of ward moves, to positive feedback from our people feeling supported by the organisation, and appreciation for the daily COVID-19 communications updates.

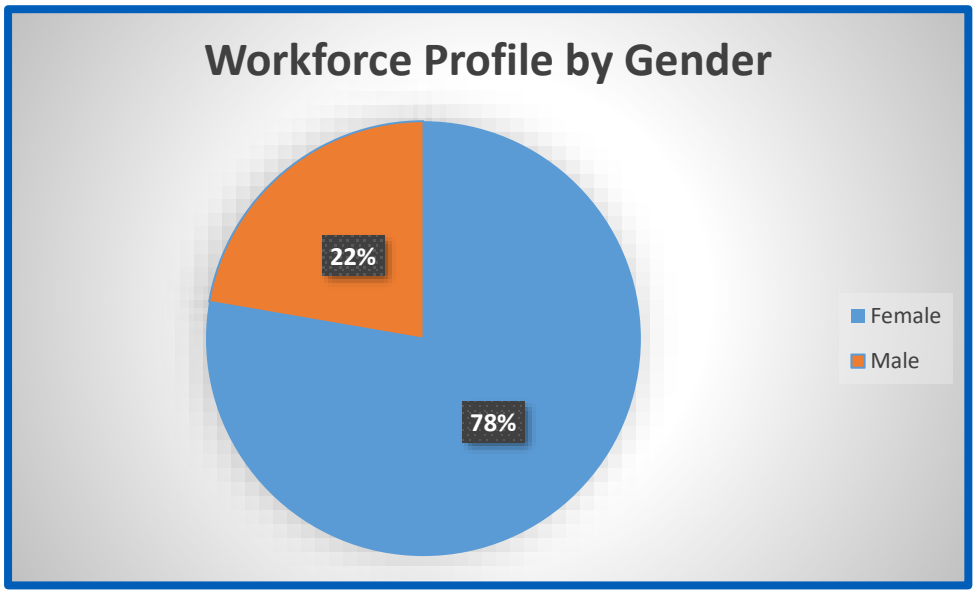
## Our staff breakdown

| Mar 2021 staff composition | Male | Female |
|---|---|---|
| Executive directors | 4 | 4 |
| Other employees | 825 | 2921 |
| **Total** | **829** | **2925** |

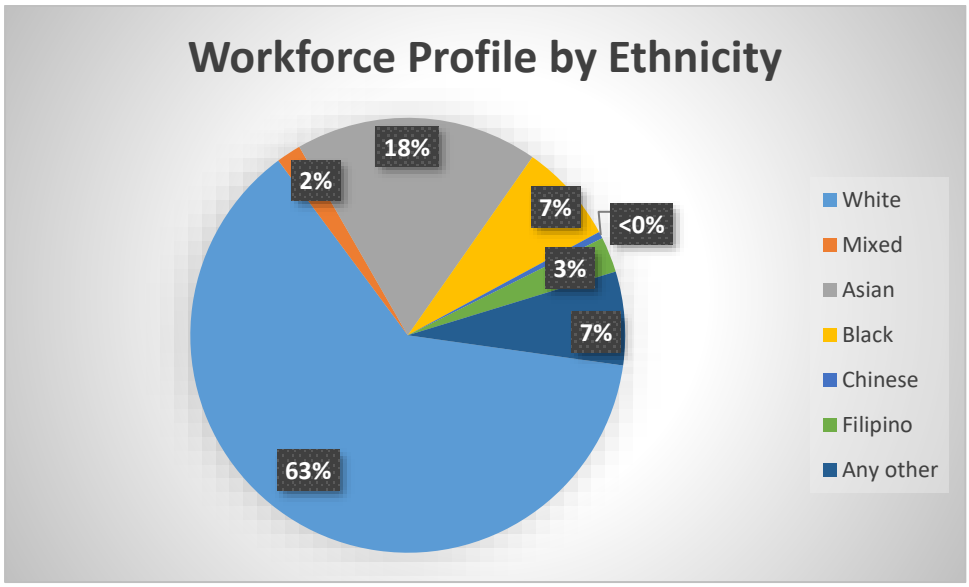
## Turnover rate

| Turnover rate | 2019-20 | Mar 20- Feb 21 |
|---|---|---|
| Overall staff turnover | 12.96% | 12.13% |
| Voluntary turnover | 10.74% | 9.89% |

## Our workforce – gender profile




## Our workforce – ethnic profile




## Equality and diversity: significant achievements during 2020-21

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 (EDI) at PAHT.

Due to the COVID-19 pandemic, the monthly meetings have been successfully held virtually. It has also required the steering group to review the ways it can highlight EDI activities, predominately through virtual events.

Black, Asian and Minority Ethnic (BAME) staff are an identified group that is disproportionately more likely to be impacted by COVID-19. In collaboration with other Trusts within the Integrated Care System (ICS), we have developed a number of initiatives to support our BAME staff:

- Establishment of a BAME staff support line
- Agreed consistent risk assessment and outcomes for **all** COVID-19 identified vulnerable groups
- Research methods were explored to understand BAME staffing needs and views on the COVID-19 response
- Creation of system-wide EDI network and BAME chairs network for ongoing transformation

The steering group agreed a calendar of events for 2020-21, to promote protected characteristics throughout the year. Some activities focused on celebrations, others on awareness and education. These events have included:

- Working in partnership with the staff health and wellbeing (SHaW) team and infection prevention control (IPC) colleagues on the content for InTouch briefings. The aim of these briefings was to raise awareness of the importance of completing COVID-19 risk assessments and to give colleagues an opportunity to ask questions of a panel of experts on COVID-19 vaccinations.
- We celebrated Black History Month in October 2020, supported by a calendar of webinars and a social media campaign with engaging content throughout the month.
- We marked International Men's Day in November 2020, with a variety of content across our internal and external communications channels to promote the work of our #PAHTPeople.
- We recognised Armed Forces Day on 27 June 2020 with a special feature in our staff newsletter, InTouch weekly.
- Linking with Essex Pride, we celebrated LGBT+ Pride in June 2020, developing bespoke graphics with quotes from our #PAHTPeople, which we promoted across our internal and external communications channels.
- We celebrated International Women's Day on 8 March 2021 and this year's theme of 'choose to challenge' across our internal and external communications channels. This included an InTouch briefing with a panel of inspirational women from PAHT sharing their experiences.

## Looking forward

As we reflect on the past year and raise our eyes to view the year to come, we must pay respect to all that we have learnt from the last year and make sure that we continue to make a difference to our patients and care for each other and those around us.

Currently (May 2021), the COVID-19 pandemic remains with us and the Government has a roadmap to the easing of lockdown restrictions. Of course, the significant difference that 12 months has brought us are the COVID-19 vaccines and the delivery of many thousands of vaccinations across our people and local communities. We will continue to support the vaccination programme and work with our system partners in ensuring people have all the information they need about the vaccination options available to them.

## Back to better

As an organisation, we have been focussing in recent months on the learning from the pandemic and on resetting how we work and provide care differently in to the future, building on the many changes that we put in place at great speed over the last year. Although we will, and need, to get back to a more familiar routine and deliver business as usual we must make sure that we continue to improve and make sure that in moving back to a new normal that this is better for our patients and for our people.

For our patients, this will mean maximising the improvements we have made to further enhance the care we provide.

For our people, this will mean a continued focus on the changes we make and the guidance, assistance and health and wellbeing support that is available.

## Working together

Aligned to the NHS Long Term Plan's ambitions around more collaboration and integration in local health and social care settings, we are proactively involved in strengthening existing partnership working. We are also at the forefront of seeking the greater efficiencies that will come from combining how services are delivered and using the time released for patients and continued improvements.

## PAHT 2030

Our vision to deliver outstanding healthcare to our community underpins our PAHT 2030 strategy and improvement plans to achieve our three goals, to be:

- ✓ Modern
- ✓ Integrated
- ✓ Outstanding

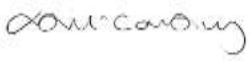
Our **PAHT 2030** plans are based on five key strategic priorities:

1. Our Culture
2. Transforming our care
3. Digital health
4. Corporate modernisation

5. New hospital

The business case development, design and build of a new hospital for local people will continue with a focused attention on ensuring we have a hospital fit for the 21st century that maximises technology to deliver the very best care for our patients,

Our focus on our journey to outstanding, delivered through the detailed plans in place for **PAHT 2030**, 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
# Annual Accounts for year ended
# 31 March 2021

## 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

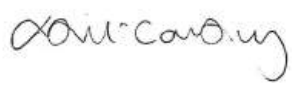
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them

- 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: 11 June 2021**

## 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: 11 June 2021**

**Finance Director** _____ **Date: 11 June 2021**

## 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 2021 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 36. 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 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 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 2021 and of its expenditure and income for the year then ended; a

• have been prepared properly in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Accounts Directions issued thereunder.

### Basis for qualified opinion

Due to the restrictions on movement imposed as a result of the Coronavirus pandemic, in 2019/20 the Trust was unable to undertake, and we were unable to observe, the counting of physical inventories at the beginning of the year. We were unable to satisfy ourselves by alternative means concerning the inventory quantities held at 31 March 2020, which are included as comparatives 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 the year ended 31 March 2021.

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.

### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 12 months to 30 June 2022 from when the financial statements are authorised for issue.

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

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

### Other information

The other information comprises the information included in the Annual Report 2020 – 2021, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report.

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.

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 course of 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 themselves. 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 comparative inventory quantities of £4.565 million held at 31 March 2020. We have concluded that where the other information refers to the comparative inventory balance, it may be materially misstated for the same reason.

### Opinion on other matters prescribed by the Health Services Act 2006

### Basis for qualification on the Remuneration Report

The Remuneration Report, set out on pages 73 to 82, does not disclose the total accrued pension, Accrued Lump Sum and the Cash Equivalent Transfer Value for the Acting Chief Medical Officer and Medical Director because the NHS Business Services Authority did not request the information from the NHS Pensions Agency.

### Qualified opinion on the Remuneration Report

Except for the reasons set out in the basis for qualification on the Remuneration report, in our opinion the part of the Remuneration Report subject to audit has been prepared properly in accordance with requirements of the National Health Service Act 2006.

### Opinion on the Staff Report

In our opinion the part of the Staff Report subject to audit has been prepared properly in accordance with requirements of the National Health Service Act 2006.

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

• we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

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

• 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 2021.

We have nothing to report in these respects.

### 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 3, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they either intend to cease operations, or has 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 ensuring that the financial statements are prepared in a format directed by the Secretary of State and 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.

### Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with

• We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

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

• We understood how The Princess Alexandra Hospital NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes, through enquiry of employees to verify Trust policies, and through the inspection of HR Policies and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

• We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue), inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

• To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust's manual year end receivable and payable accruals, challenging assumptions and corroborating the income and expenditure to appropriate evidence. We tested year-end cut-of arrangements by selecting samples of income and expenditure from either side of the 31 March 2021 balance sheet date and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year. We also undertook cut-off testing of expenditure as at month 6 of the financial year to establish whether the Trust had incorrectly included expenditure relating to later months that would trigger Reimbursement and top-up funding for that period of the financial year that it would otherwise not be entitled to.

• To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

• To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the population of manual journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were appropriate.

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 reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 2021.

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*
*17-Jun-21*

## Statement of Comprehensive Income

| | Note | 2020/21 £000's | 2019/20 £000's |
|---|---|---|---|
| Operating income from patient care activities | 3 | 267,835 | 246,747 |
| Other operating income | 4 | 47,287 | 41,744 |
| Operating expenses | 6 | (308,104) | (286,048) |
| **Operating surplus from continuing operations** | | **7,018** | **2,443** |
| Finance income | 11 | - | 85 |
| Finance expenses | 12 | (18) | (2,032) |
| PDC dividends payable | 22 | (3,034) | - |
| **Net finance costs** | | **(3,052)** | **(1,947)** |
| **Surplus for the year from continuing operations** | | **3,966** | **496** |
| **Other comprehensive income** | | | |
| Revaluations | | - | 613 |
| Other recognised gains and losses | | 1 | 117 |
| **Total comprehensive income for the period** | | **1** | **730** |
| **Adjusted financial performance (control total basis):** | | | |
| Surplus for the period | | 3,966 | 496 |
| Net impairments not scoring to DHSC expenditure limit | | 341 | - |
| Net impact of inventories received from DHSC for COVID response | | (655) | - |
| Remove I&E impact of capital grants and donations | | (1,836) | (78) |
| Remove 2018/19 post audit PSF reallocation | | - | (368) |
| **Adjusted financial performance surplus** | | **1,816** | **50** |

## Statement of Financial Position

| | Note | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 14 | 7,169 | 7,633 |
| Property, plant and equipment | 15 | 137,845 | 117,405 |
| Receivables | 18 | 1,189 | 692 |
| **Total non-current assets** | | **146,203** | **125,730** |
| **Current assets** | | | |
| Inventories | 17 | 5,697 | 4,565 |
| Receivables | 18 | 8,381 | 49,837 |
| Cash and cash equivalents | 19 | 65,242 | 1,144 |
| **Total current assets** | | **79,320** | **55,546** |
| **Current liabilities** | | | |
| Trade and other payables | 20 | (49,070) | (27,068) |
| Borrowings | 22 | (30) | (150,958) |
| Provisions | 24 | (1,142) | (1,186) |
| Other liabilities | 21 | (2,180) | (1,158) |
| **Total current liabilities** | | **(52,422)** | **(180,370)** |
| **Total assets less current liabilities** | | **173,101** | **906** |
| **Non-current liabilities** | | | |
| Borrowings | 22 | (10) | (40) |
| Provisions | 24 | (1,077) | (767) |
| **Total non-current liabilities** | | **(1,087)** | **(807)** |
| **Total assets employed** | | **172,014** | **99** |
| **Financed by** | | | |
| Public dividend capital | | 320,559 | 133,863 |
| Revaluation reserve | | 591 | 19,343 |
| Income and expenditure reserve | | (149,136) | (153,107) |
| **Total taxpayers' equity** | | **172,014** | **99** |

The notes on pages 13 to 49 form part of these accounts.

**Chief Executive**

11 June 2021
**Date**

## Statement of Changes in Equity for the year ended 31 March 2021

| | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Total |
|---|---|---|---|---|
| | £000's | £000's | £000's | £000's |
| **Taxpayers' equity at 1 April 2020** | **133,863** | **19,343** | **(153,107)** | **99** |
| Surplus for the year | - | - | 3,966 | **3,966** |
| Other transfers between reserves | - | (5) | 5 | **-** |
| Impairments | - | (18,748) | - | **(18,748)** |
| Revaluations | - | - | - | **-** |
| Other recognised gains and losses | - | 1 | - | **1** |
| Public dividend capital received | 186,696 | - | - | **186,696** |
| **Taxpayers' equity at 31 March 2021** | **320,559** | **591** | **(149,136)** | **172,014** |
| | | | | |
| **Taxpayers' equity at 1 April 2019** | **130,918** | **18,626** | **(153,616)** | **(4,072)** |
| Surplus for the year | - | - | 496 | **496** |
| Other transfers between reserves | - | (13) | 13 | **-** |
| Revaluations | - | 613 | - | **613** |
| Other recognised gains and losses | - | 117 | - | **117** |
| Public dividend capital received | 2,945 | - | - | **2,945** |
| **Taxpayers' equity at 31 March 2020** | **133,863** | **19,343** | **(153,107)** | **99** |

### 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 | 2020/21 £000's | 2019/20 £000's |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus | | **7,018** | 2,443 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 6 | **10,451** | 9,385 |
| Net impairments | 7 | **341** | - |
| Income recognised in respect of capital donations | 4 | **(1,857)** | (98) |
| Decrease / (increase) in receivables and other assets | | **41,230** | (30,746) |
| Increase in inventories | | **(1,132)** | (50) |
| Increase in payables and other liabilities | | **11,374** | 3,989 |
| Increase in provisions | | **273** | 1,015 |
| **Net cash flows from / (used in) operating activities** | | **67,698** | **(14,062)** |
| **Cash flows from investing activities** | | | |
| Interest received | | **4** | 85 |
| Purchase of intangible assets | | **(446)** | (522) |
| Purchase of PPE and investment property | | **(35,562)** | (13,042) |
| **Net cash flows from / (used in) investing activities** | | **(36,004)** | **(13,479)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | **186,696** | 2,945 |
| Movement on loans from DHSC | | **(150,467)** | 26,511 |
| Capital element of finance lease rental payments | | **(30)** | (20) |
| Interest on loans | | **(461)** | (1,937) |
| PDC dividend paid | | **(3,309)** | - |
| Cash flows used in other financing activities | | **(25)** | (11) |
| **Net cash flows from financing activities** | | **32,404** | **27,488** |
| **Increase / (decrease) in cash and cash equivalents** | | **64,098** | **(53)** |
| **Cash and cash equivalents at 1 April** | | **1,144** | **1,197** |
| **Cash and cash equivalents at 31 March** | 19 | **65,242** | **1,144** |

## 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 2020/21 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, in accordance with the definition as set out in section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Strategic Delivery Plan and NHS Long Term Plan response for the five year period 2020/21 - 2024/25 and this plan includes the continued provision of services by the Trust. In addition, the Trust continues to develop an Outline Business Case to build a new hospital, which is being supported by a variety of stakeholders. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

For the 2020/21 financial year, the Trust achieved a surplus of £1.8m against a planned deficit of £0.4m. Income from our local Clinical Commissioning Groups was largely based on the adapted finance regime introduced in response to the COVID-19 pandemic and this provided predictability and improved cash flow with the Trust finishing the year with a £65.2m cash balance. Additional costs arising from the pandemic were reimbursed in the first half the year and incorporated into a block payment basis for the second half of the year.

In April 2020, the DHSC and NHS England and NHS Improvement (NHSE/I) announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. Consequently, the Trust received PDC of £146.2m to repay these loans which had accumulated from prior year deficits. In addition, capital loans of £4.3m were also extinguished and replaced with PDC and therefore total net assets increased by £150.5m. This strengthened the value of the Trust's Statement of Financial Position and means that the Trust is no longer required to generate surpluses to service this historic debt.

## Notes to the Accounts

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

For 2021/22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding to support elective recovery post COVID.

The national financial arrangements for the second half of the year are not fully known at this stage and while the implications of COVID-19 should be greatly reduced, there is likely to be some ongoing effect and, potentially, additional funding for this. The Trust's income is largely based on commissioner block contracts which will continue throughout the second half of the year. Reducing the Trust's underlying cost base and increasing efficiencies is essential with the focus on delivering a cost-improvement programme of £6.7m (or 2.2%). In 2019/20, the Trust achieved £9.9m (or 3.4%) of cost improvements and therefore is reasonably assured of being able to achieve this target.

The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period to 30 June 2022. The cash forecast shows sufficient liquidity for the Trust to continue to operate during that period with no need to borrow. In addition, the Trust has access to working capital arrangements should the need for this arise. In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

### Note 1.2 Critical judgements in applying accounting policies

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

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

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

• Classification of leases as finance or operating leases. Leases have been reviewed to determine if they are classified as operating or finance leases in line with IAS17. Critical judgements include whether the ownership transfers at the end of the 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 (Note 1.7.2). The Valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation.

## Notes to the Accounts

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

**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**
In 2019/20 the Trust was unable to perform a complete stocktake of all inventory items, specifically the impact of COVID led to an inability to access some clinical areas e.g. Theatres. For those areas not counted in 2019/20 the Trust performed a mid year stocktake count during September 2021. In addition, during March 2021 the Trust has re-performed a full inventory count of all inventory held. To ensure completeness and accuracy of inventory verification this exercise was supported by a suitably qualified third party. The final value of the stockholding was £5.7m. This compares to the previous calculated stock value of £4.6m. The increase in inventory includes consumables and drugs increases totalling £0.5m. In addition during 2020/21, and as part of the response to COVID the Trust received 'Push' deliveries of Personal Proteactive Equipment (PPE). The cost of this PPE was funded centrally with the closing stock of PPE inventory recorded as held by the Trust. The value of this stock is £0.6m.

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

# Notes to the Accounts

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

### Note 1.4 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

**Current Year (2020/21)**

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

**Comparative period (2019/20)**

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient.

Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

## Notes to the Accounts

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

**For 2020/21 and 2019/20**
Where the effects of practical expedients mandated by the GAM are material, these should be disclosed as accounting policies. These include: (1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

**Revenue from research contracts**
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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

**Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF)**
In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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. A revised financial regime was established for 2020/21 and PSF and PRF were not included within the revised regime.

### Note 1.4.2 Other income

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

## Notes to the Accounts

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

**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**

**Short-term employee benefits**
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs - NHS Pension Scheme**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS 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
- 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.

## Notes to the Accounts

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

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.

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.

The valuation exercise was carried out from 13 January 2021 to 31 March 2021 with the valuation date being 31 March 2021. Valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted, and applied by the HMT Treasury FReM compliant with Department of Health Group Manual for Accounts. They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation - Global Standards 2017 and RICS UK National Supplement, commonly known together as the 'Red Book'.

# Notes to the Accounts

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

### Impact of COVID-19 on valuation

In applying the RICS Valuation Global Standards the valuer has recognised the outbreak of the COVID-19 pandemic on the 11 March 2020. The valuer recognises the pandemic, and the measures taken to tackle COVID-19 continue to affect economies and real estate market. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, the valuer's valuation is not reported as subject to 'material uncertainty' as defined by the RICS valuation - global standard.

In respect of the total value of estate, being the aggregate of current values, including depreciated replacement cost, of operating properties, the fair values of non-operational properties and excluding leased properties as at 31 March 2021 may be taken to be £89.985m. These values can be apportioned between land £8.150m and buildings £81.835m. On the 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 have been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

### Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

## 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 criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

**Note 1.7.4 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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

## Notes to the Accounts

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

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

| | Min life Years | Max life Years |
|---|---|---|
| Buildings | 15 | 30 |
| Plant & machinery | 5 | 15 |
| Transport equipment | 3 | 7 |
| Information technology | 5 | 8 |
| Furniture & fittings | 5 | 15 |

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

**Note 1.8 Intangible assets**

**Note 1.8.1 Recognition**
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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

Expenditure on research is not capitalised. Expenditure on development is capitalised 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. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus, with no plan to bring it back into use, is valued at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

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

## Notes to the Accounts

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

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

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

| | Min life Years | Max life Years |
|---|---|---|
| Information technology | 5 | 8 |
| Development expenditure | 8 | 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.

In 2020/21, the Trust received push inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

**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 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

**Note 1.11 Financial assets and financial liabilities**

**Note 1.11.1 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 the Office of National Statistics (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 1.11.2 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 de-recognition, 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 22.43% of outstanding receivables is included - was previously 21.79% in 2019/20).

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 1.11.3 De-recognition**
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 1.12 Leases**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

**The Trust as Lessee**

**Finance leases**
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The 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 1.12.1 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 1.12.2 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 1.13 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 0.95% in real terms (2019/20 rate was minus 0.50%).

**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 25 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 1.14 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 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.15 Public Dividend Capital**
Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at
https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

**Note 1.16 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 1.17 Climate change levy**
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

**Note 1.18 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)

### Note 1.18 Foreign exchange (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 2020/21.

## Notes to the Accounts

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

**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.

**Note 1.24 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

**Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adop**

**IFRS 16 Leases**

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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances 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.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

**Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted (cont.)**

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

| | £000's |
|---|---|
| **Estimated impact on 1 April 2022 statement of financial position** | |
| Additional right of use assets recognised for existing operating leases | 18,492 |
| **Net impact on net assets on 1 April 2022** | **18,492** |
| **Estimated in-year impact in 2022/23** | |
| Additional depreciation on right of use assets | (1,450) |
| Additional finance costs on lease liabilities | (216) |
| Lease rentals no longer charged to operating expenditure | 1,484 |
| **Estimated impact on surplus / deficit in 2022/23** | **(182)** |

**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.

| **Note 3.1 Income from patient care activities (by nature)** | **2020/21 £000's** | **2019/20 £000's** |
|---|---|---|
| **Acute Services** | | |
| Block contract / system envelope income* | 255,169 | 222,400 |
| High cost drugs income from commissioners (excluding pass-through costs) | 1,631 | 14,077 |
| Other NHS clinical income | 1,923 | 912 |
| **All services** | | |
| Private patient income | 175 | 290 |
| Additional pension contribution central funding** | 7,061 | 6,440 |
| Other clinical income | 1,876 | 2,628 |
| **Total patient income from activities** | **267,835** | **246,747** |

*As part of the COVID pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over 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: | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| NHS England | 29,662 | 29,937 |
| Clinical commissioning groups | 236,425 | 215,150 |
| Department of Health and Social Care | 22 | 27 |
| Other NHS providers | 955 | 490 |
| NHS other | 1 | 103 |
| Local authorities | - | 19 |
| Non-NHS: private patients | 175 | 290 |
| Non-NHS: overseas patients (chargeable to patient) | 100 | 93 |
| Injury cost recovery scheme | 495 | 638 |
| **Total income from activities** | **267,835** | **246,747** |

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Income recognised this year | 100 | 93 |
| Cash payments received in-year | 92 | 43 |
| Amounts added to provision for impairment of receivables | 199 | 38 |
| Amounts written off in-year | 1 | 1 |

**Note 4. Other operating income**

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **Other operating income from contracts with customers** | | |
| Research and development | 543 | 632 |
| Education and training | 7,644 | 6,772 |
| Non-patient care services to other bodies | 2,782 | 2,706 |
| Provider sustainability fund (2019/20 only) | - | 5,787 |
| Financial recovery fund (2019/20 only) | - | 21,829 |
| Marginal rate emergency tariff funding (2019/20 only) | - | 548 |
| Reimbursement and top up funding | 27,454 | |
| Other income | 1,318 | 3,271 |
| **Other non-contract operating income** | | |
| Receipt of capital grants and donations | 1,857 | 98 |
| Charitable and other contributions to expenditure | 4,888 | - |
| Rental revenue from operating leases | 801 | 101 |
| **Total other operating income** | **47,287** | **41,744** |

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Revenue recognised in the reporting period that was included within contract liabilities at the previous period end | 613 | 656 |

## Note 6. Operating expenses

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Purchase of healthcare from NHS and DHSC bodies | 2,426 | 4,741 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 4,768 | 3,880 |
| Staff and executive directors costs | 203,722 | 193,119 |
| Remuneration of non-executive directors | 114 | 94 |
| Supplies and services - clinical (excluding drugs costs) | 22,152 | 19,864 |
| Supplies and services - general | 3,133 | 3,395 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 21,087 | 20,189 |
| Consultancy and professional services | 3,419 | 3,532 |
| Establishment | 2,249 | 1,618 |
| Premises | 14,219 | 10,328 |
| Transport (including patient travel) | 652 | 816 |
| Depreciation on property, plant and equipment | 8,520 | 7,494 |
| Amortisation on intangible assets | 1,931 | 1,891 |
| Net impairments | 341 | - |
| Movement in credit loss allowance: contract receivables / contract assets | 526 | 158 |
| Change in provisions discount rate | 5 | 7 |
| Audit fees payable to the external auditor audit services - statutory audit | 138 | 73 |
| Internal audit costs | 89 | 104 |
| Clinical negligence | 13,010 | 9,924 |
| Legal fees | 382 | 416 |
| Insurance | 165 | 117 |
| Education and training | 710 | 741 |
| Rentals under operating leases | 2,624 | 2,292 |
| Redundancy | 35 | 11 |
| Car parking & security | 802 | 459 |
| Hospitality | 12 | 1 |
| Losses, ex gratia & special payments | 297 | 73 |
| Other external services | 199 | 276 |
| Other | 377 | 435 |
| **Total** | **308,104** | **286,048** |

During 2020/21 some items of operating expenditure were impacted by the response to COVID-19. For some items of expenses this led to comparative increases in expenditure and in some cases expenditure reduced when compared to 2019/20.

**Limitation on auditor's liability**

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

## Note 7. Impairment of assets

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **Net impairments charged to operating surplus** | | |
| Changes in market price | 341 | - |
| **Total net impairments charged to operating surplus** | **341** | **-** |
| Impairments charged to the revaluation reserve | 18,748 | - |
| **Total net impairments** | **19,089** | **-** |

## Note 8. Employee benefits

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Salaries and wages | 136,950 | 124,956 |
| Social security costs | 12,456 | 12,319 |
| Apprenticeship levy | 606 | 605 |
| Employer's contributions to NHS pensions | 23,171 | 21,144 |
| Pension cost - other | 36 | 35 |
| Temporary staff (including agency) | 33,141 | 35,865 |
| **Total gross staff costs** | **206,360** | **194,924** |
| **Total staff costs** | **206,360** | **194,924** |
| **Of which, included above** | | |
| Costs capitalised as part of assets | 2,603 | 1,794 |
| Redundancy | 35 | 11 |
| **Total staff and executive directors costs** | **203,722** | **193,119** |

### Note 8.1 Retirements due to ill-health

During 2020/21 there were three retirements from the Trust agreed on the grounds of ill-health (three in 2019/20). The estimated additional pension liabilities of these ill-health retirements is £147k (£151k in 2019/20).

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

## Note 9. 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.

## Note 9. Pension costs (continued)

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the

**NEST Pension Scheme**
Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.

NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2020/21 was 3% (2019/20: 3%)

## Note 10. Operating leases

### Note 10.1 The Trust as a lessor

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **Operating lease revenue** | | |
| Minimum lease receipts | 801 | 101 |
| **Total** | **801** | **101** |

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Future minimum lease receipts due:** | | |
| - not later than one year; | 311 | 101 |
| - later than one year and not later than five years; | 247 | 247 |
| - later than five years. | 146 | 146 |
| **Total** | **704** | **494** |

### Note 10.2 The Princess Alexandra Hospital NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Princess Alexandra Hospital NHS Trust is the lessee.

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **Operating lease expense** | | |
| Minimum lease payments | 2,624 | 2,292 |
| **Total** | **2,624** | **2,292** |

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Future minimum lease payments due:** | | |
| - not later than one year; | 1,881 | 2,089 |
| - later than one year and not later than five years; | 6,381 | 6,942 |
| - later than five years. | 8,606 | 9,320 |
| **Total** | **16,868** | **18,351** |

## Note 11. Finance income

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Interest on bank accounts | - | 85 |
| **Total finance income** | **-** | **85** |

**Note 12. Finance expenditure**

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **Interest expense:** | | |
| Loans from the Department of Health and | - | 2,019 |
| **Total interest expense** | **-** | **2,019** |
| Unwinding of discount on provisions | (7) | 2 |
| Other finance costs | 25 | 11 |
| **Total finance costs** | **18** | **2,032** |

**Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015**

There were nil interest charges on late payments in 2020/21 (nil in 2019/20)

**Note 13. Other gains / (losses)**

There were no gains or losses from disposals of assets in 2020/21 (nil in 2019/20)

| Note 14.1 Intangible assets - 2020/21 | Internally generated information technology £000's | Development expenditure £000's | Total £000's |
|---|---|---|---|
| **Valuation / gross cost at 1 April 2020** | **116** | **15,295** | **15,411** |
| Additions | 1,467 | - | **1,467** |
| **Valuation / gross cost at 31 March 2021** | **1,583** | **15,295** | **16,878** |
| **Amortisation at 1 April 2020** | **36** | **7,742** | **7,778** |
| Provided during the year | 3 | 1,928 | **1,931** |
| **Amortisation at 31 March 2021** | **39** | **9,670** | **9,709** |
| **Net book value at 31 March 2021** | **1,544** | **5,625** | **7,169** |
| **Net book value at 1 April 2020** | **80** | **7,553** | **7,633** |

**Note 14.2 Intangible assets - 2019/20**

| Note 14.2 Intangible assets - 2019/20 | Internally generated information technology £000's | Development expenditure £000's | Total £000's |
|---|---|---|---|
| **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** |

| Note 15.1 Property, plant and equipment - 2020/21 | 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 2020** | **8,150** | **80,176** | **11,637** | **28,028** | **279** | **21,480** | **1,169** | **150,919** |
| Additions | - | 9,762 | 25,018 | 9,064 | - | 4,169 | 36 | **48,049** |
| Impairments | - | (19,089) | - | - | - | - | - | **(19,089)** |
| Reclassifications | - | 17,340 | - | (17,404) | 64 | - | - | **-** |
| **Valuation/gross cost at 31 March 2021** | **8,150** | **88,189** | **36,655** | **19,688** | **343** | **25,649** | **1,205** | **179,879** |
| **Accumulated depreciation at 1 April 2020** | **-** | **569** | **-** | **19,701** | **109** | **12,011** | **1,124** | **33,514** |
| Provided during the year | - | 3,192 | - | 2,243 | 27 | 3,046 | 12 | **8,520** |
| **Accumulated depreciation at 31 March 2021** | **-** | **3,761** | **-** | **21,944** | **136** | **15,057** | **1,136** | **42,034** |
| **Net book value at 31 March 2021** | **8,150** | **84,428** | **36,655** | **(2,256)** | **207** | **10,592** | **69** | **137,845** |
| **Net book value at 1 April 2020** | **8,150** | **79,607** | **11,637** | **8,327** | **170** | **9,469** | **45** | **117,405** |

| Note 15.2 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 | - | 1,772 | 9,854 | 1,739 | 132 | 3,412 | - | **16,909** |
| Revaluations | - | (2,107) | - | - | - | - | - | **(2,107)** |
| Reclassifications | - | 66 | (66) | (71) | 71 | - | - | **-** |
| Disposals / derecognition | - | - | - | (160) | - | - | - | **(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 - as previously stated** | **-** | **535** | **-** | **17,783** | **28** | **9,440** | **1,114** | **28,900** |
| Provided during the year | - | 2,754 | - | 2,149 | 10 | 2,571 | 10 | **7,494** |
| Revaluations | - | (2,720) | - | - | - | - | - | **(2,720)** |
| Reclassifications | - | - | - | (71) | 71 | - | - | **-** |
| Disposals / derecognition | - | - | - | (160) | - | - | - | **(160)** |
| **Accumulated depreciation at 31 March 2020** | **-** | **569** | **-** | **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 16.3 Property, plant and equipment financing - 2020/21**

| | 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 2021** | | | | | | | | |
| Owned - purchased | 8,150 | 84,428 | 19,251 | 13,071 | 143 | 10,592 | 69 | **135,704** |
| Finance leased | - | - | - | 71 | - | - | - | **71** |
| Owned - donated/granted | - | - | - | 2,070 | - | - | - | **2,070** |
| **NBV total at 31 March 2021** | **8,150** | **84,428** | **19,251** | **15,212** | **143** | **10,592** | **69** | **137,845** |

**Note 16.4 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 | - | - | - | 83 | - | - | - | **83** |
| Owned - donated/granted | - | - | - | 134 | - | - | - | **134** |
| **NBV total at 31 March 2020** | **8,150** | **79,607** | **11,637** | **8,327** | **170** | **9,469** | **45** | **117,405** |

**Note 16.4 Donations of property, plant and equipment**

The Trust did not receive any donated assets from The PAH NHS Trust Charitable Fund (Registered Charity No 10547745) during 2020/21 (2019/20 £98k).

**Note 16.5 Revaluations of property, plant and equipment**

The Trust has undertaken a revaluation of land and buildings as at 31 March 2021 (see note 1.7.2). 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 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| Drugs | 1,668 | 1,451 |
| Consumables | 3,983 | 3,046 |
| Energy | 46 | 32 |
| Other | - | 36 |
| **Total inventories** | **5,697** | **4,565** |

Inventories recognised in expenses for the year were £34,467k (2019/20: £31,347k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,888k of items purchased by DHSC, of which £655k was held as stock at 31 March 21. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

## Note 18. Receivables

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Current** | | |
| Contract receivables | 6,242 | 47,666 |
| Allowance for impaired contract receivables / assets | (1,689) | (1,193) |
| Prepayments (non-PFI) | 1,725 | 1,241 |
| Interest receivable | - | 4 |
| PDC dividend receivable | 275 | - |
| VAT receivable | 1,655 | 1,406 |
| Other receivables | 173 | 208 |
| **Total current receivables** | **8,381** | **49,332** |
| **Non-current** | | |
| Contract receivables | 576 | 692 |
| Other receivables | 613 | 505 |
| **Total non-current receivables** | **1,189** | **1,197** |
| **Of which receivable from NHS and DHSC group bodies:** | | |
| Current | 3,607 | 44,659 |
| Non-current | 613 | 505 |

## Note 18.1 Allowances for credit losses

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Allowances as at 1 April - brought forward | 1,193 | 1,066 |
| New allowances arising | 555 | 175 |
| Reversals of allowances | (29) | (17) |
| Utilisation of allowances (write offs) | (30) | (31) |
| **Allowances as at 31 March 2021** | **1,689** | **1,193** |

## 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.

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| **At 1 April** | **1,144** | **1,197** |
| Net change in year | 64,098 | (53) |
| **At 31 March** | **65,242** | **1,144** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 12 | 22 |
| Cash with the Government Banking Service | 65,230 | 1,122 |
| **Total cash and cash equivalents as in SoFP / SoCF** | **65,242** | **1,144** |

## 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.

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Bank balances | 18 | 16 |
| **Total third party assets** | **18** | **16** |

## Note 20. Trade and other payables

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Current** | | |
| Trade payables | 7,545 | 8,598 |
| Capital payables | 18,407 | 6,757 |
| Accruals | 18,781 | 9,258 |
| Social security costs | 2,008 | 1,863 |
| Other taxes payable | 1,719 | 347 |
| Other payables | 610 | 245 |
| **Total current trade and other payables** | **49,070** | **27,068** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 3,562 | 4,663 |

## Note 20.1 Early retirements in NHS payables above

There are no early retirements included in NHS payables (nil in 2019/20)

## Note 21. Other liabilities

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Current** | | |
| Deferred income: contract liabilities | 2,180 | 1,158 |
| **Total other current liabilities** | **2,180** | **1,158** |

## Note 22. Borrowings

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Current** | | |
| Loans from DHSC | - | 150,928 |
| Obligations under finance leases | 30 | 30 |
| **Total current borrowings** | **30** | **150,958** |
| **Non-current** | | |
| Obligations under finance leases | 10 | 40 |
| **Total non-current borrowings** | **10** | **40** |

## Note 22.1 Reconciliation of liabilities arising from financing activities - 2020/21

| | Loans £000's | Finance £000's | Total £000's |
|---|---|---|---|
| **Carrying value at 1 April 2020** | **150,928** | **70** | **150,998** |
| **Cash movements:** | | | |
| Payments and receipts of principal | (150,467) | (30) | **(150,497)** |
| Payments of interest | (461) | - | **(461)** |
| **Carrying value at 31 March 2021** | **-** | **40** | **40** |

As part of the revised 2020/21 financial regime, all outstanding loans were converted to PDC and this has increased average net assets of the Trust. Interest was therefore not payable in 2020/21, but there was dividend payable of £3,034k.

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

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

## Note 23. Finance leases

### Note 23.1 The Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Gross lease liabilities** | 40 | 71 |
| of which liabilities are due: | | |
| not later than one year; | 30 | 30 |
| later than one year and not later than five years; | 10 | 41 |
| later than five years. | - | - |
| Finance charges allocated to future periods | - | (1) |
| **Net lease liabilities** | **40** | **70** |
| of which payable: | | |
| not later than one year; | 30 | 30 |
| later than one year and not later than five years; | 10 | 40 |
| later than five years. | - | - |

## Note 24. Provisions for liabilities and charges analysis

| | Pensions: early departure costs £000's | Legal claims £000's | Other £000's | Total £000's |
|---|---|---|---|---|
| **At 1 April 2020** | **842** | **302** | **809** | **1,953** |
| Change in the discount rate | 2 | - | 3 | **5** |
| Arising during the year | 1 | 541 | 260 | **802** |
| Utilised during the year | (70) | (10) | (134) | **(214)** |
| Reversed unused | (240) | (27) | (53) | **(320)** |
| Unwinding of discount | (4) | - | (3) | **(7)** |
| **At 31 March 2021** | **531** | **806** | **882** | **2,219** |
| **Expected timing of cash flows:** | | | | |
| not later than one year; | 67 | 806 | **269** | **1,142** |
| later than one year and not later than five years; | 266 | - | **613** | **879** |
| later than five years. | 198 | - | **-** | **198** |
| **Total** | **531** | **806** | **882** | **2,219** |

## Note 25. Clinical negligence liabilities

At 31 March 2021 £121.1m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2020: £107.9m).

## Note 26. Contingent assets and liabilities

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (37) | (38) |
| Employment tribunal and other employee related litigation | (416) | (128) |
| **Gross value of contingent liabilities** | **(453)** | **(166)** |

## Note 27. Contractual capital commitments

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| Property, plant and equipment | 9,237 | 8,265 |
| **Total** | **9,237** | **8,265** |

## Note 28. Financial instruments

### Note 28.1 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 28.1 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 28.2 Carrying values of financial assets

| Carrying values of financial assets held at amortised cost | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| Trade and other receivables excluding non financial assets | 5,915 | 47,377 |
| Cash and cash equivalents | 65,242 | 1,144 |
| **Total at 31 March** | **71,157** | **48,521** |

## Note 28.3 Carrying values of financial liabilities

| Carrying values of financial liabilities held at amortised cost | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| Loans from the Department of Health and Social Care | - | 150,928 |
| Obligations under finance leases | 40 | 70 |
| Trade and other payables excluding non financial liabilities | 45,343 | 24,858 |
| **Total at 31 March** | **45,383** | **175,856** |

## Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual

| | 31 March 2021 £000's | 31 March 2020 £000's |
|---|---|---|
| In one year or less | 45,373 | 175,816 |
| In more than one year but not more than five years | 10 | 41 |
| In more than five years | - | - |
| **Total** | **45,383** | **175,857** |

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

## Note 28.5 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 29. Losses and special payments

| | 2020/21 | | 2019/20 | |
|---|---|---|---|---|
| | **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 |
| Fruitless payments | 2 | 126 | - | - |
| Bad debts and claims abandoned | 1,133 | 30 | 31 | 32 |
| Stores losses and damage to property | 3 | 47 | 3 | 33 |
| **Total losses** | **1,138** | **203** | **36** | **69** |
| **Special payments** | | | | |
| Compensation under court order or legally binding arbitration award | 8 | 47 | 4 | 9 |
| Ex-gratia payments | 14 | 15 | 5 | 3 |
| **Total special payments** | **22** | **62** | **9** | **12** |
| **Total losses and special payments** | **1,160** | **265** | **45** | **81** |
| Compensation payments received | | 0 | | 0 |

## Note 30. Related parties

In accordance with IAS 24 and paragraphs 5.179-5.183 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
Other NHS Providers
CCGs and NHS England
NHS West Essex
NHS East and North Hertfordshire
NHS England
NHS Resolution
NHS Business Service Authority
Other Health Bodies and Government Departments
HM Revenue and Customs
NHS Blood and Transplant Service
NHS Professionals
NHS Pensions Agency
NHS England and NHS Improvement
Health Education England
NHS Property Services
Local Authorities

**Note 30. 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 | Income from related party | Amounts owed to related party | Amounts due from related party |
|---|---|---|---|---|---|---|---|
| | | | | £000's | £000's | £000's | £000's |
| Addenbrooke's Charitable Trust | Helen Howe | Associate Non-Executive Director | Trustee | 0 | 0 | 0 | 0 |
| Anglia Ruskin University | John Keddie | Non-Executive Director | Governor | 145 | 24 | 142 | 0 |
| Anglia Ruskin University | James McLeish | Director of Quality Improvement | Family member an employee | 145 | 24 | 142 | 0 |
| Care Quality Commission | Ahmed Soliman | Associate Medical Director - Urgent Care | Specialist Clinical Advisor | 163 | 0 | 0 | 0 |
| Holly House Hospital | John Hogan | Non-Executive Director | Private Practice | 55 | 0 | 55 | 0 |
| St Clare Hospice | Monica Bose | Consultant Gastroenterologist | Trustee | 29 | 0 | 9 | 0 |
| University of Suffolk | Steve Clarke | Chairman | Independent Director | 0 | 0 | 0 | 0 |
| East of England Ambulance Service | James McLeish | Director of Quality Improvement | Family member an employee | 42 | 0 | 21 | 0 |
| Barts Health NHS Trust | John Hogan | Non-Executive Director | Consultant Cardiologist | 329 | 503 | 404 | 339 |

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 £235k (unaudited) to the Trust (2019/20 £286k).

### Note 31. Prior Period Adjustments

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

### Note 32. Events after the reporting date

The Trust has no other adjusting events after the end of the reporting period. The Accounts were approved by the Board of Directors on 11 June 2021.

### Note 33. Better Payment Practice code

| Non-NHS Payables | 2020/21 Number | 2020/21 £000's | 2019/20 Number | 2019/20 £000's |
|---|---|---|---|---|
| Total non-NHS trade invoices paid in the year | 45,928 | 109,532 | 49,002 | 76,083 |
| Total non-NHS trade invoices paid within target | 39,957 | 92,948 | 43,722 | 64,320 |
| Percentage of non-NHS trade invoices paid within target | **87.0%** | **84.9%** | **89.2%** | **84.5%** |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 2,296 | 53,313 | 2,227 | 56,446 |
| Total NHS trade invoices paid within target | 1,912 | 48,878 | 1,805 | 47,379 |
| Percentage of NHS trade invoices paid within target | **83.3%** | **91.7%** | **81.1%** | **83.9%** |

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 34. External financing limit

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

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| External financing limit (EFL) | (27,899) | 30,083 |
| Cashflow financing | (27,899) | 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** |

## Note 35. Capital Resource Limit

| | 2020/21 £000's | 2019/20 £000's |
|---|---|---|
| Gross capital expenditure | 49,516 | 17,412 |
| Less: Donated and granted capital additions | (1,857) | (98) |
| **Charge against Capital Resource Limit** | **47,659** | **17,314** |
| Capital Resource Limit | 47,659 | 17,721 |
| **Unadjusted CRL** | **-** | **407** |
| **Adjusted financial performance (management control total)** | | |
| CT scanner funding deferred to 2020/21 included in 2019/20 limit | - | (447) |
| COVID CRL support for 2019/20 adjusted in 2020/21 | - | 509 |
| **Underspend against CRL** | **-** | **469** |

## Note 36. Breakeven duty and financial performance

### Note 36.1 Breakeven duty by Control Total

| | Control Target £000's | Actual Outturn £000's | Under-spend £000's |
|---|---|---|---|
| Net Control Total - 2020/21 | (391) | 1,816 | **2,207** |
| Net Control Total - 2019/20 | (6,168) | 50 | **6,218** |

### Note 36.2 Breakeven duty financial performance

| | 2020/21 £000's |
|---|---|
| Adjusted financial performance surplus (control total basis) | 1,816 |
| **Breakeven duty financial performance surplus** | **1,816** |

## Note 36.3. Breakeven duty rolling assessment

| | 1997/98 to £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 |
|---|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | | 511 | 415 | 461 | 122 | (16,403) | (21,998) |
| Breakeven duty cumulative position | 1,536 | 2,047 | 2,462 | 2,923 | 3,045 | (13,358) | (35,356) |
| Operating income | | 172,171 | 179,388 | 180,790 | 184,568 | 177,739 | 190,478 |
| **Cumulative breakeven position as a percentage of operating income** | | **1.19%** | **1.37%** | **1.62%** | **1.65%** | **-7.52%** | **-18.56%** |

| | 2015/16 £000's | 2016/17 £000's | 2017/18 £000's | 2018/19 £000's | 2019/20 £000's | 2020/21 £000's |
|---|---|---|---|---|---|---|
| Breakeven duty in-year financial performance | (37,714) | (26,715) | (28,435) | (16,542) | 418 | 1,816 |
| Breakeven duty cumulative position | (73,070) | (99,785) | (128,220) | (144,762) | (144,344) | (142,528) |
| Operating income | 196,124 | 209,742 | 213,231 | 236,700 | 288,491 | 315,122 |
| **Cumulative breakeven position as a percentage of operating income** | **-37.26%** | **-47.58%** | **-60.13%** | **-61.16%** | **-50.03%** | **-45.23%** |

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.