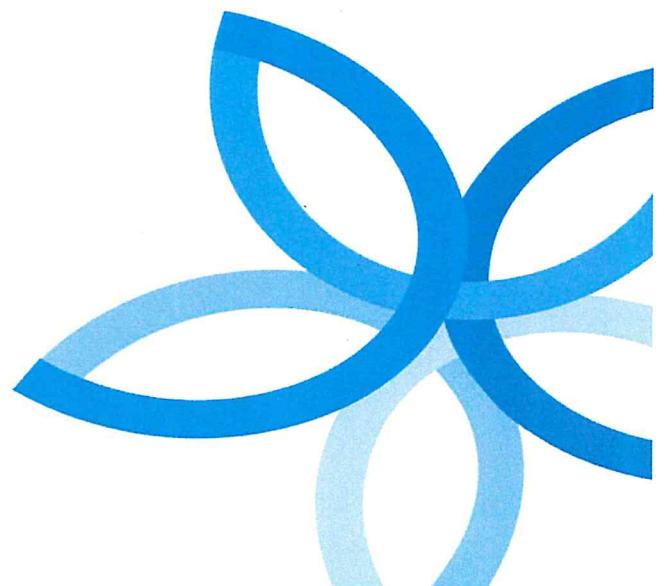


Annual Report and Accounts 2016/17

“Building for Excellence”



Building for excellence

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The Performance Report 2016/17

Overview

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

Statement from the Chairman, Acting Chief Executive and the Chief Executive

Welcome to our Annual Report for 2016/17. This has been one of Princess Alexandra's most challenging and most difficult years. The CQC assessment of our services, their rating of Inadequate and the subsequent placing of the Trust into special measures has had a significant impact on the Trust and our staff. We are, as a Board, firmly committed to changing that rating. There is a genuine drive and determination to address the issues documented by the CQC, to exit special measures as quickly as possible and to ensure the quality of our services remain paramount. That energy and drive is being harnessed through the "Quality 1st Programme"; a clinically led programme, engaging with clinical and corporate staff from all disciplines across the Trust, designed to make the quality of our services sustainable for the future.

Despite these challenges and difficult circumstances, the Trust has delivered and performed very well on many fronts; these include national standards for waiting times for surgery, diagnostic waiting times and cancer targets - these are all major achievements. The Trust's friends and family scores remain high.

Although the Trust was rated as Inadequate overall, we received a rating of Good for Caring in all areas and Maternity and Gynaecology services were rated Outstanding. The Trust also delivered on its financial targets in 2016/17, living within its revenue and capital limits for the year, reducing agency costs by c£6m and delivering over £12m of cost improvement. However, our performance against the constitutional standard requiring a minimum of 95% of patients attending the A&E department to be seen, treated and admitted or discharged in under four hours, remains our most challenging area of performance albeit an improving one.

More remains to be done within the Trust and across the health and social care system to maintain the improvements, to build on them and to build greater resilience for the future. This is being co-ordinated through the Local Delivery Board in conjunction with NHS England and NHS Improvement, our regulators.

Key to meeting our current and future challenges is the successful recruitment, retention and development of our staff; people are our biggest asset and greatest opportunity – we need the right numbers with the right skills to take our services forward. We were pleased to increase the substantive workforce this year and begin to reduce our reliance on agency staff. We are particularly proud of all the staff we are training into new roles. Recruitment of key clinical staff continues to be a challenge for us as it is elsewhere but we have continued to recruit from the UK and overseas. Our nursing and doctor numbers have gradually improved and we are indebted to our amazing staff for continuing to work so hard under difficult circumstances.

We also need to make sure our staff have the right infrastructure, equipment and facilities to best deliver our services. We are challenged with an aging estate that is clearly showing significant signs of wear and tear. In 2016/17 we invested some £4m in estate improvement, £3m in equipment and £3.5m in new technologies. These are important investments but they do not solve the longer term problems.

For 2017/8 the focus will be on developing estate solutions within the Sustainability and Transformation Plan for West Essex and Hertfordshire. In addition, future integration of local health and social care services with key partners and stakeholders is vital as part of the developing Accountable Care Partnership arrangements. These, combined with the important development of a Strategic Outline Case to build a new hospital in the future are absolutely crucial for our patients and their care. The Board recognises the scale of the task and is committed to a clear strategy which our staff, and our partners and regulators can support to make us a successful District General Hospital delivering high quality value for money healthcare to the population of West Essex and East Hertfordshire.



Trevor Smith
Acting Chief Executive (22 February 2017
– 31 May 2017



Lance McCarthy
Chief Executive (from 3 May 2017)



Alan Burns
Chairman

The Purpose and Activities of the Organisation

The Princess Alexandra Hospital NHS Trust (PAH) was established in 1995. It is a 504 bedded hospital and has an annual income of circa £209m. It provides a range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU).

The Trust currently employs approximately 2,500 whole time equivalent (WTE) staff and serves a core population of around 350,000 in West Essex and East Hertfordshire. In addition to the communities of Harlow and Epping, the Trust serves the populations of Bishop's Stortford and Saffron Walden in the North, Loughton and Waltham Abbey in the South, Great Dunmow in the East, and Hoddesdon and Broxbourne in the West. Its extended catchment (radius of 11 to 13 miles) incorporates a population of up to 500,000.

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

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

Service Portfolio

Directory of services			
Adult Critical Care	Diabetic Medicine	High Dependency Unit	Pathology
Audiology	Dietetics	Intensive Care unit	Pre Op Assessments
Breast Screening	Emergency	Interventional	Radiology

	Department	Radiology	
Breast Surgery	Endocrinology	Maternity	Respiratory Medicine
Cardiology	ENT	Medical Oncology	Rheumatology
Chemotherapy	Family Planning	Neonatal Critical Care	Special Care Baby Unit
Child Development Centre	Gastroenterology	Neurology	Trauma and Orthopaedics
Clinical Haematology	General Medicine	Obstetrics	Urology
Clinical Oncology	General Surgery	Ophthalmology	
Community Midwifery	Genito-Urinary Medicine	Oral Surgery	
Day Surgery	Geriatric Medicine	Paediatric Diabetic Medicine	
Dermatology	Gynaecology	Paediatrics	

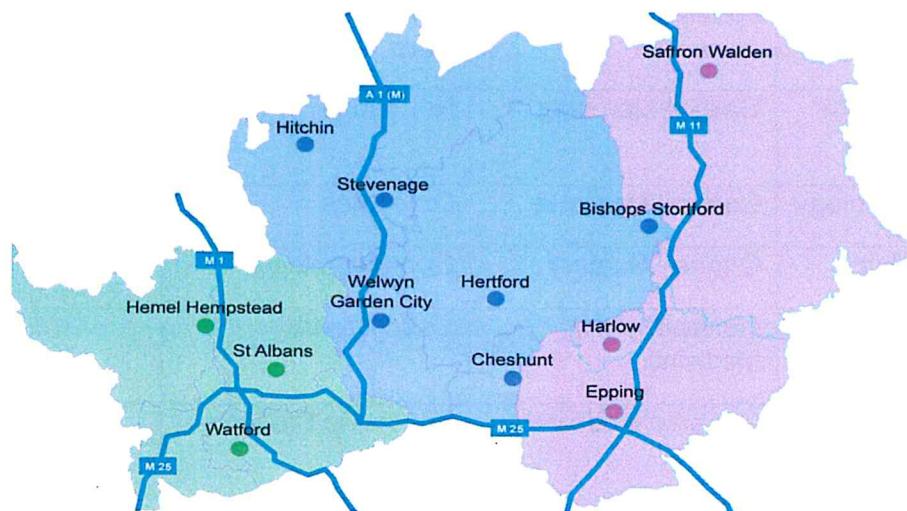
Strategic Objectives

The Trust's vision is to become an excellent provider of integrated acute care services and in support of this vision the Trust Board agreed five strategic objectives for 2016/17.



During 2016/17 the Trust worked closely with its Commissioners and partners to progress key pieces of strategic work intended to help resolve the Trust's sustainability challenges. A number of reviews conducted over the last few years concluded that the Trust would struggle to solve its financial, demand and service needs on its own and a system wide approach was required.

The Five Year Forward View set out some key priorities for acute Trusts in 2016/17. One of which was to develop an improvement plan for the next 5 years. In response to this PAH and West Essex CCG joined with Hertfordshire to form one transformational footprint.



Jointly the system developed a Sustainability Transformation Plan (STP) called "A Healthier Future: Improving health and care in Herts & West Essex". Over the next 5 years the STP will focus on three key areas:

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

Within the local West Essex system work has begun on developing an Accountable Care Partnership (ACP). This would be the vehicle to create a single integrated care organisation. It would bring together key elements of primary, community, secondary, social and mental health services which would not only deliver on the priorities of the STP but also the vision of the Five Year Forward view.

The ACP has identified a number of priorities to develop and implement during 2017/18 which would prove effective in managing demand for the hospital but also in developing a greater integrated care and a multi-disciplinary approach across providers:

- Develop multi-professional neighbourhood teams and build Population Health Management infrastructure
- Manage demand and improve patient access to services moving care closer to home where possible
- Improve service navigation and care transition across settings

- Reduce variation in care delivery and optimise the care management of complex patients with long term conditions
- Strengthen the focus on community activation, well-being and prevention – supporting people to lead healthier lives.

The hospital estate within the West Essex and East Hertfordshire health system has been a source of significant concern for a number of years. This is due to a combination of the condition and capacity of the existing estate, the needs of the local population over the next 20 years, and the plans of health leaders to transform the model of care provided to patients under an ACP.

The Trust has begun working on a Strategic Outline Case (SOC) to explore potential options for the hospital estate and site that will best fit the health and social care needs of the current and future population. It is anticipated the SOC will be presented to the Board for approval in 2017.

Going Concern

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

In approving the Trust's Annual Accounts the Board of Directors has had to satisfy itself that the Trust has prepared the Accounts on the basis of going concern recognising the following:

- The Board considers the Trust operates a significant portfolio of clinical services. The Trust's Commissioning organisations have not informed the Trust of any plans to cease commissioning services. Two year contracts with main Commissioners were signed in December 2016. These contracts span 2017/18 and 2018/19 and are agreed on the basis of continued service provision.
- At a strategic level the Trust is part of a combined West Essex and Hertfordshire Strategic Transformational Plan (STP) footprint. As part of this process local financial plans have been consolidated and collaborative work with local NHS Trusts within this footprint continues to develop. This work includes the progression of a number of STP clinical and non-clinical workstreams aimed at improving efficiency and quality of care.
- The Trust is also producing a Strategic Outline Business Case (SOC) which is developing future options for the site. Work with strategic partners will continue into 2017/18 to progress shortlisted options.
- The Trust submitted the 2017/18 Operational Plan to NHS Improvement. This includes a deficit plan of £21.6m in 2017/18. The Trust's deficit plan is underpinned by cash financing arrangements and delivery of a Cost Improvement Programme (CIP) of £8m.

The Board of Directors has carefully considered the principle of 'going concern' and recognises that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Nevertheless, interim financial support has continued to be received as planned in the early part of 2017/18 and the Board of Directors concludes the Trust has a reasonable expectation that the Trust will continue to have access to adequate cash financing to meet its liabilities and continue to provide the planned range of

clinical services in the foreseeable future. On that basis and for the reasons outlined above the Board of Directors considers it is appropriate to prepare the 2016/17 Accounts on a going concern basis.

Performance Analysis

Financial performance

At the beginning of the financial year NHS Improvement set the Trust a control target of a £29.7m deficit. The Trust's Board agreed this deficit plan subject to some conditions. The plan included the assumption the Trust would receive £7.9m of Sustainability and Transformational Funding (STF).

The Trust achieved an outturn of £26.7m deficit being £3.0m better than the £29.7m deficit plan. The over-achievement has been driven by the Trust's focus on controlling and reducing the cost base without compromising quality of care, and increasing its income. Both these actions resulted in an over-achievement of the Trust's £12m CIP programme. A series of 'back to financial balance' sessions were held during the year whereby staff developed initiatives to contribute to savings schemes. As an outcome of over-achievement of the plan and achievement of a majority of the performance targets the Trust was awarded additional STF of £2.1m.

Key drivers to reducing the deficit included reducing agency spend. The Trust reduced spend on temporary staffing by £6.0m represented by a £5.0m reduction in agency and £1m reduction in bank costs compared to the previous years. These reductions have enabled increased spend on the substantive workforce.

During the year the Trust also made significant capital investments in infrastructure, estate, ICT and medical equipment. The Trust's revised Capital plan was to spend £10.6m and the outturn was a spend of £10.5m.

In accordance with the opening financial plan during the year the Trust accessed loans totalling £29.7m. The Trust also re-financed a number of existing loans and converted some loans to lower interest rate loans. These conversions were agreed by NHS Improvement and Department of Health.

NHS Trust financial duties

The audited accounts for 2016/17 confirm:

- The Trust's 2016/17 adjusted retained deficit was £26.7m which was £3.0m better than the control target of £29.7m.
- The Trust underspent against its Capital Resource Limit of £11.5m by £1m with an outturn of £10.5m. The Trust intends to carry the underspend of £1m into 2017/18.
- The Trust underspent against its 2016/17 external financial limit by £0.3m.
- The Trust received net revenue support loans of £29.7m to meet its operating costs.

Better Payment Practice Code

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

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

Performance in 2016/17 against the Better Payment Practice Code (BPPC) is below the 95% target for all NHS organisations.

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

Performance is summarised as follows:

	2016/17 Number	2016/17 £000's	2015/16 Number	2015/16 £000's
Non-NHS Payables				
Total Trade Invoices Paid in the Year	48,282	85,479	42,896	81,672
Total Trade Invoices Paid Within Target	16,043	38,525	14,714	28,817
Percentage of Trade Invoices Paid Within Target	33.2%	45.1%	34.3%	35.3%
NHS Payables				
Total Trade Invoices Paid in the Year	2,130	16,654	1,754	12,136
Total Trade Invoices Paid Within Target	486	5,710	748	4,914
Percentage of Trade Invoices Paid Within Target	22.8%	34.3%	42.6%	40.5%

Financial plan 2017/2018

The Trust has submitted a deficit plan of £21.6m for 2017/18. The Trust Board has agreed this plan but recognise it will be very demanding and challenging but it remains achievable. These key risks include:

- Delivery of its activity plans and therefore recovery and capture of income.
- Meeting operating performance standards and targets.
- Managing local and national cost pressures.
- Further reducing interim and temporary staffing.
- Delivery of CIP (£8m) and transformation plans and associated efficiency improvements.

Our current Capital plans for 2017/18 are in the region of £27m. These plans include strategic developments such as an Emergency Assessment Centre, Fracture Clinic and Urgent Care Centre. The Trust continues to work towards securing funding to enable these schemes to progress.

Operational Performance

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

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

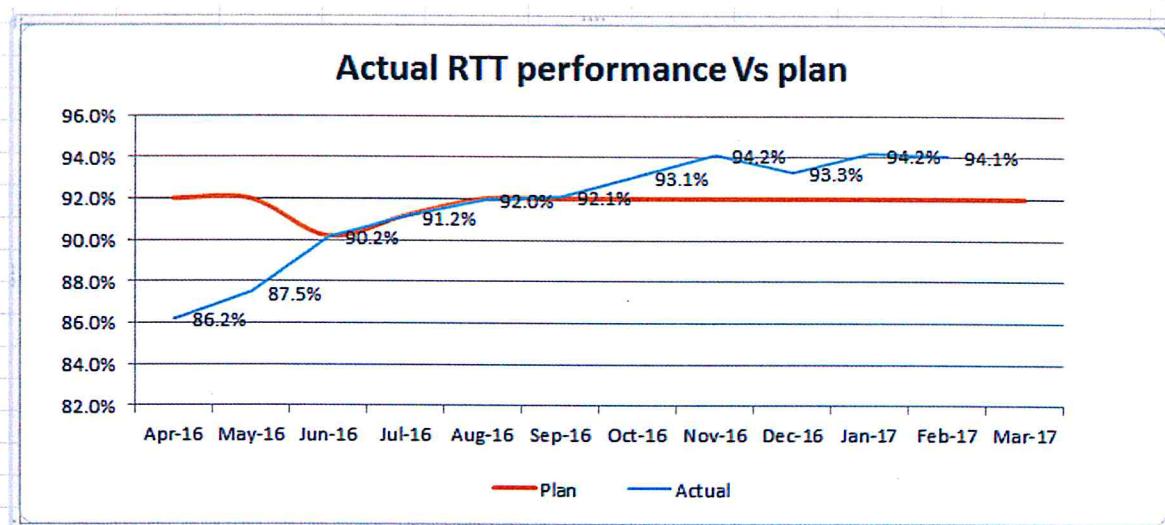
An Integrated Performance Report is presented to the Performance and Finance Committee and Board monthly. This report reflects the Trust's performance against a set of measures under the 5 key domains identified by CQC: Safe, Effective, Caring, Responsive and Well-Led.

Externally, the Trust is held to account for its operational performance by NHS Improvement.

Targets and national standards

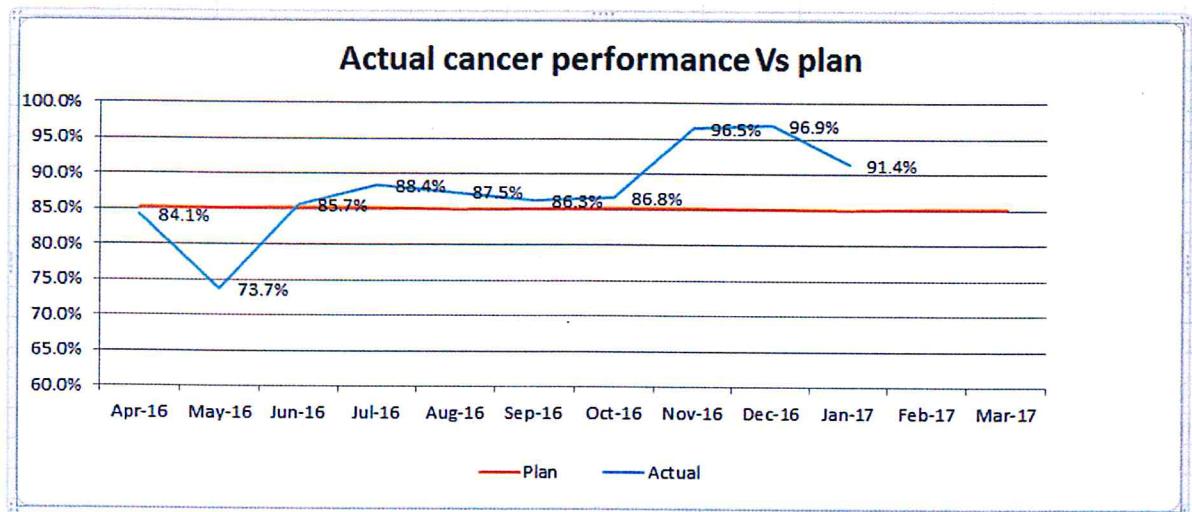
Significant progress has been made in 2016/17 in achievement of the Referral to Treatment Standards. Through working with the national Intensive Support Team to provide additional training and support to operational and clinical teams, the agreed recovery trajectory was delivered in June and July, with the 92% standard being achieved in August. This has been maintained and performance has exceeded this standard for the remainder of the year.

A significant number of patient records have been validated, waiting lists in each speciality have been reviewed and the Referral to Treatment process has been reviewed and improved. A weekly Access Board has been established to review progress made by each specialty and address any areas of concern.



At specialty level, Oral Surgery, Trauma & Orthopaedics and Urology are still working to meet the national standard, which they are aiming to deliver in Q1 of 2017/18.

Cancer performance was also challenging at the start of 2016/17 and it was not until June that the national standard was achieved. Delivery of the cancer standards has been sustained for the last eight months.



The National Standard for Diagnostics has been consistently delivered throughout the year.

The Trust is planning to ensure consistent delivery of all planned care National Access Standards in 2017/18.

The Outpatients function has been identified as an area where there may be opportunity for efficiencies. PAH is working with all partners across the health system to undertake a review of the outpatient component of a number of clinical pathways to identify clinical services where the models could be revised to deliver patient benefits and improve the utilisation of resources. A combination of national best practice and redesign projects will be utilised to support local outpatient modernisation.

The National Emergency Access Target (NEAT) requires the A&E to treat, admit or discharge 95% of attending patients within four hours. The Trust's performance has fallen below this standard, as well as the agreed trajectory for 2016/17 delivering 72.2% against the standard. The Trust has worked hard to mitigate the increased demand on the Emergency Department, particularly over the winter. In the past year 102,833 A&E attendances were recorded with 28,782 patients being admitted. The Trust's position is a reflection of the national picture which has seen emergency admissions increase by 47% in the last 15 years.

Extensive programmes of work are in place to deliver a trajectory of continuing improvement on the A&E standard. The Trust has been working in close partnership with the Clinical Commissioning Groups (CCGs), and NHS Improvement to review and enhance overall A&E performance. The Trust, with its partner organisations, participated in an external review of the Emergency Department led by the Manchester Health Academic Science Network. The national Emergency Care Partnership Improvement Team has also supported the Trust throughout the year.

The Trust ran a pilot of the Rapid Assessment and Treatment model (RAT) to support 'early senior review' of patients arriving by ambulance. The model proved to be highly effective resulting in a significant improvement in ambulance turnaround and handover times.

Additional administrative support has been allocated to ward staff to improve the admission and discharge processes. A process is underway to co-locate all social work and community teams with the hospital discharge team in an effort to improve discharge systems and processes. The Trust is also working with health and social care teams to develop a model of care that will see patients requiring a further period of assessment being assessed at home rather than in hospital. The Trust held a 'breaking the cycle' event in March 2016 with system partners to implement the SAFER model, the Red to Green day measure and also held a Multi-Agency Discharge Event (MADE). With the support of local stakeholders the Trust has gained valuable insight into areas that can be improved.

The Trust runs a rolling recruitment programme for nurses and is actively recruiting for all grades of staff to join the current team within Emergency Department and our Emergency Assessment Unit (EAU).

Despite this level of increased pressure, we have continued to strive to deliver the best possible experience to patients who attend our hospital as an emergency. The clinical teams remain vigilant in taking every action possible to improve the service we provide to our patients.

With the benefit of strong clinical leadership and thanks to our dedicated teams we are confident that the Trust can transform the delivery of urgent care and ensure sustainable, quality and safe care for all our patients.

Responding in an Emergency

Throughout 2016/17 the Resilience Team have continued to work to ensure that we are in a position to respond to, and recover from a range of emergencies, through working internally to update our plans, train our staff and to review the effectiveness of the arrangements we have in place through reviews of our response to real and simulated emergencies.

As an organisation we recognise the importance of multi-agency working, and actively engage in the work of the Local Health Resilience Partnership and the Essex Resilience Forum. As an organisation we also provide resilience advice and support to the West Essex Local Delivery Board, to ensure that our local health and care system has a robust system for the management of system pressures, which will in turn ensure a more cohesive response to emergencies.

The coming year sees a new approach to the ways that resilience training is delivered within the Trust with an exciting prospectus of training opportunities made available to our staff, along with a suite of exercises planned to ensure that the training we are providing is providing our staff with the skills to confidently respond to and recover from the challenges that may be faced by an Acute Hospital.

Clinical Performance

Infection Prevention and Control

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

Continued and sustained commitment from all staff has led to excellent control of both HCAs and antimicrobial resistance in 2016/17. Additionally this is reflected in our national position of low rates of infection in four key alert organisms, two of which have set trajectories with financial penalties attached if not met; Meticillin Resistant Staphylococcus aureus bacteraemia (MRSA) and Clostridium difficile (C difficile)

IP&C measures are embedded in day to day clinical practice and play an essential part in providing a safe environment for our patients. Antimicrobial stewardship and the control of antimicrobial resistance comply with national standards set out by the Department of Health.

There are four key alert organisms that the Trust is required to report its performance on: MRSA, Meticillin Sensitive Staphylococcus Aureus (MSSA), Escherichia Coli (E.coli) and C. difficile cases. Until 31st March 2017, trajectories were set for MRSA and C.difficile, whilst MSSA and E. coli were reported on, but no target or financial penalty attached.

MRSA Bacteraemia

There is a trajectory of zero tolerance of MRSA blood infections (bacteraemia) across the NHS. At the end of March 2017, the Trust had reported one case; our first case in two years. However, this case was assigned as third party as it could not be identified with certainty where the patient acquired the infection. A full investigation of the case was undertaken and 'lessons learnt' (though not contributing to the patient acquiring MRSA) were shared across the organisation to improve practice.

C.difficile

Once again, the Trust has met the C.difficile trajectory for the year and remains in the top performing third of all Trusts nationally. We ended the year on a total of 18 cases, only seven of these were considered to be Trust-attributable, with the remaining 11 cases successfully appealed against.

We have achieved this through hard work and effort from all staff at the Trust who have remained vigilant and committed to infection control procedures throughout the year. We have a robust Root Cause Analysis (RCA) process in place which is significant in contributing to shared learning amongst staff. Our success reflects our compliance with infection control and antimicrobial prescribing policies. This is despite the challenges of PAH being an old hospital and coming through a difficult winter. It should also be noted that PAH had a lower trajectory than our neighbouring Trusts; this reflects our excellent rates in previous years, but means we face a tighter target than other hospitals that have had higher cases.

Meticillin Sensitive Staphylococcus aureus (MSSA)

The Trust is one of the top performing NHS organisations in the country in terms of low MSSA blood infections (bacteraemia). This year there have been seven Trust apportioned cases.

Escherichia Coli (E.coli)

Numbers of Trust-apportioned Escherichia Coli (E.coli) cases are low and the Trust remains in a favourable position when compared with hospitals nationally. During 2016/17 we had 22 Trust-apportioned cases.

Learning from Incidents

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.

For 2016/17, a total of 9287 incidents were reported on the Trust's Datix incident management system, as having occurred in PAH. This is a slight decrease in incident reporting compared with 9360 over the same period last year.

The majority of incidents reported were no harm incidents (7044) representing 75.8% of the total incidents for this period. Approximately 96.4% of reported incidents during this period were a combination of no harm (7044) or minor harm (1913).

All these incidents are reported to the National Reporting and Learning System (NRLS) now part of NHS England to enable learning and comparison with similar sized organisations to occur.

Themes of Serious Incidents

There have been 28 serious incidents (SIs) at the Trust in 2016/17. This excludes SIs that have been de-escalated by the CCG as there were no care or service delivery problems or they were found not to meet the SI threshold with the emergence of further information. This is a reduction in numbers compared with 61 SIs in the same period last year.

Although there is an increasing focus on safety across the organisation, it is important to note that national reporting requirements and SI categories changed in March 2015 and the changes were implemented locally in May 2015. The changes eliminated the use of a pre-determined list of incidents that must be reported. The SI framework encourages the discussion and review of incidents on a case by case basis and a discussion of the level or degree of harm caused.

The Trust ensures open and honest review and discussion of SIs takes place through the Serious Incident Group (SIG). The group is chaired by either the Chief Medical Officer or Chief Nurse and meets every day from Monday to Friday to ensure that there is no delay. All potential SIs are presented and discussed to identify whether they meet the national SI framework requirements.

The most frequently reported SIs during this reporting period are in the category 'Treatment delay meeting SI criteria'.

Never Events

There were no Never Events in 2016/17.

Sharing the Learning (STL) Events

The Trust's central Patient Safety and Quality Team worked with relevant experts to organise and facilitate five STL events during 2016/2017:

1. **April 2016:** A Focus on the Trust's three **Sign up to Safety** (SUS) priorities – Improvements in Acute Kidney Injury, Sepsis and End of Life (EOL). These are known as the Three Big Dot items endorsed by the Trust Board.
2. **June 2016:** **Sign up to Safety** celebrated its second birthday. We celebrated with information stands, balloons, badges, goody bags, games and a competition held outside the restaurant. The central team were on hand to remind staff about the national campaign, its vision, and the Trust's priorities for improvement (Acute Kidney Injury, End of Life and Sepsis). Staff were also encouraged to sign up to support the campaign, the Trusts priorities for improvement and to make their own personal safety pledge(s).
3. **July 2016: Focus on Learning from Claims & Litigation.** The Trust was very fortunate to welcome a Solicitor firm and the NHS Litigation Authority (NHS LA) to participate in the week-long event. There was a formal launch on Monday 4 July 2016 in the Trust Board Room with an excellent presentation on the Inquest process. A session on Public and Employee Liability was held on the morning of Wednesday 6 July 2016 and followed by the Trust view on Reporting on Injuries, Diseases & Dangerous Occurrences Regulation (RIDDOR) incidents. The afternoon session focused on a mock inquest with actors. The last day of the Sharing the Learning week was divided into two sessions with morning session dedicated to the Trust Board. The Trust was very fortunate to welcome the Director of Safety and Learning from the NHS LA, who provided a presentation on how the Trust can learn from its claims and improve safety for our patients.
4. **October 2016: Focus on National Standards Safety for Interventional Procedures (NatSSIPs).** The central PSQ team invited Dr Annie Hunningher, Consultant Anaesthetist and NatSSIPs lead for the Royal Free Hospital NHS Trust, who have successfully launched and are implementing the NatSSIPs programme, to deliver a talk on how this was achieved including the challenges.
5. **November 2016: Focus on Duty of Candour,** the last STL for the year was held at a Multidisciplinary Team meeting (MDT). The central team, working closely with our Panel solicitors, designed the day around a case that had been to the Coroner's court and the Trust was highly commended for its openness and candour. Trust staff were reminded of the principles and requirements for Duty of Candour, the Duty of Candour checklist was shared and the legal requirements of Being Open were discussed.

Duty of Candour has remained a consistent feature in the Trust's activities. Posters can be seen in different areas across the Trust, reinforcing the Trust's commitment to transparency and candour.

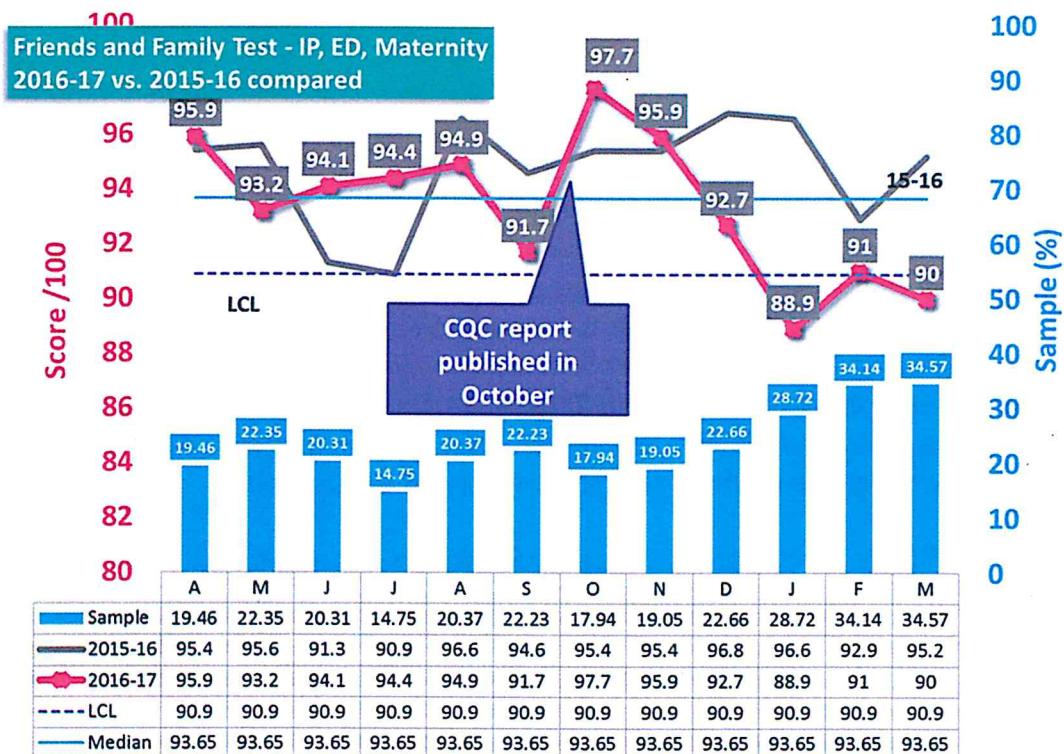
Being Open and Root Cause Analysis (RCA) Investigation Skills Training

The Trust continues to invest in Root Cause Analysis (RCA) investigation training and ensure that staff are supported in Being Open/ Duty of Candour conversations with patients and families when things go wrong. In 2016/17 the Trust held four training sessions on Being Open/ Duty of Candour and two sessions on RCA training.

Friends and Family Test

The national average for the Friends and Family Test is 93%. The Trust is just above the national average with a score of 93.3% for the year.

The evidence in the graph below shows that the publication of the CQC report had a significant impact on ratings which is also consistent with evidence from complaints and PALS services. Overall a record number of PALS cases were recorded this year - 7122 against 5030 last year and a significantly lower number of complaints were received; 251 compared with 292 in the previous year.



Mortality

The statistical markers for mortality have been as expected or better than expected for the reported period of 2016/17. The same is true for patients admitted at the weekends, unlike most acute trusts.

HSMR

The HSMR for December 2015 to November 2016 was 102.5 and statistically “as expected”. This has been “as expected as or lower than expected” for 25 months.

SMR

All diagnosis SMR for December 2015 to November 2016 was 106.1 and statistically “as expected”. This was “as expected as or lower than expected” for 25 months.

SHMI

The SHMI for July 15 to June 16 was 100.96 and “as expected”.

Priorities for Quality Improvement 2017/18

Each year we assess our performance against previous quality priorities and patient outcomes; taking account of national reports, feedback from regulators and emerging themes from incidents as well as patient and staff feedback. This year the outcomes from the Care Quality Commission (CQC) inspection report (October 2016) afforded us an opportunity to create and launch our Quality Improvement Strategy which is underpinned by the Quality 1st Programme; the Trust's plan for improvement. Essential to the achievement of Quality 1st is the removal of "Special Measures". The Trust will focus on addressing the themes from the CQC inspection report throughout 2016/17.

The following work streams in the table below have been developed with staff and patients and have been approved by the Board. The Quality First Improvement plan forms the basis of all Trust-wide improvements throughout the year ahead.

Priorities for quality improvement 2017/2018				
Ref:	Quality Improvement Area	What we are trying to improve	What success will look like	How we will monitor progress
1. Safety Culture				
SC 1.1	Getting the basics right	Compliance with essential safety standards such as emergency equipment checks	Equipment will be fit and ready for patient use. Essential resources will be available for use	Daily and weekly checks will be audited and reported on ward/department dashboards
SC 1.2	Improving the identification and treatment of patients with Acute Kidney Injury (AKI)	To build on the progress made in 2016/17 so that early recognition and treatment of AKI is fully embedded across the whole Trust	Patients leave hospital with knowledge of their diagnosis of AKI which facilitates monitoring under primary care	Audit of patient records to ensure that discharge summary contains the blood profile to alert primary care of AKI. This will be reported quarterly
SC 1.3	Timely identification and treatment of sepsis in ED and acute inpatient settings Antibiotic prescribing and	Early recognition and treatment with improved antibiotic prescribing and review; leading to reduced consumption	Patients with sepsis receive appropriate treatment within 60 minutes of diagnosis of sepsis. Reduced	Audit patient records to assess if treatment concurs with the national sepsis guidance This will be reported

	review.	per 1000 admissions	antibiotic consumption per 1000 admissions.	quarterly.
SC 1.4	Continue to enhance the care people receive at end of life while in hospital.	Provision of an appropriate care plan agreed with the patient and their appropriate next of kin when approaching the end of their life. Early transfer to the patients preferred place of care.	Patients will discuss and agree their preferred place of care to optimise end of life care. Delays associated with hospital discharge at the end of life will be eliminated. All patients at the end of life will have an individual care plan to meet their needs	All delayed transfers of care will be analysed to address barriers across the whole health economy. Regular audits to assess the quality and availability of end of life care plans
SC 1.5	To embed a Learning culture	Our ability to learn from a variety of feedback mechanisms. Encourage and support raising of concerns, celebrate success, identify root causes and demonstrate improvement and solutions. Implement process to support learning from every death	Robust governance systems that are standardised and consistently used	Monitoring compliance and use of systems. Audits Risk assessments and mitigation. In your shoes events. Records of issues and root cause analysis and development of solutions and mitigation.
SC1.6	Embed and sustain Safeguarding processes for	Training for staff which supports evidence of	Access to E learning Sharing of good practice Compliance with	Statutory Training compliance and evidence of

	children and adults	good practice in terms of compliance with agreed processes	Education and training requirements	good practice (observed and audited)
2. Patient Focus				
PF 2.1	Transforming our care (In and through and out)	Establishing a high performing Frailty Unit, ambulatory care, assessment and short stay. Implement SAFER Patient Flow Bundle, Red2Green & internal professional standards (IPS)	Improved four hour standard Reduced crowding in ED Improve patient safety, quality and experience Reduced in-patient length of stay (LOS) Reduced bed occupancy Reduced patient delays and improved patient flow Earlier discharges and more discharges per month Increased short stay admissions ED attendances reduced Improved ambulance handover performance Better patient placement	National and local reporting captured via the informatics team
PF 2.2	Co-design/personalised care	Develop and implement the discharge to assess model	Reduce standard patients (>7days LOS) Reduce DTOC patients Reduce in-patient length of stay Increase discharges with a focus on early discharges	National and local reporting captured via the informatics team
3. Our People				
OP 3.1	Recruitment and retention	Develop and improve our ability to recruit and retain staff	Improve the recruitment process identifying, reducing or	Monitor key workforce indicators in the quality improvement

			eliminating waste (non-value adding elements) Develop and implement staff retention plan	dashboard
OP 3.2	Staff engagement	Having a workforce who are fully absorbed by and enthusiastic about their work and take positive action to further the hospital's reputation and interests.	Develop and implement staff engagement plan(s)	Staff survey Staff FFT GMC Trainee Survey
OP 3.3	Communication	Have good quality, effective and clear communication in the hospital	Agree monthly communications plan	Staff survey Staff FFT GMC Trainee Survey
OP 3.4	Fit and proper	Ensure compliance with all aspects of the fit and proper persons policy	Complete associated work	Compliance records
OP 3.5	CQC preparation	Ensure PAH is regulation ready where the focus is beyond getting out of special measures with a clear understanding (plan) for what is takes to achieve 'good' or 'outstanding'.	Implement and deliver supporting plan, which addresses underlying causes and root causes	Progress recorded and tracked against QIP

4. Governance and Risk management

G&RM 4.1	Medical engagement and MDT working	Strengthening capability and competence.	Ensure underlying root causes are understood.	Evidence recorded
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		Strengthening team working	Hold workshops Make expectations clear and share best practice.	
G&RM 4.2	Risk management	Robust risk identification and management	We are able to identify, forecast and evaluate risks together with the identification of mitigation to avoid or minimise their impact.	Reporting from risk management system and QIP dashboard Spot check audits
5. Infrastructure				
Inf 5.1	Strategic Estates issues	Agree strategic intention and develop plans to ensure sustainability and service viability	Development of SOC	SOC produced
Inf 5.2	Operational estate issues	Estates and Facilities review of risks Plans to address risks fully costed	Plan for implementation approved for the Board of Directors	Risks identified are addressed and solutions implemented evidenced
Inf 5.3	IT Infrastructure	Full review of our IT needs, capability and capacity	Review and recommendations to the board of directors. Plan developed and approved for implementation.	Delivery of supporting plan

Maternity Services 2016/17

Following the CQC inspection in July of last year, Maternity and Gynaecology services were awarded an 'Outstanding' rating. The CQC observed that staff were dedicated, compassionate, caring and consistently went beyond the call of duty, to deliver the best experience possible for their patients. This is an absolute testimony to the exceptional staff across the whole multidisciplinary team and has encouraged staff to work for the service. Recruitment and retention of staff has been very effective and the midwife to birth ratio of 1:30 has improved to the best it has been for two years

During 2016/17 the Trust supported the birth of 4300 babies either in hospital or at home. Our stillbirth rate remains low at 2.37 per 1,000 births, compared to the national rate of 4.2 per 1,000 births.

In November 2016 the national maternity survey was published which highlighted the service as being one of the best performing out of 64 other Trusts surveyed.

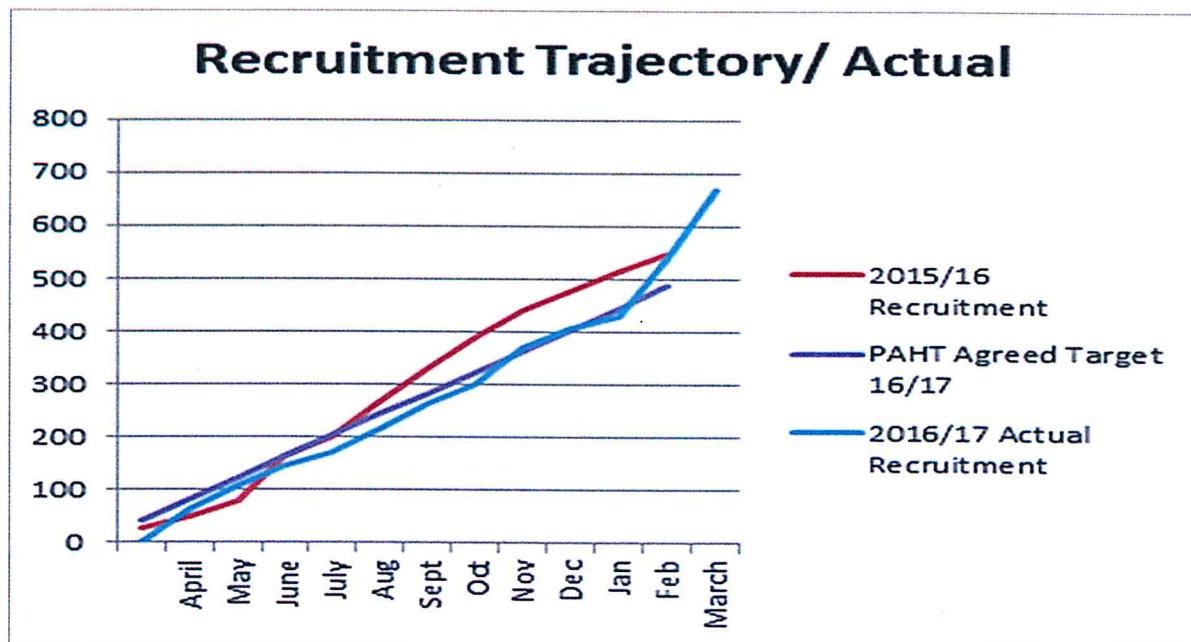
The maternity unit has also been successful in two bids over the past year; one to be part of a pilot study to improve safety within the labour ward and the second was from Health

Education England to implement packages of multi-disciplinary training, focussing on the key patient safety improvement areas.

Research, Development & Innovation

The Trust continues to support Research & Development and the main research activity is recruiting patients into high quality National Institute for Health Research (NIHR) portfolio adopted Multi-Centre studies for which the Trust receives funding from the North Thames Clinical Research Network (NT CRN) hosted at Barts Health.

During 2016/2017 14 commercial studies and 45 academic studies were approved and recruited to. 106 studies were active during the year. The target for recruitment into studies for 2016/17, was 487 patients, with the actual number of patients recruited being 671, exceeding the target by 184 patients.



Recruitment by Health Group/Speciality

Health Group	Specialty	Recruitment into Trials
Medical	Rheumatology	53
	Dermatology	16
	Respiratory	165
	Gastroenterology	9
	Diabetes	20
	Emergency	27
Cancer, Cardiology & Clinical	Cancer (including	109

Support Services	Haematology)	
	Cardiology	3
Surgery & Critical Care	Ophthalmology	11
	Urology	7
Women & Child Health	Obstetrics	1
	Sexual Health	25
Surgery	Theatres	143
	Ophthalmology	26
	Urology	20
Corporate	Health Service Delivery	57

Approved Studies

Active Studies 2016/17	
Commercial	Academic
14	45

Research Capability Funding

The Trust met the qualifying criteria to receive funding of £20,000 for achieving the High Level Objectives of Recruitment of first patient into study from receipt of protocol at 70 days and recruiting in excess of 500 patients between October 2015 and October 2016.

Good News Stories

- Women's Health became active in Research with two studies opening – one involving patients presenting with ectopic pregnancies and one to prevent pre-term birth.
- Positive Voices is a national survey of people living with HIV and is a formal research study led by Dr. Gail Crowe as the Principal Investigator. The March 2017 newsletter highlighted the Trust as the highest recruiting site having recruited 25 patients; more than twice the minimum target.
- Two commercial studies are now open in Cardiology where previously studies have been academic.

Patient & Public Involvement

A successful International Clinical Trials Day was held on 21st May 2016 showcasing:

- The new Health Research Authority Governance Approval Process

- Recruitment Data and successes of trials at the Trust
- Research Nurse Stand showcasing the equipment used in various studies across all specialties from around the Trust.

Sustainability:

A number of water saving schemes are in place across the Trust and we are working with Water Aid UK supporting families in Africa to gain access to fresh water. Over the course of the project the Trust has helped repair 391 boreholes and drill 13 new boreholes.

The Executive Management Board supported investment in a Combined Heat and Power (CHP) system which will enable the site to self-generate the majority of the on-site daytime electrical demand and full load at night time, while also improving overall energy efficiencies. The existing heating system will benefit by using the thermal by-product resulting from CHP's electrical generation.

In relation to waste management, two food-to-waste bio-digesters have been introduced to reduce the amount of waste going to landfill. The waste management contract is due for re-tender in 2017/18 and the team is actively looking at potential opportunities for collaboration within the STP footprint. A new system for managing sharps has also been introduced providing a quality product that reduces risk to staff and patients.

New energy saving LED lighting has been installed in key areas of the Trust which has a twofold effect; the first being improved environments for our patients and the second being a reduction in energy costs associated with lighting.

The Trust has not submitted a Sustainability Report to the Sustainable Development Unit by the deadline of 31 May 2017, an extension has been agreed and action is being taken to ensure its completion and urgent submission.



Trevor Smith
Acting Chief Executive

The Accountability Report 2016/17

Corporate Governance Report

Our Board

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

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

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

Members of the Trust Board

Name	Position	Voting	From	To
Executive Directors				
Phil Morley	Chief Executive Officer	Y	07/07/14	14/04/17
Trevor Smith	Chief Financial Officer	Y	15/07/13	21/02/17
	Acting Chief Executive Officer	Y	22/02/17	31/5/17
Dr Andy Morris	Chief Medical Officer	Y	01/03/15	Current
Stephanie Lawton	Chief Operating Officer	Y	02/03/16	Current
Nancy Fontaine	Chief Nurse	Y	01/11/12	Current
Marc Davis	Director of Pathways and Partnerships	N	01/10/12	Current
Liz Booth	Director of HR	N	15/09/15	Current
James Mc Leish	Director of Business Delivery	N	01/04/16	Current
Simon Covill	Acting Chief Financial Officer	Y	22/02/17	31/5/17
Non-Executive Directors				
Douglas Smallwood	Chairman	Y	01/04/13	03/10/16
Alan Burns	Chairman	Y	01/12/16	30/11/18
Neil Goulden	NED (Chair of Audit Committee)	Y	01/07/14	18/05/16
Andrew Holden	NED (Chair of PAF)	Y	01/01/15	31/03/19
Christopher (Mike) Roberts	NED (Chair of QSC)	Y	01/02/15	31/01/17
Pam Court	NED (Chair of CFC)	Y	28/09/15	27/09/17
James Anderson	NED (Interim Chair of QSC)	Y	28/09/15	27/09/17
Stephen Bright	NED (Chair of Audit Committee)	Y	03/10/16	02/10/18

Attendance at Board Meetings

Number of Board members present at Board meetings in 2016/17:

28.04.16	26.05.16	30.06.16	28.07.16	08.16	29.09.16	27.10.16	24.11.16	19.12.16	26.01.17	23.02.17	30.03.17
Public & Private	Public & Private	Public & Private	Public & Private	No meeting held	Public & Private	Public & Private	Public & Private	Extra-ordinary Trust Board	Public & Private	Public & Private	Public & Private
12/13	12/13	13/13	12/13	n/a	11/13	11/13	11/13	11/14	14/14	10/13	12/13
12/13	12/13	13/13	12/13	n/a	9/13	11/13	11/13		13/14	10/13	12/13

Note:

October 2016 – Douglas Smallwood (Chairman) left/Stephen Bright (Non-Executive Director) joined
December 2016 – Alan Burns was appointed as new Chairman

Committees

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

Audit Committee

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

Charitable Funds Committee

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

Performance and Finance Committee

The purpose of the Performance and Finance Committee is:

- Considering, challenging and recommending the Trust's Annual Business plan to the Board and undertaking bi-annual reviews of performance against the Annual Plan.
- Scrutinising operational and financial performance and monitoring achievement of national and local targets and recommending any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assuring the Board of Directors that the Trust has rigorous processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable – recommending any re-basing or re-forecasting of financial assumptions or plans to the Board;

- Monitoring progress on the Cost Improvement Programme and investigating reasons for variance from plan;
- Monitoring the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Reviewing and monitoring the management of finance, performance and contracting risks.

Quality and Safety Committee

The Quality & Safety Committee (QSC) functions as the Trust's umbrella clinical governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service.

Remuneration and Nominations Committee

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

Statement of Board Members' Interests

NAME	TITLE	INTERESTS/MEMBERSHIPS DECLARED
Alan Burns	Chairman	<ul style="list-style-type: none"> • Chair of Hinchingbrooke NHS Trust until 31 December 2016. • Independent Chair of Suffolk and North East Essex STP Board
James (Douglas) Smallwood (left Trust on 3.10.16)	Chairman	<ul style="list-style-type: none"> • Chairman, Headway Hertfordshire (Registered Charity) • Member of Diabetes UK • Member of Crohns and Colitis UK
Christopher Michael (Mike) Roberts	Non-Executive Director	<ul style="list-style-type: none"> • Consultant Physician at Barts Health • Queen Mary University of London • Programme Director Education and Capability and Population Health UCL Partners • Director of Education and Capability for UCL partners • Associate Director Clinical Effectiveness Unit, Royal College of Physicians • Consultant for NICE International

James Anderson	Non-Executive Director	<ul style="list-style-type: none"> • Principal at IMS Health
Pam Court	Non-Executive Director	<ul style="list-style-type: none"> • Chief Executive Officer of Saint Francis Hospice
Stephen Bright	Non-Executive Director	<ul style="list-style-type: none"> • Chairman Vistem Sarl • Director SDF Consulting Limited
Neil Goulden (left Trust on 18.05.16)	Non-Executive Director	<ul style="list-style-type: none"> • Chairman, Affinity Sutton Housing Association • Senior Independent Director & Chair of Remuneration Committee, Marstons plc • Chairman, The Responsible Gambling Trust (Registered Charity) • Proprietor, Neil Goulden Consulting Limited • Chairman of Governors, Nottingham Trent University • Trustee, Ambitious about Autism (Registered Charity) • Trustee at Sue Ryder (Registered Healthcare Charity) • Member of the EY Item Club (Economic Forecasts) • Government Appointed Independent Member of the Horserace Betting Levy Board (Statutory Body)
Andrew Holden	Non-Executive Director	<ul style="list-style-type: none"> • Board Director, Liaison Financial Services
Liz Booth	Chief of Workforce	<ul style="list-style-type: none"> • Director of Lorelle Consulting Limited (Dormant Company)
Marc Davis	Director of Pathways & Partnerships	<ul style="list-style-type: none"> • Seres GIFTS Limited (Spouse's Company) • Governor - Sir Charles Kao UTC • Own GP Surgery • Own Dental Surgery • Own Optician Surgery
Nancy Fontaine	Chief Nurse	<ul style="list-style-type: none"> • Professor of Nursing at Anglia Ruskin University and University of Essex • Chair of Adult Safeguarding

		Performance and Audit Committee for Essex
Stephanie Lawton	Chief Operating Officer	<ul style="list-style-type: none"> • No Interests Declared
James McLeish	Director of Business Delivery	<ul style="list-style-type: none"> • Spouse is a Paramedic for East of England Ambulance Service
Phil Morley	Chief Executive	<ul style="list-style-type: none"> • Director, Anglia Ruskin Health Partnership • Trustee, Aspire Academy
Andy Morris	Chief Medical Officer	<ul style="list-style-type: none"> • Consultant Anaesthetist
Trevor Smith	Chief Financial Officer	<ul style="list-style-type: none"> • Spouse is a Director of Salonica Consulting Limited • Auditor, Windmill Ladies Probus Society
Simon Covill	Acting Chief Financial Officer	<ul style="list-style-type: none"> • 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.

The Statement of Accounting Officer's responsibilities

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

I confirm that, 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 Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed



Trevor Smith
Acting Chief Executive

Date: **30/5/2017**

Annual Governance Statement

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Princess Alexandra Hospital NHS Trust's (the Trust's) policies, aims and objectives and statutory duties. Also, in accordance with the responsibilities assigned to me, I have personal responsibility for safeguarding public funds and the assets of the Trust. I am also responsible for ensuring that the Trust is administered by the most economic and prudent means and assuring the Board that resources are applied efficiently and effectively. I also acknowledge and accept my responsibilities as set out in the Accountable Officer Memorandum.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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.

I confirm that the system of internal control has been in place in the Trust for the year ending on 31.03.17 and up to approval of the annual report and accounts.

The Trust was inspected by the Care Quality Commission (CQC) in June 2016 and was rated as 'inadequate' and placed in Special Measures. A Quality Improvement Plan is in place with actions and Key Performance Indicators (KPIs) identified to address the concerns raised by the CQC.

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.

Trust Board – Membership and Committees

The Trust Board consists of:

- i. a Chairman
- ii. five other Non-Executive Directors
- iii. five Executive Directors (including the Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Operating Officer and Chief Nurse all of whom have voting rights and three further Executive Directors who do not have voting rights; namely the Director of HR, the Director of Pathways and Partnerships and the Director of Business Delivery.

During 2016/17 the Chairman and two Non-Executive Directors left the Trust. A new Non-Executive Director was appointed in October 2016 as Chair of the Audit Committee. A new Chairman was appointed on 1 December 2016 and the recruitment of an additional Non-Executive Director is in

progress. During 2016/17 the Trust's Director of Estates and Facilities left the Trust and oversight of this key function was assigned to the Director of Business Delivery pending substantive recruitment to the vacant post.

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

Attendance at Board and Committee meetings throughout 2016/17 has been monitored and is recorded in the Annual Report.

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

- i. Audit Committee
- ii. Quality & Safety Committee
- iii. Performance and Finance Committee
- iv. Remuneration & Nominations Committee
- v. Charitable Funds Committee.

During the year the Board decided to establish a Workforce Committee from May 2017. The establishment of this Committee will provide a specific forum and time for discussion of people matters.

An annual effectiveness review of each committee is undertaken to ensure they continue to meet their terms of reference and Monitor's Code of Governance and support the Board in delivering its objectives. The outcomes of the reviews are reported to the Trust Board. A quarterly review of Board meetings takes place.

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.

Board Development: During 2016/17 the Board held development sessions on audit, risk management, the Well-Led Framework and strategy.

Organisational Development: Embarking on the first of a three year plan, 2016/17 has seen investment and priority given to the 5 aspects of organisational development led by the Executive Team to deliver:

- Quality Improvement – development of core pathways, standards and clinical strategy
- Business Delivery – continued modernisation of systems, information and contracting
- Staff Engagement – supporting specific teams to work differently in the challenges and opportunities faced, while exploring how we involve staff differently from bespoke 'Back to Balance' sessions to a new approach and style of appraisal
- Service and System Improvement – a programme of Transforming Our Care progressing 5 workstreams with operational outcomes and developments for patients and staff
- Leadership Development – a range of leadership and management programmes and activities from practical bite-size skills development to Action Learning and 360° feedback against leadership attributes

Core programmes and development activities have been incorporated into Quality First and the Quality Improvement Programme for 2017 maximising feedback from the Trust's CQC findings and to ensure appropriate governance, leadership and impact of organisational development moving forward.

Quality Governance Arrangements

Each Health Care Group has a Patient Safety and Quality group where themes and trends from reviews of incidents and complaints and learning are reported.

At the Trust's Quality & Safety Committee, each Health Care Group is required to present an overview of its performance in line with the CQC key lines of enquiry.

Throughout 2016/17, the Quality & Safety Committee continued to receive regular reports on themes identified from serious incidents and complaints as well as "deep dives" on specific SIs and complaints by Health Groups to consider the follow-up actions and resulting learning. It was decided to introduce a monthly Quality and Safety Performance Report from each of the Health Care Groups on a rolling programme. The report covers each of the 5 CQC domains. A "Sharing the Learning Report" was presented four monthly and an annual summary provided an overview of themes, trends and learning arising from incidents, serious incidents and never events as well as on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers. This report is circulated more widely – including the Trust's commissioners.

The Quality and Safety Committee and Board received monthly reports on Nurse and Midwifery Staffing levels in line with guidance received from NHS England and the Care Quality Commission on the delivery of the 'Hard Truths' commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels. Staffing has been an ongoing challenge throughout 2016/17 and has been escalated to the Board as an area of risk. The quality metrics for those wards reporting shifts in Codes 3, 4 or 5 are also reported and monitored on an ongoing basis. Care Hours per Patient Day were included in the report in 2016/17.

The Trust supports staff by providing *Being Open/ Duty of Candour* training sessions as well as training in Root Cause Analysis (RCA) investigative techniques. Sessions were offered throughout the year.

There have been no 'never events' in 2016/17.

In line with an agreed timetable, Board members and management participate in regular "Board to Ward" walkabouts. These provide the opportunity to talk to frontline staff and patients to understand their concerns. Feedback from these discussions is captured and acted upon. The walkabouts are conducted on Board days and provide the opportunity for real-time feedback into Board meetings.

Quality Account

The Directors of the Trust are required to prepare a Quality Report for each financial year. This is developed by clinicians and senior managers within the Trust, in conjunction with stakeholders and partners. The Chief Nurse has overall responsibility to lead the production of the Trust's Quality Report and advises on all matters relating to the preparation of the Trust's annual quality account. Each year the Trust assesses performance against previous quality priorities and patient outcomes; taking account of national reports, feedback from regulators and emerging themes from incidents as well as patient and staff feedback. This year the outcomes from the Care Quality Commission (CQC) inspection report (October 2016) prompted the launch of the Quality Improvement Strategy which is underpinned by Quality 1st, the Trust's plan for improvement. Essential to the achievement of Quality 1st is the removal of "Special Measures". To achieve this in 2017/18 the Trust will focus on the themes from the inspection report:

- Safety Culture
- Patient Focus
- Our People
- Governance and Risk Management
- Infrastructure

Risk Assessment

Board Assurance Framework

The Trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor strategic risks, controls and the effectiveness of the assurance processes.

Each risk on the BAF has an executive lead and a designated Committee; this ensures that each risk is regularly reviewed and subjected to scrutiny and challenge by a Committee. The full BAF is also regularly reviewed at the Trust Board and by the Risk Management Group established in December 2016.

There are currently 14 risks reflected on the BAF:

- Inconsistent outcomes in clinical quality, safety and patient experience.
- Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.
- Failure to achieve Trust Access targets & National Delivery standards – ED and Delayed Transfers of Care.
- Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as the Trust moves towards having Integrated Care Records.
- Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery.
- Concerns around failure to meet financial plan including cash.
- Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.
- Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.
- Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.
- Failure of the STP to deliver a strategy for the PAH estate and infrastructure including a new hospital **(new risk added in January 2017 and discussed at Board in March 2017 with recommendations made for changes)**.
- Failure to communicate key messages and organisational changes to front line staff.
- Concerns about falling productivity and increasing numbers of staff
- Concerns around the ability of the health system to deliver a sustainable health and care system.
- Capacity & capability of Trust leaders to influence both internally and externally the required strategic changes.

Information Governance/Data Security Risks

The Trust reported two Level 2 Information Governance (IG) data security breaches to the Information Commissioner's Office (ICO) during 2016/17.

The first related to sensitive information having been sent to the correct recipient, but via an insecure email transfer route. The ICO's response to this declaration was as follows:

"We have considered the information you have provided and we have decided that no further action is necessary on this occasion. This is because the data was sent to an organisation entitled to receive it and because the failure to secure it was the responsibility of an appropriately trained employee. There is no evidence whatsoever of any detriment having been caused to the individuals concerned. Consequently, the case, as reported to us, does not appear to meet the criteria set out in our Data Protection Regulatory Action Policy necessitating further action by the ICO"

The second breach related to a clinical handover sheet having been found off site by a member of Trust staff (Doctor). The ICO's response to this declaration was as follows:

"We have considered the information you have provided about a breach of the DPA and have decided that no further action is necessary at this stage. In particular we have noted the following in our deliberations:

- *The handover sheet had been found by a medical staff member and therefore disclosure was contained by a medical professional;*
- *The handling of handover sheets is covered in Trust induction and all IG awareness sessions. The amount of information contained has also previously been considered and instructions provided to limit the amount of information with the use of initials where possible;*
- *It is unfortunate that the staff member cannot be identified as being responsible at this stage but one remedial step going forward is the automated printing of the document owner on the handover sheet.*

To complement the actions already taken and following a full investigation, it is appropriate that waste disposal bags with bins are consistently located across Trust premises and are appropriately secured. The use of awareness raising should be utilised further with the use of posters and signs in key areas, if not already. It would also be advisable that walk arounds are conducted specifically to monitor data security and confidential waste management".

Taking the above into account, the case, as reported to us and following the responses provided, does not appear to meet the criteria set out in our Data Protection Regulatory Action Policy necessitating further action by the ICO"

In addition to the above IG data security breaches, one cyber security Level 2 breach was reported via the IG Toolkit Incident Reporting Tool. This related to the Trust website having been defaced, but with no person confidential data having been compromised. This cyber report did not trigger an operational response, as the reporting of such incidents leads to improved strategic knowledge and understanding of potential future cyber risks, and flow of consolidated intelligence to the network of Senior Information Risk Owners (SIROs).

The Risk and Control Framework

Leadership

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.

As Accountable Officer, I recognise that 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.

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

- i. a Risk Management Strategy (for the effective management of clinical and non-clinical risk)
- ii. a Committee structure with clear reporting mechanisms to the Board
- iii. a Risk Management Group
- iv. Monitoring systems for incidents and complaints.

The Trust's Risk Management Strategy which was updated in February 2017 details my overall accountability to the Board for risk management within the Trust. 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. The Chief Medical Officer (CMO), is the delegated executive lead for operational and clinical risk management within the Trust, ensuring effective processes are in place for the management of risk with responsibility for maintaining a framework of assurance for the Board. Operational risk management sits with each member of the Executive Team in providing leadership to each of their portfolios and associated operational roles.

Risk Management Approach

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

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

The Risk Management Group was established in December 2016 and meets on a monthly basis. The Group's objectives are:

- To champion and promote the identification, proactive management of risks and sound risk management practices across the Trust, facilitating and embedding a strong risk management process and culture
- To ensure the identification of the burden of risks across the Trust by providing a critical review of risks on all risk registers.
- To offer constructive challenge, serving as risk moderators in the Trust's risk escalation process and ensuring that significant risks are appropriately escalated.
- To support the delivery of the Trust 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

In 2017 the Trust will make greater use of technology to support the risk management process; this includes the use of the Allocate system to improve functionality and management reporting.

Training

Trust staff receive risk management and related training at induction and updates as required. The training covers topics such as risk assessment, 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.

The Trust also supports a programme of Counter fraud training and awareness provided by the Local Counter Fraud Specialist team.

External review

The Trust's Risk Management and Assurance Framework was the subject of an Internal Audit report during Q4 of 2016/17. The review assessed the Trust's general compliance with the risk management strategy and the extent to which the risk management process is embedded within the organisation's systems. The review also considered the Trust response to CQC action plans on risk management. The overall assurance assessment was one of 'reasonable assurance'.

Elective waiting time data

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

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

Review of the Effectiveness of Risk Management and Internal Control

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 content of monthly and quarterly internally produced information reported to the Board, along with self-assessments, peer reviews and external reviews. My review is also underpinned by the Internal Audit process and informed by comments made by the External Auditors in their management letter and other reports.

Assurances

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

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

- Temporary Staffing – recommendations were made to review the current processes for approval of temporary staff and a policy and 'how to' guide for authorising managers is to be written.
- Capital Expenditure – a review of the teams responsible for delivery of Capital projects was recommended along with a revision of the Terms of Reference for the Capital Planning Group. A timetable for submission of business cases was also suggested.
- E-Rostering Workforce Planning – recommendations related to the current processes and actions were identified to improve compliance with the use of the system.
- Business Continuity – the audit recommended that business impact analyses need to be carried out, Health Care Group Business Plans are to be developed and policies and reporting processes require review
- Outpatients – SOPs are to be updated, processes for fast track referrals require improvement and a centralised action plan for DNA's is to be developed.

Action plans to address Internal Audit's recommendations have been agreed with senior managers. Progress in implementing the recommendations is reported in the Internal Audit progress reports presented to the Audit Committee. The Executive Team as well as the Audit Committee continue to focus on the implementation of recommendations to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed. The Board agreed a revised approach to the Internal Audit programme whereby mandated audit areas were supplemented by three to four in-depth audit reviews each year to maximise the value of the activity. Good progress has been made against this plan.

The Head of Internal Audit Opinion for 2016/17 is that:

'We note that the Trust is currently forecasting a year-end deficit of £29.7m, which is in line with its control total projected at the start of the financial year.'

*Our opinion on the organisation's system of internal control has taken this factor into account.
My opinion is set out as follows:*

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

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;*

The basis for forming my opinion is as follows:

- *An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and*
- *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.

The commentary below provides the context for the opinion and together with the opinion should be read in its entirety.

Board Assurance Framework (Reasonable Assurance – Draft)

The review demonstrated that the Trust's strategic objectives were agreed and approved by the Trust Board with the final sign-off taking place in April 2016. The Risk Management Strategy (RMS) provides in-depth guidance to staff members on managing risks and supports the organisation's risk appetite and Board Assurance Framework. The RMS was recently updated to include changes made to the risk management process which were introduced in December 2016 following the CQC inspection report. The RMS was presented to and approved by the Trust Board on 26th January 2017 and to the Risk Management Group on 27th January 2017.

The Trust currently uses a spread sheet to document risks. In order to make the risk management process more visible and effective, the Trust will commence use of the Risk Assure System (Allocate) from end of February 2017. Data from the spread sheets will be migrated to the system and all the Patient Safety and Quality leads have been required to fully update their risk registers by the end of January 2017. The Board receives assurance on the key risks which could impact on the delivery of the Trust's objectives through the assurance committees of the Board (Performance and Finance Committee (PAF) and Quality and Safety Committee (QSC)). The BAF is overseen by the Head of Corporate Affairs. Audit reviewed the BAF for December 2016 and confirmed that there are 14 risks in the BAF, which are aligned the Trust's strategic objectives. It was noted that the causes and effects of the risks, key controls, sources of assurance, positive assurances on the effectiveness of controls, gaps in control and where applicable, gaps in assurances have been included for all the risks in the BAF. Whilst the Trust has adopted a bottom up approach to risk management, the audit found for a sample of healthcare groups that the risk registers are not regularly updated by the risk leads.'

Care Quality Commission

Following an inspection of the Trust in June 2016, the Trust was rated as inadequate overall and placed in Special Measures. However, the Trust received an outstanding rating for Maternity and Gynaecology Services.

A Quality Improvement Plan has been developed to address the areas requiring improvement (38 'must and should' recommendations were made) and is monitored by the Executive Management Board, Quality and Safety Committee and Trust Board. The Trust has also identified a plan which

goes beyond the recommendations made by CQC and provides a platform for continuous quality improvement over a long period of time (2016-2020). The plan is known as the Quality First Improvement Plan and is being monitored by the Quality Improvement Board. A Quality 1st Philosophy is currently being launched which focuses on 3 areas: '*Safety First, Patient First and Our People*'.

Discharge of Statutory Functions

In addition to the quality governance arrangements set out above the arrangements in place for the discharge of statutory functions have been checked for any irregularities and the Trust currently has no outstanding improvement notices. However, the Trust has not submitted a Sustainability Report to the Sustainable Development Unit by the deadline of 31 May 2017; action is being taken to ensure its completion and urgent submission. This area of non-compliance has been reported to the Audit Committee and Trust Board.

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 timescales detailed in the Regulations.

Significant Issues

The following is a summary of significant issues which will be the focus of the Board's attention and direct the Trust's management efforts during 2016/17 (and beyond):

Quality

As noted above, following the CQC inspection in June 2016, the Trust was rated as inadequate overall and placed in Special Measures. A Quality Improvement Plan has been developed to address the areas requiring improvement (38 'must and should' recommendations were made) and is monitored by the Executive Management Board, Quality and Safety Committee and Trust Board. The Trust has also identified a plan which goes beyond the recommendations made by CQC and provides a platform for continuous quality improvement over a long period of time (2016-2021). The plan is known as the Quality First Improvement Plan and is being monitored by the Quality Improvement Board which is chaired by the Chief Executive. A Quality 1st Philosophy is currently being launched which focuses on 3 areas: '*Safety First, Patient First and Our People*'.

Operational Performance – A&E Standard

The Trust has struggled to deliver against this standard throughout the year and a revised system trajectory to achieve 95% for the year was agreed. Year to date the Trust achieved 72.2% against the revised trajectory. A key factor driving this underperformance has been the significant workforce challenges the Trust has faced this year together with physical space and size of the ED department to see and treat patients. The number of available urgent care beds, medical and nursing staffing numbers, delayed transfers of care internally and across the health economy has impacted on performance. Recovery plans are in place to address these issues both internally and across the health and social care system to progress with the improvements the Trust has started to see. These will be monitored by the Local Delivery Board chaired by the Chief Executive. A number of specific actions are being undertaken including:

- Transforming Our Care, led by senior clinicians which has identified work streams and actions which support improvements in flow and operational performance.
- The development of an integrated discharge team to improve the discharge process for patients from the Trust.
- The implementation of the SAFER bundle and Red to Green Days.
- The Trust is in the process of developing a completely new operating model which will require both internal and external system changes.

The Trust is currently being supported by The National Emergency Care Improvement Team to improve performance against this standard. This will build upon the work started in 2016/17 and contribute to delivery of the national 4 hour standard.

Financial Sustainability and Strategic Options

The Trust's deficit plan for 2016/17 was £29.7m. This plan was consistent with the notified control total set by NHSI and, subject to some conditions the Trust Board agreed to work towards delivery of this target. The plan included an assumption that the Trust would receive £7.9m of Sustainability and Transformation funding. The Trust's Adjusted Retained deficit outturn position in 2015/16 was £37.7m and therefore the 2016/17 control target represented a significant improvement in the deficit position. The plan was underpinned by a £12m cost improvement programme which was inclusive of a target to reduce agency spend by £6.9m from 2015/16 levels and thus targeting to reduce agency spend to £13.6m. The plan assumed that the deficit would be supported by a combination of revenue support and working capital loans which was supported by NHSI. The plan also recognised an increased capital investment from 2015/16 levels and established an £11.7m programme targeting Estates, ICT and Medical Equipment.

At a strategic level the Trust continued to work with its Commissioners and partners to assess options to determine a financially and clinically sustainable configuration for the future delivery of acute hospital services to patients living in the areas which it serves. The Trust forms part of the West Essex / East Herts STP footprint and as part of this process local financial plans have been consolidated into the footprint and collaborative work with local NHS Trusts within this footprint continues to develop including progression of a number of STP workstreams aimed at improving efficiency and quality of care. However, at the current time, the Trust's plans do not achieve its statutory financial duty of cumulative break-even over a three year period and, in line with their duties as Auditors, the Trust's External Auditors have reported this position to the Secretary of State. The Trust's external auditors qualified their 2015/16 value for money conclusion; the purpose of this is to bring the Trust's financial standing to the attention of the public and to seek the Trust's response to:

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

Moving forward into 2017/18 the Trust is submitting plans to reduce its deficit position to £21.6m and then £15.4m in 2018/19. In 2017/18 the Trust has submitted capital requirements totalling £27m which are inclusive of strategic developments in Emergency Assessment Centre and Fracture Clinic and Urgent Care Centres although these developments remain subject to business case approval. The Trust has also commissioned the preparation of a Strategic Outline Case to consider potential options for a new hospital development.

Estate

A major challenge for the organisation remains the quality and safety of the estate premises at a time of significant financial constraint. This, together with increasing demands and an exceptionally high utilisation rate, is all the more critical in light of projected population growth and service changes proposed within our current Strategic Transformation Plan. The majority of services are currently provided on the Princess Alexandra Hospital Site but the Trust also leases various properties from third parties, for the provision outpatient and diagnostic patient services, most notably at St. Margaret's hospital in Epping and Herts and Essex hospital in Bishop's Stortford.

The majority of the estate, nearly 60% is well over 50 years old. It should be noted that nearly 60% of the current estate facilities provided on the PAH site are considered to be not satisfactory, with almost 10% considered to be unacceptable and where nothing but a re-build will suffice.

Following the Six Facet Survey, key estates issues and challenges were identified. The Six Facet Survey indicated a total backlog and future maintenance requirement of £28.2 million. A critical infrastructure schedule of works has been risk assessed and prioritised to commit limited expenditure to address the high risk backlog maintenance issues. The following areas were highlighted:

- The Emergency Assessment Unit (EAU) is beyond normal life expectancy and is in need of urgent replacement. A business case for a new EAU has been developed.
- The maternity department urgently requires replacement of its labour ward theatres which date from 1965.
- The mains sewage and water supply system requires urgent replacement
- The existing Outpatient Department at Princess Alexandra Hospital is too small for the required functional content and therefore a new build rather than refurbishment should be considered.
- The modular section of the Alexandra Day Stay Unit has come to the end of its normal working life and its replacement should be considered alongside the refurbishment of the original facility constructed in 1994.
- The temporary theatres installed in 1993/4 with an expected 18 month life expectancy are planned to be decommissioned as part of the current transformation programme.
- The Trust's existing educational training facilities are accommodated in numerous buildings across the site, including Pardon Hall, which currently has £2 ½ million worth of back log maintenance.
- The current ward configurations offers limited single bed accommodation with no annual refurbishment programme. Current occupancy rates, together with no decanting facilities, would make any upgrade refurbishment programme very challenging. The facilities built in the 1960s and 70s are not capable of expansion and therefore any redesign would inevitably impact on operational capacity; reduction in beds.
- The mechanical services infrastructure is almost 50 years old and although well maintained, components such as isolation valves are reaching the end of their useful life. Equally the risk of service failure with this ageing plant remains very high.
- The Trust does not have enough space to cope with the current volume of treatment taking place (excluding future population/demand growth). Many patient areas do not comply with the space requirements set out in the current health building notes. Key national initiatives such as the move toward single bed occupancy are not being addressed.
- The provision and dignity of patients is being compromised as there is generally a lack of counselling and interview spaces, inadequate changing facilities and poor bathroom and toilet facilities.

The Trust has commenced work on a Strategic Outline Case for a new hospital and intends to progress this work in 2017.

Conclusion

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



Trevor Smith
Acting Chief Executive

Remuneration and Staff Report

Background

This report includes details regarding “senior managers” remuneration in accordance with paragraphs 2.30 to 2.53 of the DH (Department of Health) Group Accounting Manual 2016/17. The Remuneration Report set out below is subject to audit by our external auditors.

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

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

Staff report

Pay Multiples

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 director in The Princess Alexandra Hospital NHS Trust in the financial year 2016/17 was £270k to £275k (2015/16, £270k to £275k). This was 13.3 times (2015/16, 13.0 times) the median remuneration of the workforce, which was £20k (2015/16, £21k).
- In 2016/17, no employees received remuneration in excess of the highest paid director (this was the same in 2015/16). Remuneration ranged from the bands £0k-£5k to £290k-£295k (2015/16 £0k-£5k to £270k to £275k).
- 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. As a result of making these adjustments the highest paid director for the purpose of calculating pay multiples is not the highest paid director disclosed in the Table of Executive Salaries on Page 47

Reason for Increase in Pay Multiple

The highest paid director in 2016/17 was the Chief Medical Officer who had a salary banding of £270k -£275k. The Chief Medical Officer was also the highest paid director in 2015/16 with a salary banding of £270 - £275k.

Consultancy and Professional Services Spend

2016/17 total expenditure on consultancy and professional services was £2,140k (2015/16 £3,339k).

Employee Benefits and Staff Numbers

Employee Benefits

Gross Expenditure 2016/17	Total £000's	2015/16 Permanently employed £000's	Other £000's
Salaries and wages	129,133	103,773	25,360
Social Security costs	10,035	10,035	0
NHS Pensions Scheme	12,082	12,082	0
Termination Benefits	13	13	0
Total employee benefits	151,263	125,903	25,360
Employee costs capitalised	1,286	526	760
Gross Employee Benefits excluding capitalised costs	149,977	125,377	24,600

The Termination Benefits total of £13k represents year termination costs of £146k offset and reduced by the removal of a provision for £133k made in 2015/16 that was not used.

Gross Expenditure 2015/16	Total £000's	2015/16 Permanently employed £000's	Other £000's
Salaries and wages	129,295	97,930	31,365
Social Security costs	8,967	7,978	989
NHS Pensions Scheme	11,577	11,577	0
Termination Benefits	364	364	0
Total employee benefits	150,203	117,849	32,354
Employee costs capitalised	2,053	244	1,809
Gross Employee Benefits excluding capitalised costs	148,150	117,605	30,545

Average Staff Numbers

Average Staff Numbers	Total Number	Permanently Employed Number	Other Number	Total Prior Year Number	Permanently Employed Number	Other Number
Medical and Dental	480	410	70	445	386	59
Administration and Estates	588	549	39	588	551	37
Healthcare Assistants and Other Support Staff	255	253	2	259	256	3
Nursing, Midwifery and Health Visiting Staff	885	762	123	873	748	125
Nursing, Midwifery and Health Visiting Learners	420	357	63	415	344	71
Scientific, therapeutic and Technical Staff	239	218	21	231	208	23
Healthcare Science Staff	151	151	0	146	146	0
Other	118	110	8	118	95	23
Total	3,136	2,810	326	3,075	2,734	341
Staff Engaged on Capital Projects (including above)	22	10	12	41	8	33

Staff sickness absence and ill health retirements

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

	2016/17	2015/16
	Number	Number
Total days lost	24,076	20,676
Total staff years	2,830	2,725
Average working days lost	8.5	7.6
	2016/17	2015/16
	Number	Number
Number of persons retired early due to ill health grounds	3	1
	£000s	£000s
Total additional pension liabilities accrued in the year	0	0

Exit Packages 2016/17 Table 1

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Whole numbers only	*Cost of compulsory redundancies £s	Number of other departures agreed Whole numbers only	Cost of other departures agreed £s	Total number of exit packages Whole numbers only	Total cost of exit packages £s
Less than £10,000	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	1	34,594	0	0	1	34,594
£50,001 - £100,000	0	0	0	0	0	0
£100,001- £150,000	1	111,069	1	118,240	2	229,309
£150,001 - £200,000	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0
Total	2	145,663	1	118,240	3	263,903

The other departure disclosed above is in respect of a director, and is further disclosed within the Executive Directors Table of Salaries page on page 47. The total cost of exit packages disclosed above in Table 1 differs from the redundancy charge in the Accounts because £118,240 was charged to pay cost, and redundancy provision movements have been excluded from Table 1.

There were no special payments made in 2016/17.

Note * this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

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.

Exit Packages 2015/16 Table 1

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Whole numbers only	*Cost of compulsory redundancies £s	Number of other departures agreed Whole numbers only	Cost of other departures agreed £s	Total number of exit packages Whole numbers only	Total cost of exit packages £s
Less than £10,000	0	0	1	7,500	1	7,500
£10,000 - £25,000	1	19,167	0	0	1	19,167
£25,001 - £50,000	3	140,189*	2	74,650	5	214,839

£50,001 - £100,000	1	62,330	0	0	1	62,330
£100,001- £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0
Total	5	221,686	3	82,150	8*	303,836

*£140,819 cost of compulsory redundancies was disclosed in last year's Annual Report Table 1, which was a transposition error. The figure should have been £140,189. The total number of exit packages which was 8, was not disclosed in last year's Annual Report Table 1.

Exit Packages 2016/17 Table 2 Non-Compulsory departures

Exit packages-Other Departures analysis	2016/17		2015/16	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000's	Number	£000's
Contractual payments in lieu of notice	1	118	2	75
Exit payments following Employment Tribunals or court orders	0	0	1	7
Total	1	118	3	82

Off payroll arrangements

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

During 2016/17 there were no Executive posts covered by off-payroll arrangements.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	1
Of which, the number that have existed	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New Off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	1
Number of new engagements which include contractual clauses giving the Princess Alexandra NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number of whom assurance has been requested	1
Of which number that have existed	
assurance has been received	1
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Table 3: Off-payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or senior officers with significant financial responsibility, between 1 April 2016 and 31 March 2017

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	0

i. **Table of salaries**
Executive Directors

None of the directors received remuneration other than their salary and pension related benefits tabled below

Name	Title	Period	2016/17		2015/16	
			All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Period	Salary (bands of £5,000) £000
Trevor Smith*1	Chief Financial Officer	All Year	135-140	30-32.5	165-170	All Year
Nancy Fontaine*1	Chief Nurse*1	All Year	125-130	30-32.5	160-165	All Year
Phil Morley*2	Chief Executive *2	All Year	290-295	-	290-295	All Year
Gloria Barber	Chief of Workforce	-	-	-	01/04/15-13/10/15	175-180
Marc Davis	Director of Pathways and Partnerships	All Year	100-105	22.5-25	120-125	All Year
James McLeish	Director of Business Delivery	All Year	100-105	102.5-106	205-210	-
Stephanie Lawton*1	Chief Operating Officer	All Year	105-110	32.5-35	140-145	All Year
Andrew Morris*3	Chief Medical Officer	All Year	270-275	72.5-75	340-345	All Year
Elizabeth Booth	Director of Human Resources	All Year	90-95	22.5-25	115-120	15/09/15-31/03/16
					50-55	10-12.5
						60-65

Simon Covill* ¹	Acting Chief Financial Officer	22/02/17-31/03/17	10-15	2.5-5	10-15	-	-	-
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*1. These directors held the following acting up roles, for which none of them received acting up allowances during 2016/17: Trevor Smith was Acting Chief Executive from 22/02/17 to 31/03/17, and Deputy Chief Executive from 01/04/16 to 21/02/17. Stephanie Lawton was Acting Deputy Chief Executive from 22/02/17 to 31/03/17. Simon Covill was Acting Chief Financial Officer from 22/02/17 to 31/03/17. Prior to this, he was the Deputy Chief Financial Officer. Nancy Fontaine was Acting Deputy Chief Executive throughout the year.

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

*3. £100k of the salary within the total £270k-£275k salary banding disclosed for Andrew Morris, Chief Medical Officer, is for their clinical role (2015/16 £94k of the total £270-£275k salary of Andrew Morris was for their clinical role).

Non-Executive Directors

Name	Title	Period	2016/17			2015/16		
			Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £	TOTAL (bands of £5,000) £000	Period	Salary (bands of £5,000) £000	Expense payments (taxable) to nearest £100 £
Douglas Smallwood	Chairman	01/04/16-03/10/16	10-15	0	10-15	All Year	25-30	0
Alan Burns	Chairman	01/12/16-31/03/17	10-15	0	10-15	-	-	-
Neil Goulden	Non-Executive Director	01/04/16-18/05/16	0-5	0	0-5	All Year	5-10	0
Andrew Holden*	Non-Executive	01/04/16-16/10/16	5-10	100	5-10	All Year	5-10	0

	Director	01/12/16-31/03/17					
Mike Roberts	Non-Executive Director	01/04/16-31/01/17	5-10	0	5-10	All Year	5-10
Philip Wilson	Non-Executive Director	-	-	-	-	01/04/15-31/08/15	0-5
Sarah Coffey	Non-Executive Director	-	-	-	-	01/04/15-31/08/15	0-5
James Anderson	Non-Executive Director	All Year	5-10	100	5-10	28/9/15-31/3/16	0-5
Pam Court	Non-Executive Director	All Year	5-10	0	5-10	28/9/15-31/3/16	0-5
Stephen Bright	Non-Executive Director	03/10/16-31/03/17	0-5	100	0-5	-	-

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

Salary pension entitlement of Senior Managers

Name	Title	Real increase / (decrease) in pension at pension age (bands of £2500) £000	Real accrued pension at pension age as at 31 March 2017 (bands of £5000) £000	Total accrued pension at pension age related to accrued pension at 31 March 2017 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 1 April 2016 £000	Real Increase in Cash Equivalent Transfer Value £000
Executive Directors								
Trevor Smith	Chief Financial Officer	2.5-5	0	50-55	145-150	892	841	51
Nancy Fontaine	Chief Nurse	2.5-5	0-2.5	40-45	115-120	760	711	49
Marc Davis	Director of Pathway and Partnership	0-2.5	0	20-25	55-60	372	341	31
James McLeish	Director of Business Delivery	5-7.5	15-17.5	20-25	60-65	408	283	125
Stephanie Lawton*1	Chief Operating Officer	0-2.5	0	40-45	105-110	563	525	37
Andrew Morris	Chief Medical Officer	5-7.5	2.5-5	85-90	240-245	1,597	1,442	155
Elizabeth Booth	Director of Human Resources	0-2.5	0	0-5	0	33	11	22

Simon Covill	Acting Chief Financial Officer	2.5-5	0-2.5	35-40	90-95	549	509	40
Phil Morley, Chief Executive, was opted out of the NHS Pension Scheme.								

*1 The Cash Equivalent Transfer Value (CETV) at 1 April 2016 of £525k disclosed for Stephanie Lawton includes her £504k 1995 scheme and £21k 2015 Scheme membership. Stephanie Lawton's CETV at 31 March 2016 disclosed in the 2016 annual report senior managers salary pension entitlement was £504k, and was incorrect, as it excluded her £21k 2015 Scheme membership.

- There are no entries in respect of pensions for Non-Executive members as they do not receive pensionable remuneration.
- CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Staff Survey and Staff Friends and Family Test Results

The annual NHS Staff Survey and the quarterly Staff Family and Friend Test are crucial barometers of how employees view their workplace. The feedback is useful in helping us highlight improvements that will make the hospital both a better place to work and be treated. Some of the key weaker areas identified in the last Staff Survey (2016) compared with other NHS Trusts were:

- Some staff had not had an appraisal in the last 12 months
- Staff do not have adequate material, supplies and equipment to do their work
- Not enough staff in the organisation to do the job properly
- Organisation definitely takes positive action on health and wellbeing
- Organisation treats staff involved in errors fairly

However, staff did report an improvement in the quality of staff appraisals in that the Trust values were definitely discussed.

We have looked at the results and have developed some key action points to address the weaker issues. Each Health Group/Directorate has received their own staff survey report and will develop their own action plans to address their key areas of weakness.

On the Staff Family and Friends Test in Quarter 4 (Jan-Mar 2017) 68% of staff said they would recommend the Trust to family and friends if they needed care or treatment here. This is 1% above the target of 67% set by the Department of Health, and gives PAHT a 'green' rating. 55% of staff said they would recommend PAHT as a place to work, which is below our Department of Health target of 61%, and gives PAHT an 'amber' rating.

Our staff breakdown

Number of Senior Managers by Salary Band in 2016/17								
Salary Band	£10k-£15k	£90k-£95k	£100k-£105k	£105-110k	£125k-£130k	£135-£140k	£270k-£275k	£290-£295k
Number	1	1	2	1	1	1	1	1

Number of Senior Managers by Salary Band in 2015/16								
Salary Band	£40k-£45k	£50k-£55k	£95-100k	£125k-£130k	£130k-£135k	£135-£140k	£175k-£180k	£270k-£275k
Number	1	1	1	1	1	1	1	1

2016/17 Staff Composition	Male	Female
Executive Directors	6	3
Other Employees	732	2,533
Total	738	2,536

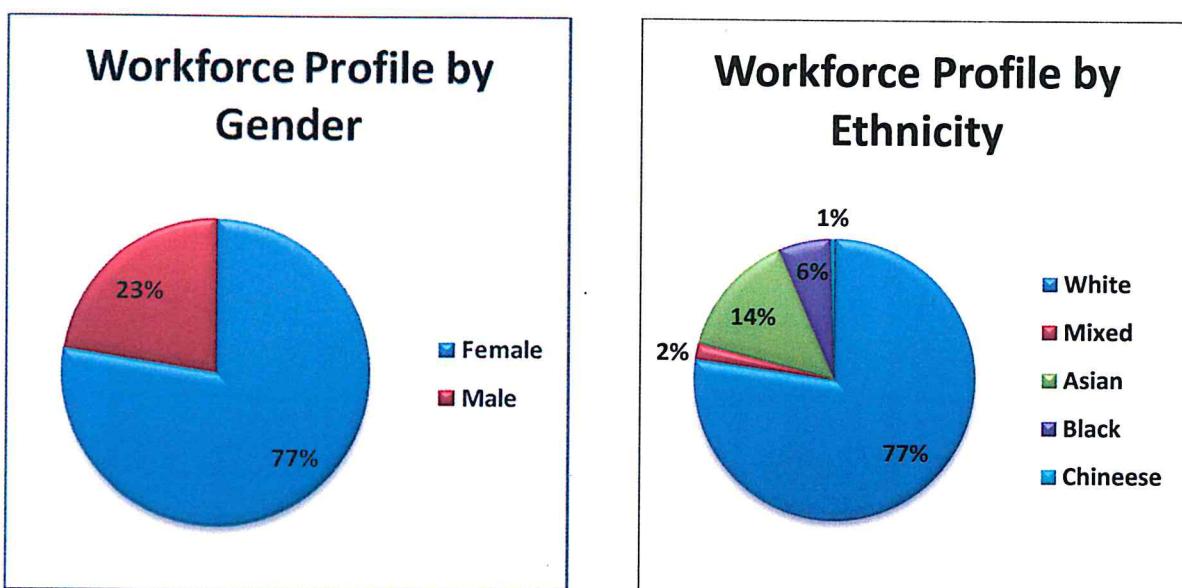
Turnover rate

Turnover Rate		
	2016/17	2015/16
Overall Staff Turnover Rate	22.2%	20.0%
Voluntary Turnover Rate	15.5%	15.7%

The overall staff turnover rate increased due to more recruitment of staff than in the previous year because of a high turnover within Nursing & Midwifery.

Equality and diversity

The Trust regularly monitors the equality profile of its workforce. An Equality and Diversity Steering Group has been formed to develop a Trust-Wide Equality and Diversity strategy to ensure our patients and staff are treated fairly and consistently and our workforce represent the demographic profile for the East of England region. The ratio of male to female remains the same as previous year.



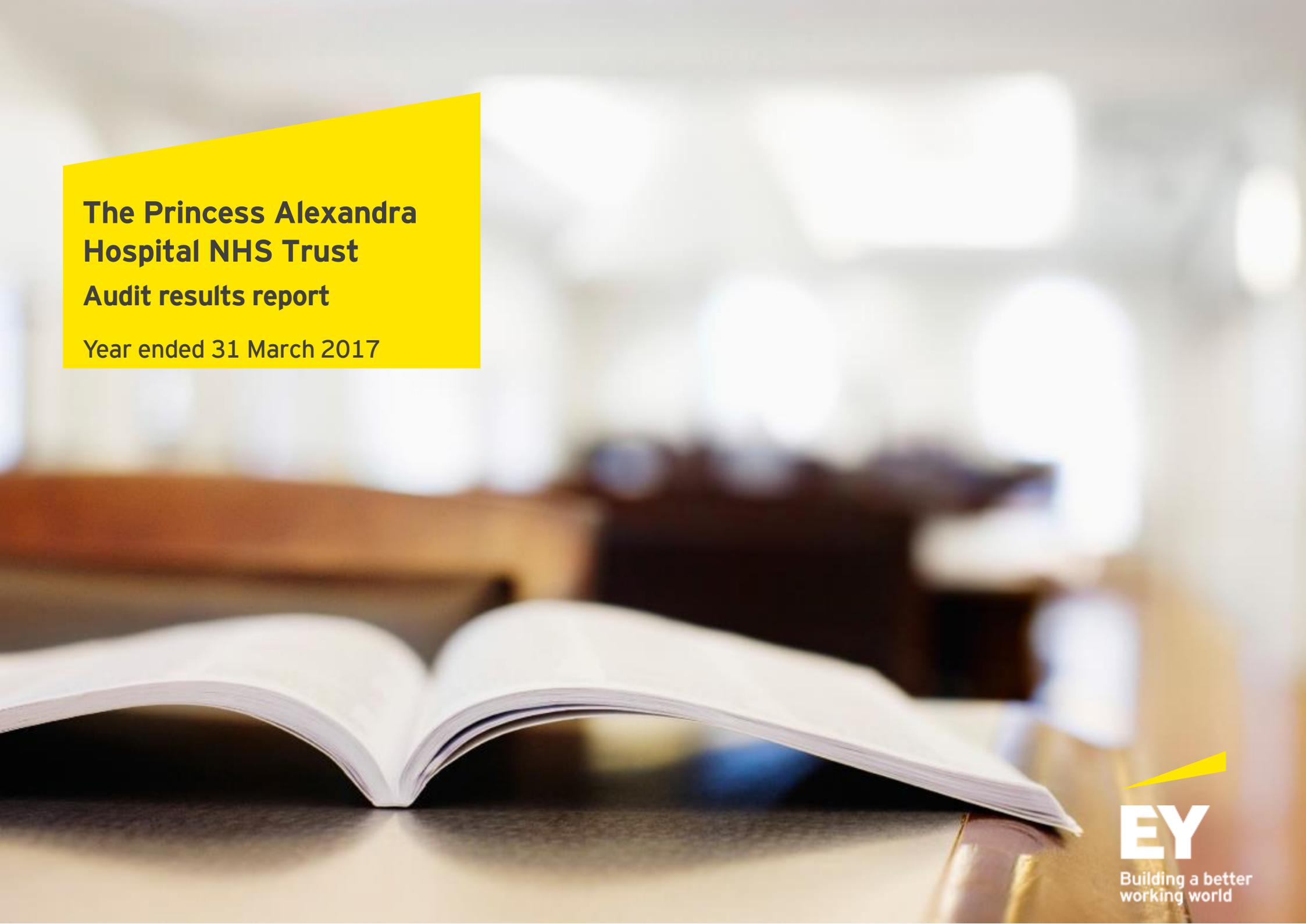
Policy in Relation to Disabled Employees

The Trust has in place a robust Attendance Management Policy which includes the management of conditions classed as a disability. This includes providing extra support for regular appointments as well as flexible working options to assist the employee in managing their condition. Those who acquire a condition whilst in the Trust's employment are supported and assessed for reasonable adjustments involving the Staff Health and Wellbeing team, HR, Trade Unions and their Line Manager, so that they are able to continue to work and use their skills.

The Trust has retained the two ticks symbol which guarantees a disabled applicant an interview provided they meet the essential requirements of the person specification.

Only 1.8% of our employees have indicated that they have a disability, however the actual figure may be higher.

Trevor Smith
Acting Chief Executive



The Princess Alexandra
Hospital NHS Trust
Audit results report

Year ended 31 March 2017

Private and Confidential

26 May 2017

Dear Audit Committee Members

We have substantially completed our audit of The Princess Alexandra Hospital NHS Trust (the Trust) for the year ended 31 March 2017.

Subject to the adequate resolution of the outstanding matters listed in our report, we confirm that we anticipate being in a position to issue an unqualified audit opinion on the financial statements in the form that appears in section 4 of this report, before the statutory deadline on 1 June 2017. We are reporting a number of matters about your arrangements to secure economy, efficiency and effectiveness in your use of resources.

This report is intended solely for the use of the Audit Committee, other members of the Board of Directors and senior management, and should not be used for any other purpose nor given to any other party without our prior written consent.

We would like to thank your staff for the assistance provided to us during the engagement.

We look forward to the opportunity of discussing with you any aspects of this report or any other issues arising from our work.

Yours faithfully

Kevin Suter
Executive Director

For and on behalf of Ernst & Young LLP

United Kingdom

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09 Appendices

In April 2015 Public Sector Audit Appointments Ltd (PSAA) issued "Statement of responsibilities of auditors and audited bodies". It is available from the PSAA website (www.PSAA.co.uk). The Statement of responsibilities serves as the formal terms of engagement between appointed auditors and audited bodies. It summarises where the different responsibilities of auditors and audited bodies begin and end, and what is to be expected of the audited body in certain areas. The "Terms of Appointment (updated September 2015)" issued by the PSAA sets out additional requirements that auditors must comply with, over and above those set out in the National Audit Office Code of Audit Practice (the Code) and in legislation, and covers matters of practice and procedure which are of a recurring nature..

This report is made solely to the Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust in accordance with the statement of responsibilities. Our work has been undertaken so that we might state to the Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust those matters we are required to state to them in this 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 Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust for this report or for the opinions we have formed. It should not be provided to any third-party without our prior written consent.

A blurred background image showing a person's hands holding a silver tablet device, with a white document or paper visible behind it.

01 Executive Summary



Executive Summary

Executive summary

Overview of the audit

Scope and materiality

In our Audit Plan presented at the 2 March 2017 Audit Committee meeting, we provided you with an overview of our audit scope and approach for how we intended to carry out our responsibilities as your auditor. We carried out our audit in accordance with this plan.

We planned our procedures using a materiality of £4,618,000. We have reassessed this based on the actual results for the financial year and have made no change since our audit plan. The basis that we use to calculate materiality has changed as this is our second year as the Trust's external auditors. The basis this year is 2% of expenditure (prior year 1% of expenditure). The threshold for reporting audit differences remains £230,900.

We also identified areas where misstatement at a lower level than our overall materiality level might influence the reader and developed an audit strategy specific to these areas:

- ▶ Remuneration disclosures including any severance payments, and
- ▶ Exit packages and termination benefits.

Where an error is identified that would change the banding for a transaction this is reported to management for amendment.

Status of the audit

We have substantially completed our audit of the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2017 and have performed the procedures outlined in our Audit plan.

We received the draft financial statements by the deadline of the 26th April and we noted that there was an improvement in the quality of the accounts and the working papers over the prior year. We had agreed with the Trust that we could commence our audit work on those areas that were complete from the 24th April. This year the Finance team made all the working papers available electronically and provided access to a shared folder and Trust email address in order to facilitate the audit.

Subject to satisfactory completion of the following outstanding items we expect to issue an unqualified opinion on the Trust's financial statements in the form which appears in Section 4. However, until we have completed our outstanding procedures, it is possible that further matters requiring amendment may arise.



Executive Summary

Executive summary (continued)

Status of the audit (continued)

Areas yet to be completed are:

- ▶ review of the final version of the financial statements
- ▶ completion of subsequent events review
- ▶ receipt of the signed management representation letter
- ▶ resolution of outstanding queries from testing.

We expect to issue the audit certificate at the same time as the audit opinion.

Audit differences

There are no unadjusted or adjusted audit differences arising from our audit.

The Trust was notified during the audit that it had been awarded a further £699,000 of sustainability and transformation funding by NHS Improvement and changes have been made to the financial statements to reflect this.



Executive Summary

Executive summary (continued)

Areas of audit focus

In our Audit Plan we identified a number of key areas of focus for our audit of the financial statements of The Princess Alexandra Hospital NHS Trust. This report sets out our observations and conclusions in relation to these areas, including our views on areas which might be conservative and areas where there is potential risk and exposure. Our consideration of these matters and others identified during the period is summarised within the "Key Audit Issues" section of this report.

We request that you review these and other matters set out in this report to ensure:

- ▶ There are no residual further considerations or matters that could impact these issues
- ▶ You concur with the resolution of the issue
- ▶ There are no further significant issues you are aware of to be considered before the financial report is finalised.

There are no matters, other than those reported by management or disclosed in this report, which we believe should be brought to the attention of the Audit Committee.

Value for money

We have considered your arrangements to take informed decisions; deploy resources in a sustainable manner; and work with partners and other third parties. In our Audit Plan we identified significant risks in respect of the Trust's financial sustainability and the findings from the review of the Trust by the Care Quality Commission.

We have the following matters to report about your arrangements to secure economy efficiency and effectiveness in your use of resources.

In 2015/16 we issued an adverse conclusion based around key factors including the significant financial deficit and overspends, and a lack of clear strategic direction for the Trust as an organisation including its primary hospital location and estate. Addressing these issues was unlikely to be a short term process.

Since that conclusion the Trust was rated inadequate by the CQC and put into special measures, under which it remains at the end of the year.

While we recognise significant progress compared to the prior year in controlling costs, the Trust's financial position is still a significant annual and cumulative deficit with no plans to return to annual financial balance. We have seen that a clearer strategic direction for the Trust is starting to emerge, but this has not progressed significantly to be able to clearly articulate the future model of services and location, and their impact on the Trust's finances.

Therefore, while wishing to recognise progress being made, we are still of the view that there are significant weaknesses in the Trust's arrangements, and consequently we intend to issue an adverse value for money conclusion on the Trust's arrangements as at 31 March 2017.



Executive Summary

Executive summary (continued)

Other reporting issues

We have reviewed the information presented in the Annual Report and Annual Governance Statement for consistency with our knowledge of the Trust. We have audited the parts of the remuneration and staff report disclosures that are required to be audited.

Overall we noted an improvement in the Annual Report that was made available to the audit team during the audit, compared to the prior year. The structure of the document clearly followed the guidance in the Group Accounting Manual. However we did find that the section in the Annual Report on environmental sustainability did not follow the template provided by the Sustainable Delivery Unit (SDU) for NHS Trusts which Trusts are expected to complete by 31 May. As a consequence the Trust has not made a number of mandated disclosures but is taking action to make the required return.

Alongside our work on the financial statements, we also report to the Trust on differences, within a tolerance of £250,000, between the Trust's consolidation schedules and the audited financial statements. We also report to the NAO under its group instructions. We are currently concluding our work in these areas and will report any matters that arise to the Audit Committee.

As members of the Audit Committee will be aware we issued a report under s30 of the Local Audit and Accountability Act 2014 on 17 May 2016. The Trust has a statutory duty to break even taking one financial year with another. Our report on 17 May 2016 referred to the deficit incurred in 2015/16 and the two preceding years. Therefore, the Trust had not achieved its breakeven duty. Our report also referred to the planned deficit for 2016/17, therefore, we are not required to issue another report in respect of the year ended 31 March 2017. However, we still include reference to the 17 May 2016 referral in our Auditor's Report.

We have no other matters we wish to report.



Executive Summary

Executive summary (continued)

Control observations

We have not identified any significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware.

Independence

Please refer to Appendix B for our update on Independence.



02

Understanding Financial Statements



Understanding Financial Statements

Key components of net expenditure

The adjusted retained deficit in the draft financial statements received for audit for the year ended 31 March 2017 was £27.4m, a decrease of £10.3m compared with the prior year.

This was subsequently revised to £26.7m following receipt of further STF funding.

The Trust had forecast for the majority of the year that it would have an outturn in line with the control total agreed with NHS Improvement of £29.7m. This was an improvement over the prior year when the Trust's deficit position escalated in the latter part of the year. The final outturn for 2016/17 was in fact better than the control total agreed with NHS Improvement at the start of the year. As the control total was achieved the Trust was awarded incentive and bonus sustainability and transformation funding of £1.893m for meeting its targets. A further £0.699m was subsequently awarded when NHS Improvement made a further distribution.

During the year there have been a number of significant events that have occurred that have impacted the outturn of the Trust. The following provides an overview of the material items:

- The Trust has demonstrated a significant improvement in its ability to manage its cost base. It exceeded by £2.7m its cost improvement target of £12m, which was £6.9m for staff and £5.1m for other costs.
- Spend on temporary staff, previously a significant contributor to the Trust's deficit financial position has reduced by £6m compared with the prior year.

The Trust has undershot against its external financing limit and its capital resource limit primarily because capital expenditure in year was below the level planned.



03

Areas of Audit Focus





Areas of Audit Focus

Audit issues and approach: Key issue: Going concern

Going Concern

What judgements are we focused on?

We focused on the assessment undertaken by the Board on the going concern assumption and its appropriateness.

What did we do?

We obtained letters from the Acting Chief Financial Officer and the Chair of the Audit Committee, explaining why the going concern assumption had been applied.

We reviewed the Trust's cash flow forecast for 2017/18, which is consistent with the £21.6 million deficit plan for that year. This shows the Trust maintaining positive in-year cash balances on a monthly basis but is predicated on in-year support in line with the deficit, with further support of £17.5 million (subject to agreement) for the capital programme.

We reviewed the disclosure made in the accounting policies section of the draft financial statements, against the requirements of the Group Accounting Manual and the NHS Improvement guidance issued in February 2017 setting out the disclosures likely to be required of NHS Trusts. We found that the Trust's disclosures followed this guidance. However, we requested that amendments be made to the disclosures to make clearer the uncertainties with regard to future funding and financing, and the Trust agreed to this.

What are our conclusions?

We concluded that the Trust has included proper disclosure in the draft financial statements explaining why the going concern assumption is appropriate.

Due to the significant future unconfirmed funding requirement for the Trust, for both its 2017/18 budgeted deficit and capital expenditure, we are including an emphasis of matter paragraph in our audit report. This is not a qualification of our audit report.



Significant Risk



Areas of Audit Focus

Audit issues and approach: Key issue: Revenue recognition

Revenue Recognition

What are our conclusions?

Our testing has not identified any material misstatements with respect to revenue and expenditure recognition.

Overall our audit work did not identify any material issues or unusual transactions which indicated that there had been any misreporting of the Trust's financial position.



Significant Risk

What is the risk?

Risk of fraud in revenue recognition

Under ISA240 there is a presumed risk that revenue may be misstated due to improper recognition of revenue. In the public sector this requirement is modified by Practice Note 10, issued by the Financial Reporting council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition. The NHS as a whole is experiencing financial pressures, and there is pressure on The Princess Alexandra Hospital NHS Trust to achieve its financial forecast.

What did we do?

- We reviewed and discussed with management any significant accounting estimates on revenue or expenditure recognition for evidence of bias for example estimated STF funding. We reviewed the movements and closing position on provisions and obtained relevant supporting evidence. We also reviewed the position on STF funding to which the Trust was entitled in year. We tracked the reporting of delivery against targets in year and NHSI correspondence which supported the final bonus awarded to the Trust.
- We reviewed and tested cut-off at the year-end date, to ensure income and expenditure transactions have been recorded in the correct period.
- We reviewed any critical judgements made by the Trust, including the resolution of any contract disputes and challenges. Last year the Trust had a provision of £1m against an invoice raised to its primary commissioner for work done to meet Referral to Treat (RTT) targets. This was resolved in year and we have seen evidence for the settlement at 50% of the value claimed. In addition The Agreement of Balances exercise shows that both parties have an agreed position as at 31 March 2017.
- We considered the outcome of the Department of Health Agreement of Balances exercise. We noted an improvement over the prior year. There were very few significant differences for the Trust, and for those that did arise the Trust took prompt action to address them. There were no significant differences on debtors. There was a £401,000 difference on the creditor position with East and North Hertfordshire NHS Trust which had recorded a lower debtor. This difference was reduced in the resubmission data to £132,000 and we were satisfied with the evidence to support the Trust's position.



Areas of Audit Focus

Audit issues and approach: Key issue: Management override

Management override

What are our conclusions?

We have not identified any material weaknesses in controls or evidence of material management override.

We have not identified any instances of inappropriate judgements being applied.

We did not identify any other transactions during our audit which appeared unusual or outside the Trust's normal course of business



Significant Risk

What is the risk?

Risk of management override

As identified in ISA 240, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We identify and respond to this fraud risk on every audit engagement.

What did we do?

- ▶ We tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements. We obtained full list of journals posted to the general ledger during the year, and analysed these journals using criteria set to identify any unusual journal types and amounts. Our procedures are still to be completed, but we have nothing to report at this time. We will update the committee on our findings;
- ▶ We reviewed accounting estimates for evidence of management bias, the valuation of land and buildings was reviewed in particular as we considered this to be a significant estimate, with susceptibility to bias impacting the depreciation calculations; and
- ▶ We evaluated the business rationale for any significant unusual transactions.



04 Audit Report





Draft audit report

Our opinion on the financial statements

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

We have audited the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2017 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 30. 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 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 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).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- ▶ the table of salaries and allowances of senior managers and related narrative notes on pages 47 to 49;
- ▶ the table of pension benefits of senior managers and related narrative notes on pages 50 and 51;
- ▶ the tables of exit packages and related notes on page 44 and 45;
- ▶ the analysis of staff numbers and costs and related notes on pages 42 and 43; and
- ▶ the table of pay multiples and related narrative notes on page 41.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 61, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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.



Audit Report

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

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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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.



Audit Report

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Emphasis of matter – Going Concern

In forming our opinion, which is not modified, we have also considered the adequacy of the disclosures made in note 1.1 to the financial statements concerning the Trust's ability to continue as a going concern. The conditions described in note 1.1 indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters:

- in our opinion the governance statement does not comply with NHS Improvement's guidance ; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

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



Audit Report

- **Referral to the Secretary of State**

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

On 17 May 2016, we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014, as in reporting a deficit for the financial year ended 31 March 2016 and setting a deficit budget for the financial year ended 31 March 2017 the Trust had breached its breakeven duty as set out in Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 as interpreted by the Department of Health in its detailed guidance on breakeven duties.

- **Proper arrangements to secure economy, efficiency and effectiveness**

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

Basis for qualified conclusion (Adverse) on reporting by exception

The Trust reported a deficit of £26.7 million in its financial statements for the year ending 31 March 2017, in line with the operational plan agreed with NHS Improvement. It also reported deficits in the previous three financial periods. Therefore it continues to breach its duty, under paragraph 2 (1) of Schedule 5 of the National Health Service Act 2006, to break even.

Whilst the Trust has been successful in achieving the planned deficit agreed with NHS Improvement for 2016/17 it has not succeeded in addressing the underlying deficit in its budget and is forecasting further deficits of £21.6 million and £15.4 million for 2017/18 and 2018/19 respectively.

On 19 October 2016 the Care Quality Commission put the Trust into special measures following its inspections in June and July 2016. The Trust is working with other stakeholders to deliver against the Quality Improvement Plan that it has developed in response, but is yet to be re-inspected and remains in special measures.

The above factors are evidence of weaknesses in proper arrangements to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion on reporting by exception

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, we are not satisfied that, in all significant respects, The Princess Alexandra NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.



Audit Report

Certificate

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

Kevin Suter

for and on behalf of Ernst & Young LLP

Luton

xx May 2017

The maintenance and integrity of The Princess Alexandra Hospital NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.



05 Audit Differences

Audit differences

In the normal course of any audit, we identify misstatements between amounts we believe should be recorded in the financial statements and the disclosures and amounts actually recorded. These differences are classified as 'known' or 'judgemental'. Known differences represent items that can be accurately quantified and relate to a definite set of facts or circumstances. Judgemental differences generally involve estimation and relate to facts or circumstances that are uncertain or open to interpretation.

Summary of adjusted differences

There were some amendments made to disclosures and there were no uncorrected misstatements.

The Trust received notification during the audit of the award of a further £699,000 of STF which has been reflected in the revised financial statements.

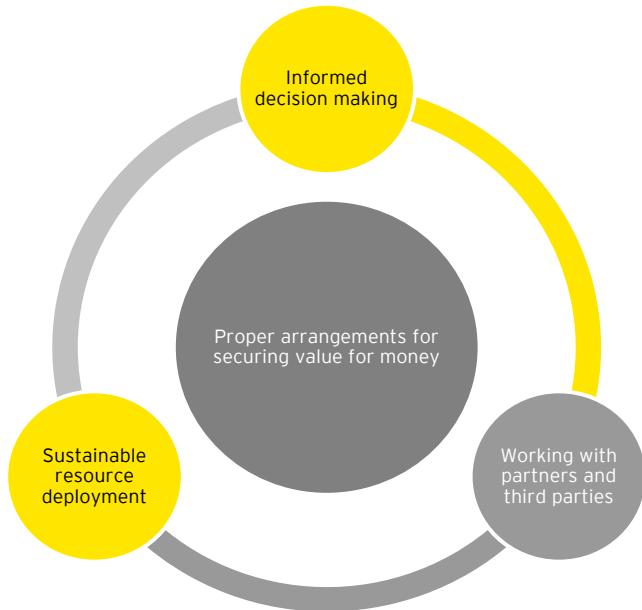


06 Value for Money





Value for Money



Overall conclusion

We identified two significant risks in relation to these arrangements. The tables below presents the findings of our work in response to the risk areas in our Audit Plan. On the basis of those findings, we expect to issue a qualified (adverse) report about your arrangements to secure economy, efficiency and effectiveness in your use of resources.

Economy, efficiency and effectiveness

We are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This known as our value for money conclusion.

Proper arrangements are defined by statutory guidance issued by the National Audit Office. They comprise your arrangements to:

- ▶ Take informed decisions;
- ▶ Deploy resources in a sustainable manner; and
- ▶ Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.



VFM risks

We are only required to determine whether there are any risks that we consider significant within the Code of Audit Practice which defines significant as:

"A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public"

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work.

The table below presents the findings of our work in response to the risk areas in our Audit Plan.

What is the significant VFM risk?	What arrangements did this impact?	What are our findings?
<p>In 2015/16 we qualified the VFM conclusion due to the Trust's significant in-year deficit and accumulated deficit.</p> <p>The control total set for the Trust for 2016/17 was £29.7m, less than the £42.2m deficit originally submitted in its initial operating plan, with a significant part of the difference being £7.9m funding from the STF.</p> <p>At month 6 performance was on track, but non-recurrent measures of £1.3m had been taken to achieve that position.</p> <p>Control totals set by NHSI for subsequent years were £21.6m and £15.4m, representing a significant challenge as a reduction from 2016/17.</p> <p>In qualifying our conclusion in 2015/16, as well as reflecting on the cumulative deficit and breach of the statutory duty to break-even, we also reflected on the lack of clear strategic direction for the NHS Trust, the significant limitations of its estate and primary location, and previous reviews confirming lack of financial sustainability in the Trust's current form.</p> <p>We therefore focused on:</p> <ul style="list-style-type: none">• The Trust's progress in dealing with its ongoing financial challenge;• Its performance against its 2016/17 financial budget; and• Its progress in establishing a clear strategic direction for the future of the Trust.	Deploying resources in a sustainable manner	<p>The Trust achieved its control total and triggered STF funding which is reflected in the final adjusted retained deficit of £26.7m. The Trust has made significant improvements in both controlling expenditure and increasing income levels. Addressing the cost base has been a priority. As part of this process the Trust has reduced spend on temporary staff by £6m. This, combined with other actions to control costs and generate income has led to an over delivery of the Trusts CIP programme by £2.7m (£14.7m outturn compared to £12m plan). These factors are a significant improvement on prior years, demonstrating improvements in controlling the Trust's expenditure, and managing its finances to plan.</p> <p>The future strategic direction of the Trust has started to become clearer with it remaining a stand-alone organisation rather than being merged. With partners there is an intent to work towards an ACO model. The Trust also now forms part of the Hertfordshire and West Essex Sustainability and Transformational Plan (STF). This footprint is developing a number of clinical workstreams for efficiency and patient benefit. As part of this work the Trust is continuing closer collaborative working with E&N Herts NHS Trust. The ACO plan is only slowly starting to emerge, and there is a significant way to go.</p> <p>The Trust received permission to produce a Strategic Outline Case during the year to examine the feasibility of a new hospital site and/or a Health and Social Care campus. This is being produced taking account of demand and capacity forecasts, and the clinical workstreams mentioned above. All of these factors demonstrate an improving direction of travel for the Trust compared to the prior year.</p> <p>However, £26.7m is still a significant deficit. The cumulative deficit is now £100m, and is expected to increase in the next two years with deficit budgets for that period. There is still no plan for a return to annual, or cumulative balance and the plans for an ACO and the case for a new hospital site are yet to be progressed sufficiently to be clear how these will impact the future finances. Therefore, there are still significant weaknesses in the Trust's arrangements.</p>



VFM risks

What is the significant VFM risk?	What arrangements did this impact?	What are our findings?
<p>The CQC re-inspected the Trust in June and July 2016. This resulted in an 'inadequate' rating, and the Trust was put into special measures in October 2016.</p> <p>The CQC raised a number of issues that cut across the VFM criterion and categories of the expected arrangements.</p> <p>Our approach focused on the Trust's response to the CQC inspection.</p>	<p>Taking informed decisions Deploying resources in a sustainable manner Working with partners and other third parties</p>	<p>The Trust has put in place arrangements to respond to the CQC's findings and recommendations, and to improve quality.</p> <p>The Trust has put in place a Quality Improvement Plan (QIP), Quality First.</p> <p>Governance responsibilities have been reviewed, these include a RAG monitoring system introduced to monitor the implementation of required actions and a Risk Management Group. The timetable for completion of the actions within the QIP range from short-term immediate actions, to a much longer term targets. This recognises, as did the CQC in their report, some of the underlying issues the Trust needs to address, such as the review of its Estate.</p> <p>As at the end of the financial year the Trust is still in special measures</p>

Overall Conclusion

In 2015/16 we issued our adverse conclusion based around key factors including the significant financial deficit and overspends, and lack of clear strategic direction for the Trust as an organisation and including its primary hospital location and estate. Addressing these issues was unlikely to be a short term process.

Since that conclusion, the Trust was rated inadequate by the CQC and put into special measures, under which it remains as at the end of the year.

While we recognise progress compared to the prior year in controlling costs, the Trust's financial position is still a significant annual and cumulative deficit with no plans to return to annual financial balance. We have seen that a clearer strategic direction for the Trust is starting to emerge, but this has not progressed significantly to be able to clearly articulate the future model of services and location, and their impact on the Trust's finances.

Therefore, while wishing to recognise progress being made, we are still of the view that there are significant weaknesses in the Trust's arrangements, and consequently we intend to issue an adverse value for money conclusion on the Trust's arrangements as at 31 March 2017.



07

Other reporting issues

CAUTION: Federal law prohibits the transfer of this drug to
anyone other than the patient for whom it was prescribed.

Other reporting issues

Annual Report including Annual Governance Statement

We are required to give an opinion on the consistency of the Annual Report and other information published with the financial statements and the parts of the remuneration report that are required to be audited. We are also required to review the Annual Governance Statement for completeness of disclosures, consistency with other information we are aware of from our work and whether it complies with relevant guidance.

We noted an improvement in the overall arrangements for producing the 2016/17 Annual Report. The structure of the document clearly followed the guidance in the Group Accounting Manual. Financial information within the Annual Report published with the financial statements was consistent with the Annual Accounts. We noted during our review of the Annual Report that the section on sustainability did not follow the reporting template issued by the Sustainable Delivery Unit (SDU) for NHS trusts. The template has been developed to assist Trusts in making the mandated disclosures. We are aware that the Trust's Estates section has had a number of staff changes and that the post of Director of Estates and Facilities is currently vacant. The template provided by the SDU for NHS trusts is required to be completed by 31 May. Since raising this issue with the Trust steps have been taken to agree an extension to the deadline for the submission to the SDU to mid- June. The Trust's Annual Governance Statement has been updated to reflect the non-compliance. We have suggested that the Trust may wish to consider separate publication of the sustainability information on the Trust web site once this has been completed.

The remuneration and staff report was prepared properly and within the rules set and we had no matters to report although a number of changes were required to the remuneration tables from the original version provided.

We have reviewed the Annual Governance Statement and can confirm it is consistent with other information that we are aware of from our audit of the financial statements and we have no other matters to report

Whole of Government Accounts

Alongside our work on the financial statements, we also report to the Trust on differences, within a tolerance of £250,000, between the Trust's consolidation schedules and the audited financial statements. We also report to the NAO under its group instructions.

We are currently concluding our work in this area and will report any matters that arise to the Audit Committee.

Other reporting issues

Other powers and duties

We must report to the Secretary of State any matter where we believe a decision has led to, or would lead to, unlawful expenditure, or some action has been, or would be, unlawful and likely to cause a loss or deficiency.

We reported to the Secretary of State on 17 May 2016 the Trust's failure to meet its statutory breakeven duty as at 31 March 2016. Within that report we also referred to the Trust's deficit budget for 2016/17. We therefore were not required to make any further referral in respect of 2016/17, but continue to draw attention to the previous referral in our Audit Report on the 2016/17 financial statements.

We also have a duty under the Local Audit and Accountability Act 2014 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public. We did not identify any issues which required us to issue a report in the public interest.

Other matters

As required by ISA (UK&I) 260 and other ISAs specifying communication requirements, we are required to communicate to you significant findings from the audit and other matters that are significant to your oversight of the Trust's financial reporting process, including the following:

- ▶ Significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures;
- ▶ Significant difficulties, if any, encountered during the audit;
- ▶ Significant matters, if any, arising from the audit that were discussed with management;
- ▶ Written representations we are seeking;
- ▶ Expected modifications to the audit report;
- ▶ Other matters if any, significant to the oversight of the financial reporting process;
- ▶ Related parties;
- ▶ External confirmations;
- ▶ Consideration of laws and regulations.

During the audit we found that the quality of the accounts had improved over the prior year. There was also access to more working papers and supporting documents in electronic format and this helped the efficiency of the audit.



08

Assessment of Control Environment



Assessment of control environment

Financial controls

It is the responsibility of the Trust to develop and implement systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. Our responsibility as your auditor is to consider whether the Trust has put adequate arrangements in place to satisfy itself that the systems of internal financial control are both adequate and effective in practice.

As part of our audit of the financial statements, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed.

Although our audit was not designed to express an opinion on the effectiveness of internal control we are required to communicate to you significant deficiencies in internal control. There are no significant deficiencies. We make other control observations below.

Reliance on Internal audit

As in the previous year we adopted a largely substantive approach to our audit, with the exception of some reliance over authorisation controls of accounts payable transactions and expenditure with NHS Professionals. We were able to place reliance on the work of Internal Audit on accounts payable.

Payroll

We initially planned to undertake a controls approach and place reliance on the work of Internal Audit for our audit strategy for payroll. The Trust's payroll internal audit was given a 'reasonable assurance' rating. However, Internal Audit's testing found that for two of their sample where changes had been implemented to staff pay there was no evidence of authorisation by an appropriate manager of the change. This meant that we had to revert to a substantive audit approach. The Trust has responded to the recommendations by Internal Audit and the Workforce team will ensure that starter/leaver/change forms are appropriately authorised before they are sent to Payroll.

Plant and equipment verification

The Trust seeks to undertake a fixed asset verification exercise for its plant and equipment assets (net book value in excess of £16.9 million). Not all departments submitted their returns ahead of the audit. We selected a sample of 18 items to verify during our on site work. Three of these could not be found and for two of these it was established that they had been disposed of. As their net book value was nil we assessed that there was no net impact on the Trust's statement of financial position although the gross value for the cost and depreciation of assets shown in the fixed asset movement note was overstated by £114k for these assets and we assess that for all net book value assets on the register the amount could be £0.9m.

Verification is an important control over a material element of the Trust's asset base. We would suggest that departments are reminded of the requirement to provide information on a timely basis.



9

Appendices



Appendix A

Required communications with the Audit Committee

There are certain communications that we must provide to the Audit Committee of UK clients. We have detailed these here together with a reference of when and where they were covered:

Required communications	What is reported?	Our Reporting to you	
		  When and where	
Terms of engagement	Confirmation by the Audit Committee of acceptance of terms of engagement as written in the engagement letter signed by both parties.		The statement of responsibilities serves as the formal terms of engagement between the PSAA's appointed auditors and audited bodies.
Planning and audit approach	Communication of the planned scope and timing of the audit, including any limitations.		2 March 2017 Audit Plan
Significant findings from the audit	<ul style="list-style-type: none">▶ Our view about the significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures▶ Significant difficulties, if any, encountered during the audit▶ Significant matters, if any, arising from the audit that were discussed with management▶ Written representations that we are seeking▶ Expected modifications to the audit report▶ Other matters if any, significant to the oversight of the financial reporting process▶ Findings and issues regarding the opening balance on initial audits (delete if not an initial audit)		30 May 2017 Audit Results Report
Going concern	Events or conditions identified that may cast significant doubt on the entity's ability to continue as a going concern, including: <ul style="list-style-type: none">▶ Whether the events or conditions constitute a material uncertainty▶ Whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements▶ The adequacy of related disclosures in the financial statements		30 May 2017 Audit Results Report



Appendix A

		 Our Reporting to you
Required communications	 What is reported?	 When and where
Misstatements	<ul style="list-style-type: none">▶ Uncorrected misstatements and their effect on our audit opinion▶ The effect of uncorrected misstatements related to prior periods▶ A request that any uncorrected misstatement be corrected▶ In writing, corrected misstatements that are significant	30 May 2017 Audit Results Report
Fraud	<ul style="list-style-type: none">▶ Enquiries of the Audit Committee to determine whether they have knowledge of any actual, suspected or alleged fraud affecting the entity▶ Unless all of those charged with governance are involved in managing the entity, any fraud that we have identified or information we have obtained that indicates that a fraud may exist involving:<ul style="list-style-type: none">(a) management;(b) employees who have significant roles in internal control; or(c) others where the fraud results in a material misstatement in the financial statements.▶ A discussion of any other matters related to fraud, relevant to Audit Committee responsibility.	We have made enquiries of management and those charged with governance. We have not become aware of any fraud or illegal acts during our audit
Related parties	Significant matters arising during the audit in connection with the entity's related parties including, when applicable: <ul style="list-style-type: none">▶ Non-disclosure by management▶ Inappropriate authorisation and approval of transactions▶ Disagreement over disclosures▶ Non-compliance with laws and regulations▶ Difficulty in identifying the party that ultimately controls the entity	We have no matters we wish to report
Subsequent events	<ul style="list-style-type: none">▶ Enquiry of the Audit Committee where appropriate regarding whether any subsequent events have occurred that might affect the financial statements.	We have made enquiries of management and those charged with governance. We have no matters we wish to report
Other information	<ul style="list-style-type: none">▶ Where material inconsistencies are identified in other information included in the document containing the financial statements and management refuses to make the revision.	We have no matters we wish to report



Appendix A

		Our Reporting to you	
Required communications	What is reported?	When and where	
External confirmations	<ul style="list-style-type: none"> ▶ Management's refusal for us to request confirmations ▶ Inability to obtain relevant and reliable audit evidence from other procedures. 	At the time of drafting this report we had not received confirmation from the Trust's bankers of bank account balances. We have therefore undertaken alternative procedures	
Consideration of laws and regulations	<ul style="list-style-type: none"> ▶ Audit findings regarding non-compliance where the non-compliance is material and believed to be intentional. This communication is subject to compliance with legislation on tipping off ▶ Enquiry of the Audit Committee into possible instances of non-compliance with laws and regulations that may have a material effect on the financial statements and that the Audit Committee may be aware of. 	We have made enquiries of management and those charged with governance. We have not identified any material instances or non-compliance with laws and regulations	
Significant deficiencies in internal controls identified during the audit	<ul style="list-style-type: none"> ▶ Significant deficiencies in internal controls identified during the audit. 	30 May 2017 Audit Results Report	
Independence	<p>Communication of all significant facts and matters that bear on EY's objectivity and independence.</p> <p>Communication of key elements of the audit engagement partner's consideration of independence and objectivity such as:</p> <ul style="list-style-type: none"> ▶ The principal threats ▶ Safeguards adopted and their effectiveness ▶ An overall assessment of threats and safeguards ▶ Information about the general policies and process within the firm to maintain objectivity and independence <p>Communications whenever significant judgments are made about threats to objectivity and independence and the appropriateness of safeguards put in place,</p>	30 May 2017 Audit Results Report	
Fee Reporting	<p>Breakdown of fee information at the agreement of the initial audit plan</p> <p>Breakdown of fee information at the completion of the audit</p> <p>Any non-audit work undertaken</p>	30 May 2017 Audit Results Report	



Appendix B

Independence

We confirm there are no changes in our assessment of independence since our confirmation in our audit planning board report dated January.

We complied with the APPB Ethical Standards and the requirements of the PSAA's Terms of Appointment. In our professional judgement the firm is independent and the objectivity of the audit engagement partner and audit staff has not been compromised within the meaning of regulatory and professional requirements.

We consider that our independence in this context is a matter that should be reviewed by both you and ourselves. It is therefore important that you and your Audit Committee consider the facts of which you are aware and come to a view. If you wish to discuss any matters concerning our independence, we will be pleased to do so at the forthcoming meeting of the Audit Committee on 30 May 2017.

We confirm we have undertaken non-audit work outside of the PSAA Code requirements in relation to our work on the Quality Accounts. We have adopted the necessary safeguards in our completion of this work.

As part of our reporting on our independence, we set out below a summary of the fees you have paid us in the year ended 31 March 2017.

We incurred some additional costs in respect of payroll testing and will be agreeing our outturn fee with the Chief Financial Officer, the figure asterisked in the table below is the planned fee including an amount of £3,600 for this additional cost. Any additional fee has to be agreed with the Chief Financial Officer and PSAA.

We confirm that we have undertaken non-audit work outside of the PSAA Code requirements on the Trust's Quality Account. Non audit work is work not carried out under the Code. We have adopted the necessary safeguards in our completion of this work and complied with Auditor Guidance Note 1 issued by the NAO in December 2016.

Description	Final fee 2016/17 £	Planned fee 2016/17 £	Scale fee 2016/17 £	Final fee 2015/16 £
Total Audit fee - Code work	*58,773	55,173	55,173	60,946
Non-audit work - Quality Accounts	10,000	10,000	-	10,000



Appendix C

Outstanding matters

The following items relating to the completion of our audit procedures are outstanding at the date of the release of this report:

Item	Actions to resolve	Responsibility
Management representation letter	Receipt of signed management representation letter	Management
Subsequent events review	Completion of subsequent events procedures to the date of signing the audit report	EY and management
Resolution of outstanding queries from testing.	In progress	EY and management
Review of the final version of the financial statements	In progress	EY



Appendix D

Management representation letter

Management Rep Letter

Kevin Suter
Executive Director
Ernst & Young
400 Capability Green
Luton
LU1 3LU

Dear Mr Suter

This letter of representations is provided in connection with your audit of the financial statements of The Princess Alexandra Hospital NHS Trust ("the Trust") for the year ended 31 March 2017. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the financial statements give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as of 31 March 2017 and of its financial performance (or operations) and its cash flows for the year then ended in accordance with the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM).

We understand that the purpose of your audit of our financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing (UK and Ireland), which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:



Appendix D

A. Financial Statements and Financial Records

1. We have fulfilled our responsibilities, under the relevant statutory authorities, for the preparation of the financial statements in accordance with the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM).
2. We acknowledge, as members of management of the Trust our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance (or results of operations) and cash flows of the Trust in accordance with Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM), and are free of material misstatements, including omissions. We have approved the financial statements.
3. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.
4. As members of management of the Trust, we believe that the Trust has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM) that are free from material misstatement, whether due to fraud or error.
5. There are no unadjusted audit differences identified during the current audit and pertaining to the latest period presented.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.
2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
3. We have disclosed to you all significant facts relating to any frauds, suspected frauds or allegations of fraud known to us that may have affected the Trust (regardless of the source or form and including, without limitation, allegations by "whistle-blowers"), whether involving management or employees who have significant roles in internal control. Similarly, we have disclosed to you our knowledge of frauds or suspected frauds affecting the entity involving others where the fraud could have a material effect on the financial statements. We have also disclosed to you all information in relation to any allegations of fraud or suspected fraud communicated by employees, former employees, analysts, regulators or others, that could affect the financial statements.

C. Compliance with Laws and Regulations

1. We have disclosed to you all identified or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements

D. Information Provided and Completeness of Information and Transactions

We have provided you with:

- ▶ Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- ▶ Additional information that you have requested from us for the purpose of the audit; and
- ▶ Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.



Appendix D

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.
3. We have made available to you all minutes of the meetings of the Trust Board, and Audit committee (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the year to the most recent meeting on the following date: 25 May 2017.
4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.
5. We believe that the significant assumptions we used in making accounting estimates, including those measured at fair value, are reasonable.
6. We have disclosed to you, and the Trust has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.
2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.
3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent.

F. Subsequent Events

1. Other than as described in Note 27 to the financial statements, there have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Agreement of Balances and key judgments

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counter-parties irrespective of whether or not they have been included in the 2016/17 Agreement of Balances Exercise
2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.
3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust's reported financial outturn for financial year ended 31 March 2017.

H. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the annual report.
2. We confirm that the content contained within the other information is consistent with the financial statements.



Appendix D

I. Segmental reporting

1. We have reviewed the operating segments reported internally to the Board and We are satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8:Operating Segments, they are similar in each of the following respects:
 - ▶ The nature of the products and services
 - ▶ The nature of the production processes
 - ▶ The type or class of customer for their products and services
 - ▶ The methods used to distribute their products

J. Going Concern

1. Note 1.1 to the financial statements discloses all of the matters of which we are aware that are relevant to the Trust's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

K. Use of the Work of a Specialist

1. We agree with the findings of the specialists that we engaged to evaluate the value of the Trust's land and buildings and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

L. Estimates

Land and Buildings Valuation Estimate

1. We believe that the measurement processes, including related assumptions and models, used to determine the accounting estimate have been consistently applied and are appropriate in the context of the applicable financial reporting framework.
2. We confirm that the significant assumptions used in making the Land and Buildings Valuation Estimate appropriately reflect our intent and ability to carry out the delivery of services from the sites valued.
3. We confirm that the disclosures made in the financial statements with respect to the accounting estimates are complete and made in accordance with the applicable financial reporting framework.
4. We confirm that no adjustments are required to the accounting estimate and disclosures in the financial statements due to subsequent events.

Yours sincerely,



Appendix D

Simon Covill (Acting Chief Financial Officer)

Stephen Bright (Chairman of the Audit Committee)

About EY

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ED None

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The Princess Alexandra Hospital NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. 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 with the approval of the Treasury 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.

I confirm that, 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 Trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed.....  Acting Chief Executive

Date 30/5/2017

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 the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

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

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

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

By order of the Board

30/5/2017.....Date..... ..... Acting Chief Executive

30/5/2017.....Date..... ..... Acting Chief Financial Officer

**Statement of Comprehensive Income for year ended
31 March 2017**

	Note	2016/17 £000's	2015/16 £000's
Gross employee benefits	8.1	(149,977)	(148,150)
Other operating costs	6	(83,420)	(82,125)
Revenue from patient care activities	3	187,056	184,461
Other operating revenue	4	22,686	11,663
Operating Deficit		(23,655)	(34,151)
Investment revenue	10	161	21
Finance costs	11	(1,129)	(326)
Deficit for the financial year		(24,623)	(34,456)
Public dividend capital dividends payable		(2,396)	(3,498)
Retained Deficit for the year		(27,019)	(37,954)

Other Comprehensive Income

	2016/17 £000's	2015/16 £000's
Net gain on revaluation of property, plant & equipment	5,615	9,108
Total comprehensive income for the year	(21,404)	(28,846)

Financial performance for the year

Retained Deficit for the year	(27,019)	(37,954)
Impairments (excluding IFRIC 12 impairments)	252	171
Adjustments in respect of donated govt grant asset reserve elimination		
Adjusted Retained Deficit	52	69
	(26,715)	(37,714)

The notes on pages 66 to 91 form part of these Accounts.

**Statement of Financial Position as at
31 March 2017**

		31 March 2017	31 March 2016
	Note	£000's	£000's
Non-current assets:			
Property, plant and equipment	13	136,668	127,916
Intangible assets	14	12,177	13,649
Total non-current assets		148,845	141,565
Current assets:			
Inventories	17	4,114	4,407
Trade and other receivables	18.1	15,764	15,681
Cash and cash equivalents	19	3,416	1,524
Total current assets		23,294	21,612
Total assets		172,139	163,177
Current liabilities:			
Trade and other payables	20	(27,393)	(28,527)
Provisions	24	(671)	(1,336)
Borrowings	21	(177)	(238)
DH revenue support loan	21	0	(300)
Total current liabilities		(28,241)	(30,401)
Net current liabilities		(4,947)	(8,789)
Total assets less current liabilities		143,898	132,776
Non-current liabilities:			
Provisions	24	(840)	(1,037)
Borrowings	21	(24)	(286)
DH revenue support loan	21	(69,019)	(39,054)
Total non-current liabilities		(69,883)	(40,377)
Total assets employed:		74,015	92,399
FINANCED BY:			
Public Dividend Capital		125,912	122,912
Retained earnings		(105,576)	(78,623)
Revaluation reserve		53,679	48,110
Total Taxpayers Equity:		74,015	92,399

The notes on pages 66 to 91 form part of these Accounts.

The financial statements on pages 62 to 65 were approved by the Board of Directors on 30 May 2017 and signed on its behalf by

Acting Chief Executive:



Date: *30/05/2017*

Statement of Changes in Taxpayers Equity
For the year ending 31 March 2017

	Public Dividend capital £000's	Retained earnings £000's	Revaluation reserve £000's	Total reserves £000's
Balance at 1 April 2016	122,912	(78,623)	48,110	92,399
Changes in taxpayers equity for 2016/17				
Retained deficit for the year	0	(27,019)	0	(27,019)
Net gain on revaluation of property, plant, equipment	0	0	5,615	5,615
Transfers between reserves	0	59	(59)	0
Reclassification Adjustments				
Temporary and permanent PDC received - cash	3,000	0	0	3,000
Other movements	0	7	13	20
Net recognised revenue/(expense) for the year	3,000	(26,953)	5,569	(18,384)
Balance at 31 March 2017	125,912	(105,576)	53,679	74,015
 Balance at 1 April 2015	 124,892	 (40,683)	 38,840	 123,049
Changes in taxpayers equity for the year ended 31 March 2016				
Retained deficit for the year	0	(37,954)	0	(37,954)
Net gain on revaluation of property, plant, equipment	0	0	9,108	9,108
Transfers between reserves	0	14	(14)	0
Reclassification Adjustments				
New PDC received - cash	1,020	0	0	1,020
PDC repaid in year	(3,000)	0	0	(3,000)
Other movements	0	0	176	176
Net recognised revenue/(expense) for the year	(1,980)	(37,940)	9,270	(30,650)
Balance at 31 March 2016	122,912	(78,623)	48,110	92,399

Information on reserves

1. Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS Trusts by the Department of Health (DH). A charge, reflecting the cost of capital utilised by the NHS Trust, is payable to the DH as the public dividend capital dividend.

2. Income and expenditure reserve

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

3. Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Statement of Cash Flows for the Year ended 31 March 2017

	Note	2016/17 £000's	2015/16 £000's
Cash Flows from Operating Activities			
Operating deficit		(23,655)	(34,151)
Depreciation and amortisation	6	8,586	6,831
Impairments and reversals	15	252	171
Decrease in Inventories		293	115
(Increase)/Decrease in Trade and Other Receivables		(83)	(2,689)
Increase/(Decrease) in Trade and Other Payables		(3,604)	8,984
Provisions utilised		(493)	(1,865)
Decrease in movement in non cash provisions		(379)	(69)
Net Cash Outflow from Operating Activities		(19,083)	(22,673)
Cash Flows from Investing Activities			
Interest Received		161	21
Payments for Property, Plant and Equipment		(7,599)	(8,126)
Payments for Intangible Assets		(434)	(1,516)
Rental Revenue		132	0
Net Cash Outflow from Investing Activities		(7,740)	(9,621)
Net Cash Outflow before Financing		(26,823)	(32,294)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		3,000	1,020
Gross Temporary and Permanent PDC Repaid		0	(3,000)
Loans received from DH - New Revenue Support Loans		50,922	54,754
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		(21,257)	(16,300)
Other Loans Repaid		(211)	(256)
Capital Element of Payments in Respect of Finance Leases		(52)	(224)
Interest paid		(1,022)	(326)
PDC Dividend paid		(2,665)	(3,558)
Net Cash Inflow from Financing Activities		28,715	32,110
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		1,892	(184)
Cash and Cash Equivalents at Beginning of the Period		1,524	1,708
Cash and Cash Equivalents at Year End	19	3,416	1,524

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of Trust's shall meet the accounting requirements of the DH Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016/17 issued by the DH. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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.

Going Concern

These Accounts have been prepared on a going concern basis

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

In approving the Trust's Annual Accounts the Board of Directors has had to satisfy itself that the Trust has prepared the Accounts on the basis of going concern recognising the following:-

- The Board considers the Trust operates a significant portfolio of clinical services. The Trust's Commissioners have not informed the Trust of transfers of significant services and indeed are supporting repatriation of activity to the Trust.
- The Trust has cost improvement plans in place to reduce its deficit.
- The Trust has included £27m of capital requirements in its 2017/18 operating plan which includes £19m of strategic capital requests. In addition the Trust has commissioned the development of a Strategic Outline Business Case (SOC) which is considering a number of site redevelopment options.
- The Trust has submitted a deficit plan to NHS Improvement (NHSI) totalling £21.6m in 2017/18. This plan is supported by the request to receive Interim Revenue Support loans to the value of the forecast deficit. The Trust is also planning to receive Sustainability and Transformation funding in 2017/18 (£7.5m).

The Board of Directors has carefully considered the principle of 'going concern' and recognises that there are material uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Nevertheless, interim financial support has continued to be received as planned in the early part of 2017/18 and the Board of Directors concludes the Trust has a reasonable expectation that the Trust will continue to have access to adequate cash financing to meet its liabilities and continue to provide the planned range of clinical services in the foreseeable future. On that basis and for the reasons outlined above the Board of Directors considers it is appropriate to prepare the 2016/17 Accounts on

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

NOTES TO THE ACCOUNTS

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.

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical judgements in applying accounting policies

The following are the critical 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 going concern basis (see note 1.1)

- Classification of leases as finance or operating. 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 lease term, the level of risk transfer between lessor and lessee, 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 payments is substantially all of the fair value of the asset.

1.4.2 Key sources of estimation uncertainty

The following are key areas where estimation uncertainty at the end of the reporting period have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities in future accounting periods.

Provisions

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

Public liability claims are based on information received from the NHS Litigation Authority (NHS LA), which handles claims on behalf of the Trust. For cases not yet concluded, provision is made according to the NHS LA view on the expected outcome.

Pension provisions are based on information received from the NHS Business Services Authority.

Other provisions for legal and constructive obligations are made by management and/or informed by professional opinion. Provisions are made where past events are known and settlement by the Trust is probable and a reliable estimate can be made. As actual settlement is not known at the reporting date provisions are calculated on the best information available on likely settlement at the date the Accounts are approved. Note 24 provides more detail on provisions.

Accruals

At the end of each accounting period, management review expenditure items that are outstanding and estimate the amount to be accrued in the closing 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.

NOTES TO THE ACCOUNTS

Receivables

Included in receivables are estimates made for bad debts and accrued income for partially completed spells. The Trust has adhered to guidance stipulated in the DH Group Accounting Manual 2016/17 and relevant financial standards in applying estimates to receivables. The Trust estimated the level of recovery of its non NHS receivables and made allowances for the expected level of impairments to those receivables in Note 18.3 of the Accounts. Actual outcomes may differ from these estimates.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

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 e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions' Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.6 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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

Retirement benefit 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 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.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

NOTES TO THE ACCOUNTS

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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 that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost basis.

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

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

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

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

NOTES TO THE ACCOUNTS

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.10 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

NOTES TO THE ACCOUNTS

The following summarises the range of minimum and maximum useful lives applied by asset category:

	Min - Max	Life (yrs)
Building and Dwellings		0-63
Plant and Machinery		2-15
Furniture and Fittings		0-8
Transport Equipment		0-7
Information Technology		0-5
In House Information Technology & third party software		0-5
Development Expenditure		0-8

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

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

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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 so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

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

NOTES TO THE ACCOUNTS

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates as follows:

	2016/17	2015/16
Early retirement provisions are discounted using HM Treasury's pension discount rate:	Positive 0.24%	Positive 1.37%
All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:		
A short term rate for expected cash flows up to and including 5 years:	Minus 2.70%	Minus 1.55%
A medium term rate for expected cash flows over 5 years up to and including 10 years:	Minus 1.95%	Minus 1.00%
A long term rate for expected cash flows over 10 years:	Minus 0.80%	Minus 0.80%

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 24.

1.17 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 the NHS Litigation Authority 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 as and when they become due.

NOTES TO THE ACCOUNTS

1.18 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the Trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.19 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.20 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

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

NOTES TO THE ACCOUNTS

1.21 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the DH are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from DH, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 Value Added Tax

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.

1.23 Foreign currencies

The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March 2017. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.24 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.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the DH as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

NOTES TO THE ACCOUNTS

1.26 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.27 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.28 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

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

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.

3. Revenue from patient care activities

	2016/17 £000's	2015/16 £000's
NHS Trusts	1,946	1,200
NHS England	15,214	14,921
Clinical Commissioning Groups	167,815	159,656
Foundation Trusts	56	177
DH	0	4
NHS Other (including Public Health England and Prop Co)	718	0
Additional income for delivery of healthcare services	0	3,000
Non-NHS:		
Local Authorities	339	2,248
Private patients	335	276
Overseas patients (non-reciprocal)	12	46
Injury costs recovery	566	740
Other Non-NHS patient care income	55	2,193
Total Revenue from patient care activities	187,056	184,461

4. Other operating revenue

	2016/17 £000's	2015/16 £000's
Education, training and research	6,417	5,729
Receipt of charitable donations for capital acquisitions	5	0
Non-patient care services to other bodies	3,535	2,789
Sustainability & Transformation Fund income	9,998	0
Income generation (Other fees and charges)	2,266	2,166
Rental revenue from operating leases	132	132
Other revenue	333	847
Total Other operating revenue	22,686	11,663
Total operating revenue	209,742	196,124

Sustainability & Transformation Fund Income has been confirmed by NHS Improvement (£9,998k). (2015/16 Nil)

5. Overseas Visitors Disclosure

	2016/17 £000's	2015/16 £000's
Income recognised (invoiced amounts and accruals)	12	46
Cash payments received in-year relating to receivables at previous year end	42	19
Cash payments received in-year relating to invoices issued in the year	4	42
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	17	47
Amounts written off in-year (irrespective of year of recognition)	22	0

6. Operating Expenses

	2016/17 £000's	2015/16 £000's
Services from other NHS Trusts	969	951
Services from CCGs/NHS England	0	0
Services from other NHS bodies	954	522
Services from NHS Foundation Trusts	1,636	816
Total Services from NHS bodies*	3,559	2,289
*Services from NHS bodies does not include expenditure which falls into a category below.		
Purchase of healthcare from non-NHS bodies	5,680	4,681
Trust Chair and Non-executive Directors	55	53
Supplies and services - clinical	35,823	35,748
Supplies and services - general	3,098	3,671
Consultancy and professional services	2,139	3,339
Establishment	2,157	1,901
Transport	133	187
Business rates paid to local authorities	860	932
Premises	8,832	9,177
Impairments and Reversals of Receivables	(172)	1,209
Inventories write down	147	65
Depreciation	6,809	6,382
Amortisation	1,777	449
Impairments and reversals of property, plant and equipment	252	171
Internal Audit Fees	99	55
Audit fees	64	66
Other auditor's remuneration	11	12
Clinical negligence	10,804	9,821
Education and Training	509	610
Change in Discount Rate	11	0
Other	773	1,307
Total Operating Expenses (excluding employee benefits)	83,420	82,125
Employee Benefits		
Employee benefits excluding Board members	148,560	146,875
Board members	1,417	1,275
Total Employee Benefits	149,977	148,150
Total Operating Expenses	233,397	230,275

7. Operating Leases

7.1. The Princess Alexandra Hospital NHS Trust as lessee

	Land £000's	Buildings £000's	Other £000's	2016/17 Total £000's	2015/16 £000's
Payments recognised as an expense					
Minimum lease payments				1,313	2,177
Contingent rents				0	0
Sub-lease payments				0	0
Total				1,313	2,177
Payable:					
No later than one year	0	770	91	861	971
Between one and five years	0	2,351	157	2,508	2,985
After five years	0	2,123	0	2,123	2,357
Total	0	5,244	248	5,492	6,313

7.2. The Princess Alexandra Hospital NHS Trust as lessor

	2016/17 £000's	2015/16 £000's
Recognised as revenue		
Rental revenue	132	132
Total	132	132
Receivable:		
No later than one year	132	132
Between one and five years	527	527
After five years	791	923
Total	1,450	1,582

8. Employee benefits

8.1. Employee benefits

	2016/17	2015/16
	Total	Total
	£000's	£000's
Employee Benefits - Gross Expenditure		
Salaries and wages	129,133	129,295
Social security costs	10,035	8,967
Employer Contributions to NHS BSA - Pensions Division	12,082	11,577
Termination benefits	13	364
Total employee benefits	151,263	150,203
Employee costs capitalised	1,286	2,053
Gross Employee Benefits excluding capitalised costs	149,977	148,150

8.2. Retirements due to ill-health

	2016/17	2015/16
	Number	Number
	£000's	£000's
Number of persons retired early on ill health grounds	3	1
Total additional pensions liabilities accrued in the year	86	0

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

8.3. 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 in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

9. Better Payment Practice Code

9.1. Measure of compliance

	2016/17 Number	2016/17 £000's	2015/16 Number	2015/16 £000's
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	48,282	85,479	42,896	81,672
Total Non-NHS Trade Invoices Paid Within Target	16,043	38,525	14,714	28,817
Percentage of NHS Trade Invoices Paid Within Target	33.23%	45.07%	34.30%	35.28%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,130	16,654	1,754	12,136
Total NHS Trade Invoices Paid Within Target	486	5,710	748	4,914
Percentage of NHS Trade Invoices Paid Within Target	22.82%	34.29%	42.65%	40.49%

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

9.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016/17 £000's	2015/16 £000's
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

10. Investment Revenue

	2016/17 £000's	2015/16 £000's
Investment Revenue		
Bank interest	24	21
Other financial assets	137	0
Total investment revenue	161	21

11. Finance Costs

	2016/17 £000's	2015/16 £000's
Interest		
Interest on loans and overdrafts	1,130	267
Interest on obligations under finance leases	0	4
Total interest expense	1,130	271
Other finance costs	0	41
Provisions - unwinding of discount	(1)	14
Total	1,129	326

12. Finance Costs

12.1. Other auditor remuneration

	2016/17 £000's	2015/16 £000's
Other auditor remuneration paid to the external auditor:		
Other assurance service - review of Quality Account	11	12
Total	11	12

13 Property, Plant and Equipment
13.1. Property, Plant and Equipment current year

	Land £'000's	Buildings excluding dwellings £'000's	Dwellings £'000's	Assets under construction & payments on account £'000's	Plant & machinery £'000's	Transport equipment £'000's	Information technology £'000's	Furniture & fittings £'000's	Total £'000's
2016/17									
Cost or valuation:									
At 1 April 2016	15,568	96,924	0	110	25,186	170	18,808	1,488	158,254
Additions of Assets Under Construction	0	0	0	1,038	0	0	0	0	1,038
Additions Purchased	0	3,590	0	0	3,172	20	2,373	0	9,155
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	5	0	0	0	5
Reclassifications	0	115	0	(115)	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(660)	0	(2,363)	(53)	(3,076)
Revaluation	3,007	(449)	0	0	0	0	0	0	2,558
Impairments/reversals charged to operating expenses	0	(132)	0	0	(4)	0	(116)	0	(252)
At 31 March 2017	18,575	100,048	0	1,033	27,699	190	18,702	1,435	167,682
Depreciation									
At 1 April 2016	0	0	0	0	16,968	158	11,787	1,425	30,338
Disposals other than for sale	0	0	0	0	(660)	0	(2,363)	(53)	(3,076)
Revaluation	0	(3,057)	0	0	0	0	0	0	(3,057)
Charged During the Year	0	3,057	0	0	2,139	3	1,597	13	6,809
At 31 March 2017	18,575	100,048	0	0	18,447	161	11,021	1,385	31,014
Net Book Value at 31 March 2017	18,575	100,048	0	1,033	9,252	29	7,681	50	136,668
Asset financing:									
Owned - Purchased	18,575	100,048	0	1,033	9,028	29	7,681	50	136,444
Owned - Donated	0	0	0	0	105	0	0	0	105
Held on finance lease	0	0	0	0	119	0	0	0	119
Total at 31 March 2017	18,575	100,048	0	1,033	9,252	29	7,681	50	136,668
Revaluation Reserve Balance for Property, Plant & Equipment									
Additions to Assets Under Construction in 2016/17									
Buildings excl Dwellings	4,797	42,846	0	0	324	5	45	93	48,110
Movements	3,006	2,622	0	0	(25)	0	(31)	(3)	5,569
At 31 March 2017	7,803	45,468	0	0	299	5	14	90	53,679
Buildings as at YTD									
Plant & Machinery									184
									854
									1,038

13.2. Property, plant and equipment prior-year

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
2015/16									
Cost or valuation:									
At 1 April 2015	15,428	89,385	0	0	24,917	170	15,575	1,508	146,983
Additions Purchased	0	1,536	0	110	0	0	0	0	110
Disposals other than for sale	0	(8)	0	0	1,817	0	3,260	1	6,614
Revaluation	140	6,174	0	0	(1,540)	0	(27)	(21)	(1,596)
Impairment/reversals charged to reserves	0	(163)	0	0	0	0	0	0	6,314
At 31 March 2016	15,568	96,924	0	110	25,186	170	18,808	0	(171)
Depreciation									
At 1 April 2015	0	0	0	0	16,315	156	10,447	1,428	28,346
Disposals other than for sale	0	(8)	0	0	(1,540)	0	(27)	(21)	(1,596)
Revaluation	0	(2,794)	0	0	0	0	0	0	(2,794)
Charged During the Year	0	2,802	0	0	2,193	2	1,367	18	6,382
At 31 March 2016	15,568	96,924	0	110	8,218	12	11,781	1,425	30,338
Net Book Value at 31 March 2016									
Asset financing:									
Owned - Purchased	15,568	96,924	0	110	7,837	12	6,984	63	127,498
Owned - Donated	0	0	0	0	157	0	0	0	157
Held on finance lease	0	0	0	0	224	0	37	0	261
Total at 31 March 2016	15,568	96,924	0	110	8,218	12	7,021	63	127,916

The Trust has undertaken a revaluation of its Land and Buildings as at 31 March 2017. This work was carried out by Giles Awford BSc (Hons) MRICS, Principal Surveyor, District Valuer Services (DVS), the specialist property arm of the Valuation Office Agency (VOA).

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

14. Intangible non-current assets

14.1. Intangible non-current assets

	IT - in-house & 3rd party software £000's	Development Expenditure - Internally Generated £000's	Total £000's
2016/17			
At 1 April 2016	43	14,084	14,127
Additions Purchased	0	305	305
At 31 March 2017	43	14,389	14,432
 Amortisation			
At 1 April 2016	18	460	478
Charged During the Year	9	1,768	1,777
At 31 March 2017	27	2,228	2,255
Net Book Value at 31 March 2017	16	12,161	12,177
 Asset Financing: Net book value at 31 March 2017 comprises:			
Purchased	16	12,161	12,177
Total at 31 March 2017	16	12,161	12,177

14.2. Intangible non-current assets prior year

	IT - in-house & 3rd party software £000's	Development Expenditure - Internally Generated £000's	Total £000's
2015-16			
Cost or valuation:			
At 1 April 2015	37	13,036	13,073
Additions - purchased	6	1,048	1,054
At 31 March 2016	43	14,084	14,127
 Amortisation			
At 1 April 2015	17	12	29
Charged during the year	1	448	449
At 31 March 2016	18	460	478
Net book value at 31 March 2016	25	13,624	13,649
 Net book value at 31 March 2016 comprises:			
Purchased	25	13,624	13,649
Total at 31 March 2016	25	13,624	13,649

Development Expenditure relates to the Trust's Electronic Patient Record (EPR) system. This asset is operational and is being depreciated over eight years.

15. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment £000's	Intangible Assets £000's	Non-Current Assets Held for Sale £000's	Total £000's
Impairments and reversals taken to SoCI				
Unforeseen obsolescence	120	0	0	120
Changes in market price	132	0	0	132
Total charged to Annually Managed Expenditure	252	0	0	252
Total Impairments of Property, Plant and Equipment charged to SoCI				
	252	0	0	252

16. Commitments

16.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000's	31 March 2016 £000's
Property, plant and equipment	670	396
Intangible assets	8	116
Total	678	512

16.2. Other financial commitments

From 1st April 2016 to 31st March 2017 the Trust has not entered into non-cancellable contract arrangements (which are not leases or PFI Contracts or other service concession arrangements). (2015 - 16 Nil)

17. Inventories

	Drugs £000's	Consumables £000's	Energy £000's	Other £000's	Total £000's	Of which held at NRV £000's
Balance at 1 April 2016	1,262	3,023	101	21	4,407	0
Additions	17,518	1,367	20	10	18,915	0
Inventories recognised as an expense in the period	(17,518)	(1,524)	(10)	(9)	(19,061)	0
Write-down of inventories (including losses)	(147)	0	0	0	(147)	0
Balance at 31 March 2017	1,115	2,866	111	22	4,114	0

18.1. Trade and other receivables

	Current	
	31 March 2017 £000's	31 March 2016 £000's
NHS receivables - revenue	3,157	7,451
NHS receivables - capital	0	0
NHS prepayments and accrued income	8,351	4,243
Non-NHS receivables - revenue	804	1,001
Non-NHS receivables - capital	0	0
Non-NHS prepayments and accrued income	1,725	1,574
PDC Dividend prepaid to DH	149	0
Provision for the impairment of receivables	(925)	(1,625)
VAT	821	1,192
Interest receivables	3	2
Other receivables	1,679	1,843
Total	15,764	15,681
Total current and non current	15,764	15,681
Included in NHS receivables are prepaid pension contributions:		0

The great majority of trade is with NHS Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care no credit scoring of them is considered necessary.

18.2. Receivables past their due date but not impaired

	31 March 2017 £000's	31 March 2016 £000's
By up to three months	1,279	4,208
By three to six months	1,047	4,920
By more than six months	1,074	2,988
Total	3,400	12,116

18.3. Provision for impairment of receivables

	2016/17 £000's	2015/16 £000's
Balance at 1 April 2016	(1,625)	(432)
Amount written off during the year	528	16
Amount recovered during the year	630	59
(Increase)/decrease in receivables impaired	(458)	(1,268)
Balance at 31 March 2017	(925)	(1,625)

The Trust provides for overdue non NHS debts which are greater than one year, except for low value prescription charges which are provided for after six months. No collateral is held on overdue debt.

19. Cash and Cash Equivalents

	31 March 2017 £000's	31 March 2016 £000's
Opening balance	1,524	1,708
Net change in year	1,892	(184)
Closing balance	3,416	1,524
Made up of		
Cash with Government Banking Service	3,382	1,489
Commercial banks	24	25
Cash in hand	10	10
Cash and cash equivalents as in statement of financial position	3,416	1,524
Cash and cash equivalents as in statement of cash flows	3,416	1,524

20. Trade and other payables

	Current	
	31 March 2017 £000's	31 March 2016 £000's
NHS payables - revenue	711	832
NHS payables - capital	0	0
NHS accruals and deferred income	8,648	9,053
Non-NHS payables - revenue	533	1,420
Non-NHS payables - capital	4,966	2,496
Non-NHS accruals and deferred income	10,746	11,594
Social security costs	1,467	1,264
PDC Dividend payable to DH	0	120
Accrued Interest on DH Loans	150	44
VAT	0	251
Tax	134	1,309
Other	38	144
Total payables - Current	27,393	28,527

Included above:

outstanding pension contributions at the year end

1,721

1,454

21. Borrowings

	Current		Non-current	
	31 March 2017 £000's	31 March 2016 £000's	31 March 2017 £000's	31 March 2016 £000's
Loans from DH	0	300	69,019	39,054
Loans from other entities	95	116	0	190
Finance lease liabilities	82	122	24	96
Total	177	538	69,043	39,340
Total other liabilities (Current and Non-current)	69,220	39,878		

Borrowings / Loans - repayment of principal falling due in:

	DH £000's	31 March 2017 Other £000's	31 March 2017 Total £000's
0 - 1 Years	0	161	161
1 - 2 Years	26,737	40	26,777
2 - 5 Years	42,282	0	42,282
Over 5 Years	0	0	0
TOTAL	69,019	201	69,220

During the period the Trust took out the following loans:

	Value £000's	Rate %
Revolving Working Capital Loan (DH)	5,640	3.50%
Interim Revenue Support Loan (DH)	45,282	1.50%

During the Period the Trust repaid the following loans:

Revolving Working Capital Loan (DH)	20,957	3.50%
Working Capital Loan (DH)	300	0.79%

All loans have received Board of Directors, NHS Improvement and DH approval.

22. Deferred income

	· Current	
	31 March 2017 £000's	31 March 2016 £000's
Opening balance at 1 April 2016	152	400
Deferred revenue addition	62	152
Transfer of deferred revenue	(152)	(400)
Current deferred Income at 31 March 2017	62	152
 Total deferred income (current and non-current)	 62	 152

23. Finance lease obligations as lessee

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease	
	31 March 2017 £000's	31 March 2016 £000's	31 March 2017 £000's	31 March 2016 £000's
Within one year	83	124	82	122
Between one and five years	24	97	24	96
After five years	0	0	0	0
Less future finance charges	(1)	(3)	0	0
Minimum Lease Payments / Present value of minimum lease payments	106	218	106	218
 Included in:				
Current borrowings			82	0
Non-current borrowings			24	0
			106	0

The Trust did not have any amounts payable under finance leases in respect of land and buildings (2015/16 Nil).

24. Provisions

	Comprising:				
	Total £000's	Early Departure Costs £000's	Legal Claims £000's	Other £000's	Redundancy £000's
Balance at 1 April 2016	2,373	1,065	238	971	99
Arising during the year	387	40	109	238	0
Utilised during the year	(493)	(72)	(29)	(362)	(30)
Reversed unused	(766)	(131)	(51)	(515)	(69)
Unwinding of discount	(1)	(1)	0	0	0
Change in discount rate	11	11	0	0	0
Balance at 31 March 2017	1,511	912	267	332	0

Expected Timing of Cash Flows:

	£000's				
No Later than One Year	671	72	267	332	0
Later than One Year and not later than Five Years	289	289	0	0	0
Later than Five Years	551	551	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in respect of Clinical Negligence Liabilities:

	£000's
As at 31 March 2017	76,021
As at 31 March 2016	52,658

Provisions arising during the year include provisions against 2016/17 activity. The Trust has also provided for contractual obligations, legal and regulatory claims and clinical excellence awards.

25. Contingencies

	31 March 2017 £000's	31 March 2016 £000's
Contingent liabilities		
NHS Litigation Authority legal claims	(22)	(38)
Net value of contingent liabilities	(22)	(38)

The Trust has contingent liabilities associated with liability to third parties involving eight cases.

The Trust has no contingent assets (2015/16 Nil).

26. Financial Instruments

26.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the DH (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

26.2. Financial Assets

	Loans and receivables £000's	Available for sale £000's	Total £000's
Receivables - NHS	3,157	0	3,157
Receivables - non-NHS	804	0	804
Cash at bank and in hand	3,416	0	3,416
Other financial assets	0	1,679	1,679
Total at 31 March 2017	7,377	1,679	9,056
Receivables - NHS	7,451	0	7,451
Receivables - non-NHS	1,001	0	1,001
Cash at bank and in hand	1,524	0	1,524
Other financial assets	0	1,843	1,843
Total at 31 March 2016	9,976	1,843	11,819

26.3. Financial Liabilities

	Other £000's	Total £000's
NHS payables	711	711
Non-NHS payables	5,498	5,498
Other borrowings	69,114	69,114
PFI & finance lease obligations	106	106
Other financial liabilities	150	150
Total at 31 March 2017	75,579	75,579
NHS payables	832	832
Non-NHS payables	3,916	3,916
Other borrowings	39,660	39,660
PFI & finance lease obligations	218	218
Other financial liabilities	144	144
Total at 31 March 2016	44,770	44,770

27. Events after the end of the reporting period

The Trust has no adjusting events after the end of the reporting period. The Accounts were approved by the Board of Directors on 30th May 2017.

28. Related party transactions

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

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
Trust Chief Executive - Anglia Ruskin Health Partnership *	£ 66,819	£ 0	£ 4,095	£ 0
Andrew Holden -Non Executive Director - Liaison	2,666,641	0	8,927	0

* Anglia Ruskin Health Partnership is a partnership of nine health and social care organisations in Essex and Anglia Ruskin University. The Trust is one of those partners. As a partner the Trust's Chief Executive has a non-remunerated role as a Director of the Partnership

The DH is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

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

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

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The members of the Trust Board are also Trustees of the PAH NHS Trust Charitable Funds (Registered Charity No 10547745) The charity's objective is to provide support both generally and in certain areas of the Trusts activities. During the Year the Charity contributed £389k (unaudited) to the Trust (2015/16 £463k)

29. Losses and special payments

The total number of losses cases in 2016/17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	127,309	388
Special payments	58,777	26
Total losses and special payments and gifts	186,086	414

The total number of losses cases in 2015/16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	78,427	466
Special payments	206,328	21
Total losses and special payments	284,755	487

30. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

30.1. Break-even performance

	2006-07 £000's	2007-08 £000's	2008-09 £000's	2009-10 £000's	2010-11 £000's	2011-12 £000's	2012-13 £000's	2013-14 £000's	2014-15 £000's	2015-16 £000's	2016-17 £000's
Turnover	136,763	149,202	161,295	172,171	179,388	180,790	184,568	177,739	190,478	196,124	209,742
Retained surplus/(deficit) for the year	4,408	4,534	3,222	511	415	(4,506)	(63)	(16,498)	(22,274)	(37,954)	(27,019)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	0	0	4,930	228	5	271	171
Adjustments for impact of policy change re donated/government grants assets											
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*							37	(43)	90	5	69
Absorption accounting adjustment	0	0	0	0	0	0	0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	4,408	4,534	3,222	511	415	461	122	(16,403)	(21,998)	(37,714)	(26,715)
Break-even cumulative position	(6,220)	(1,686)	1,536	2,047	2,462	2,923	3,045	(13,358)	(35,356)	(73,070)	(99,785)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, The Trust's financial performance needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Break-even performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (i.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	3.22	3.04	2.00	0.30	0.23	0.25	0.07	(9.23)	(11.55)	(19.23)	(12.74)
Break-even cumulative position as a percentage of turnover	(4.55)	(1.13)	0.95	1.19	1.37	1.62	1.65	(7.52)	(18.56)	(37.26)	(47.58)

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

30.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016/17 £000's	2015/16 £000's
External financing limit (EFL)	30,794	36,722
Cash flow financing	30,510	36,178
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	30,510	36,178
Under/(over) spend against EFL	284	544

The Trust undershot against the EFL due mainly to the underspend on its Capital Resource Limit which the Trust intends to carry forward in to 2017/18.

30.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016/17 £000's	2015/16 £000's
Gross capital expenditure	10,507	7,778
Less: book value of assets disposed of	0	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(5)	0
Charge against the capital resource limit	10,502	7,778
Capital resource limit	11,500	8,411
(Over)/underspend against the capital resource limit	998	633

The underspend was notified to NHS Improvement with the intention of carrying it forward to 2017/18.

