The Princess Alexandra Hospital NHS
NHS Trust

Annual Report and Accounts 2015/16

"Building for Excellence"

Building for excellence

Contents

The Performance Report 2015/16

1. Overview

1.1. Statement from the Chairman and the Chief Executive

A warm welcome and introduction to our Annual Report.

In these challenging times, in busy weeks and stressful moments we continue to uphold the founding principles of our beloved NHS, free at the point of delivery, based around people, meeting needs, with compassion and kindness.

Everything we try to do is based on these values, the desire to build our services around our patients and service users, their families and carers and our staff who make it all possible. We also recognise that a great NHS depends on relationships with partners, our GPs, Community Care, Mental Health, Social Services and Voluntary Sector. More than ever our patients tell us when we get this right, their care is outstanding. However, if we get it wrong poor communication and a lack of joined up working all adds to delays and stress which leaves them feeling let down and frustrated. This is an area we have worked hard on and is part of the future.

Once more we have seen the work increasing, the frail elderly needing more attention, urgent and emergency care coping with higher acuity patients, and women choosing to have their children in our amazing maternity department. Without doubt, the pressure at the front door, through A&E, acute assessment and urgent care has been immense. As a small District General Hospital we have one of the busiest emergency departments in England. Not only that, but we have seen far more births, more cancer care, more urgent operations and more elective care than ever before.

The buildings are literally creaking around us; a hospital that was built over 50 years ago for the most part is coming to the end of its life. Where possible we have built new areas, we are currently refurbishing the fracture clinic, orthopaedics, pharmacy, maternity and some ward areas. But we are developing plans to address the fundamental poor estate that sometimes gets in the way of positive patient experience.

Despite all the business and buildings issues, we continue to deliver high quality outcomes and a really positive patient experience. We are one of the few hospitals where complaints are actually on the decrease and our friends and family test gets better and better.

We were visited by the Care Quality Commission (CQC) in July and although we received a Requires Improvement overall we did achieve a "Good" in every domain for Caring, they also paid tribute to the efforts and commitment of all our staff.

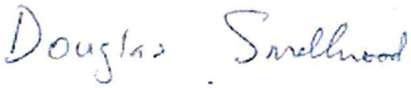
This is only possible because day-in and day-out and night-in, night-out our 3,000 staff put their hearts on their sleeves, caring, giving and believing in the NHS we love. Many days have seen unprecedented pressures, yet staff still gave of themselves, working additional hours of unpaid overtime, extra shifts, responding to significant incidents and sacrificing their own family time to care for those who need it most.

The Trust has been supported through the year by its commissioners and everyone is clear that there is a future for hospital services in Harlow. We are working with NHS England and NHS Improvement and our local politicians and the District Councils to ensure clinically and financially stable services with fully integrated care are given to our patients in the future, in buildings that are fit for purpose.

In many ways there is no harder time to be a part of the NHS, challenged in so many ways, facing unprecedented demand, in the spotlight, needed and wanted by so many. Yet in so

many ways this is also the best time to be in the NHS. It is humbling to see the talent we have in our hospital, to see the dedication that shines through even our darkest days and through the feedback we receive from our patients, their families and carers, from our service users and from our partners. We will continue to improve, to strive for better every day, to be more reliable and more consistent in all that we do.

We commend this report to you and welcome your feedback and ideas for the future.



Phil Morley
Chief Executive

Douglas Smallwood
Chairman

1.2 The Purpose and Activities of the Organisation

The Princess Alexandra Hospital NHS Trust (PAH) was established in 1995; it is a 480 bedded hospital and has an annual income of circa £196million. It provides a full range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU). PAH currently operates over forty different services to meet the needs of its patients (see Service Portfolio below).

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.

1.3 Service Portfolio

Directory of services			
Adult Critical Care	Diabetic Medicine	High Dependency Unit	Pathology
Audiology	Dietetics	Intensive Care unit	Patient Appliances
Breast Screening	Emergency Department	Interventional Radiology	Pre Op Assessments
Breast Surgery	Endocrinology	Maternity	Radiology
Cardiology	ENT	Medical Oncology	Respiratory Medicine
Chemotherapy	Family Planning	Neonatal Critical Care	Rheumatology
Child Development Centre	Gastroenterology	Neurology	Sexual Health Services

Clinical Haematology	General Medicine	Obstetrics	Special Care Baby Unit
Clinical Oncology	General Surgery	Ophthalmology	Stroke
Community Midwifery	Genito-Urinary Medicine	Oral Surgery	Trauma and Orthopaedics
Day Surgery	Geriatric Medicine	Paediatric Diabetic Medicine	Urology
Dermatology	Gynaecology	Paediatrics	

1.4 Trust Objectives

The Trust Board is clear on its focus to achieve excellence, listed below are the five objectives to achieve this goal. These are being executed and delivered through the Quality Improvement Strategy and the Organisational Development Programme agreed by the Trust Board. By delivering these five objectives every individual, team and service will achieve excellence every day and be the best provider of integrated care.

Quality and patient safety: delivering great patient outcomes and personalised care

Operational performance: delivering all regulatory and national operating standards

Managing our resources: delivering value through improved efficiency and increased productivity

Engaging with and developing our people: delivering great opportunities through learning, research and innovation

Planning our future with partners : delivering on our commitments and ensuring an organisation fit for the future

1.5 Going Concern

As part of the Annual Accounts preparation process, management are required to assess the Trusts ability to continue as a going concern. The HM Treasury Financial Reporting Manual directs that in 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 Trusts 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 Trusts Commissioning organisations have not informed the Trust of any plans to cease commissioning service and 2016/17 contracts with Commissioners have been agreed in order to continue services provisions. The Trust is working in partnership with organisations to potentially develop a future Accountable Care Partnership. If

this Partnership is developed it will potentially involve the transfer of services to provide an integrated provision of services in a single entity.

- The Trust has submitted a Long Term Financial Model to its regulator (formerly NHS Trust Development Agency now NHS Improvement). This model supported the Trust's loan applications and as part of this process long term loans were approved during 2015/16.
- The Trust has also submitted its 2016/17 Operational plan to NHS Improvement. This plan includes a deficit plan of £42.2m in 2016/17 together with details of the cash financing requirements. The Trust's deficit plan is underpinned by delivery of a Cost Improvement Programme (CIP).
- The Trust received a letter from NHS Improvement which confirms it is reasonable for the Board of Directors to assume that sufficient cash financing will be available over the next twelve months to enable the Trust to meet its current liabilities.

The Board of Directors therefore has a reasonable expectation that the Trust will continue to have access to adequate cash financing to meet its liabilities in the foreseeable future. On that basis the Board of Directors considers it is appropriate to prepare the 2015/16 Accounts on a going concern basis.

1.6 Performance Summary

The Trust ended a challenging financial year with a £37.9m deficit (£22.3m 2014/15).

Key financial matters included an increase in pay cost of 9% with a significant increase in expenditure on temporary pay (2015/16 outturn £30m) compared to the previous financial year (£23m). Temporary staffing costs escalated significantly in Quarter 2 reaching a monthly high of circa £3.1m before being managed down and stabilising at circa £2.2m per month in the latter half of the year.

Financial performance was impacted by the number of unfunded escalation facilities and staffing requirements to meet emergency operational pressures; these costs were often at premium rate, over and above budgeted levels and contributed to growth in both temporary and total staffing costs. Clinical costs rose with increased patient activity and the impact of extended working.

The Trust achieved its cost improvement target; however, it did not do so in line with the opening plans set at the start of the year. This has meant that financial mitigation that could have addressed some of the financial pressures experienced in-year was instead absorbed in meeting this shortfall. It has also led to circa 50% of the programme being met on a non-recurrent basis, therefore impacting the underlying deficit going forward.

The Trust returned to national reporting in November 2015 based on October performance data following the introduction of the Electronic Patient Record (EPR) system in July 2014. A number of data quality issues continue to be addressed incurring further significant expense in both capital and revenue for data validation. The Trust has a data recovery action plan in place across the Health Groups - it must continue to improve its data input and quality, moving them to business as usual activities ensuring the full capture, coding and charging for the complete range and scale of services provided. During the year the Trust was again subject to significant financial deductions by the Clinical Commissioning Group (CCG) some of which were linked to these issues.

Net revenue support loans of £38.4m were received following successful applications to the NHS Financing Facility via the Trust Development Authority (TDA). Furthermore, the Trust secured £1.0m of public dividend capital (PDC). However the timing of these funds did impact on payment performance.

1.7 NHS Trust financial duties

The pre audited accounts for 2015/16 confirm:

- The Trust's 2015/16 forecast outturn changed over the year. The Trust met its changed 2015/16 forecast outturn
- Operational financial performance is shown in the Statement of Comprehensive Income as a £37.9m adjusted retained deficit
- The Trust underspent against its revised 2015/16 external financial control target
- The Trust underspent against its Capital Resource Limit of £7.8m by £0.6m for 2015/16
- The Trust received net revenue support loans of £38.4m to meet its operating costs

1.8 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

For the reasons noted in 1.1.6 above, performance against the Better Payment Practice Code (BPPC) fell in 2015/16 and is below the 95% target for all NHS organisations.

Implementing efficiencies in the procurement to pay process and continued revenue support from the TDA in 2016/17 should enable improvement against the BPPC target. The Trust will also continue to work closely with its lead commissioner to manage the cash position.

Performance is summarised as follows:

	2015/16 Number	2015/16 £000's	2014/15 Number	2014/15 £000's
Non-NHS Payables				
Total Trade Invoices Paid in the Year	42,896	81,672	46,349	80,632
Total Trade Invoices Paid Within Target	14,714	28,817	28,991	45,791
Percentage of Trade Invoices Paid Within Target	34.3%	35.3%	62.5%	56.8%

	2015/16 Number	2015/16 £000's	2014/15 Number	2014/15 £000's
NHS Payables				
Total Trade Invoices Paid in the Year	1,754	12,136	2,203	12,973
Total Trade Invoices Paid Within Target	748	4,914	1,537	7,252
Percentage of Trade Invoices Paid Within Target	42.6%	40.5%	69.8%	55.9%

1.9 Financial plan 2016/2017

The Trust faces major financial challenges and risks going forward. These include:

- Delivery of its activity plans
- Meeting operating performance standards and targets
- Managing local and national cost pressures
- Further reducing interim and temporary staffing
- Delivery of transformation plans and associated efficiency improvements
- Completion of data reporting improvements
- The minimum requirement to meet a 2% efficiency target is embedded in the tariff

The Trust has submitted a deficit plan for 2016/17 including an increase in clinical insurance premium, national insurance and pension costs.

Current Capital Investment Plans for 2016/17 total circa £8m and will require additional capital funding applications to meet the development needs of the sites and services.

2. Performance Analysis

2.1 Key Performance Measures

Four Quality Performance Indicators have been set for 2016/17. Outcomes will be monitored throughout the financial year and reported in the Quality Accounts for 2016/17.

Each year we assess our performance against previous quality priorities and take account of national reports and emerging themes. This year we have again evaluated our focus for the coming year and have identified a number of quality indicators for 2016/17.

The following indicators in the table below have been approved by the Board and will form the basis of all Trust-wide improvements throughout the year ahead. These priorities are part of the Trust's overarching Quality Improvement Strategy which aims to improve outcomes for patients including the mortality rate which is measured at a national level.

Priorities for quality improvement 2016/2017				
Ref:	**Quality Improvement Area**	**What we are trying to improve**	**What success will look like**	**How we will monitor progress**
1. Patient Safety Priorities				
PS 1.1	Improving the identification and treatment of patients with Acute Kidney Injury (AKI)	To improve early recognition of Acute Kidney Injury to allow intervention and treatment	Patient have a 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
PS 1.2	Improving the identification and treatment of patients with	Standardisation and early recognition of sepsis and treatment with	Patients with sepsis receive timely appropriate treatment in line with the national sepsis	Audit patient records to ensure that treatment concurs with the national sepsis

	Sepsis.	first dose antibiotics for both inpatient and those presenting in the emergency department.	guidance.	guidance and that first dose antibiotics are delivered in 60 minutes of a formal diagnosis of sepsis. This will be reported quarterly.
PS 1.3	To improve Trust wide antibiotic stewardship.	To improve antibiotic prescribing, to ensure rationale and duration are in accordance with best practice.	To reduce antibiotic consumption per 1000 inpatient admissions.	To reduce antibiotic consumption per 1000 inpatient admissions.
2. Clinical Outcome Priorities				
CO 2.1	Continue to enhance the care people receive at end of life while in hospital.	To ensure that patients at the end of life have an appropriate care plan agreed with them and their appropriate next of kin.	To ensure that a preferred place of care is discussed and agreed with patients to optimise end of life care. Early discharge to preferred place of care is expedited whenever possible	CQUIN milestones
CO 2.2	Continue to improve the care received by people living with dementia in accordance with the recommendations identified as best practice in the national Alzheimer's Society 4th Annual Report (July, 2015)	Early detection and onward referral to memory clinics and other appropriate support for patients screened for dementia. To demonstrate that patient with dementia received best practice care and treatment.	Screening of all admitted patients aged over 65 (for their potential dementia risk) in line with the local and national CQUIN schemes. Improved environment for dementia patients. Continuation of dementia champions programme as part of the dementia training programme as required for the local and national dementia CQUIN. Implementation of dementia volunteers	Compliance with >90% patients screened and referred. Monthly submission to UNIFY. Compliance with agreed standards for the environment for dementia patients. At least one dementia champion in each clinical area.

			national programme.	
CO 2.3	Successful introduction of a Hospital at Night service supporting a 24 hour critical care outreach team 7 days per week.	To facilitate seamless and equitable care 24 hours a day for acutely deteriorating patients outside of a critical care environment.	Reduce avoidable cardiac arrests thereby reducing avoidable harm. Reduced number of unplanned admission and readmissions to ITU. Reduced number of 'failure to rescue'/suboptimal care' incidents.	Critical Care Outreach lead to plan and implement a 24 hour Hospital at Night service. Compliance with local CQUIN milestones, such as reduction of sub-optimal care incidents where deterioration has not been recognised or there has been delay in escalation.
3. Patient Experience Priorities				
PE 3.1	Improvements in transfers of care as detailed by 7 areas for improvement in the National Inpatient Survey.	To ensure patients are assessed and transferred to the most appropriate setting outside of the hospital when medically fit for discharge.	Increased involvement for patients and families in agreeing transfers of care to alternative facilities when ready for discharge. Clearer contact information if a patient is unwell again and on key items such as medication side effects.	Board and committee reports updating on progress operationally and providing qualitative assurance. Co-design Improvement workshops involving patients, families and all relevant stakeholders. Clinical Friday audit programme. Direct patient and family feedback and learning from complaints and 'point of care' discussions. The National Inpatient Survey

				2016.
PE 3.2	Achieve at least 3 areas in the top 20% for ED and Inpatient Surveys for 2016.	Improve Patient Experience	Ensure all 77 Inpatient Survey indicators are at least in the middle 60% or above with at least three indicators in the top 20% of Trusts in England and Wales.	Monthly Integrated Performance Review. Real-time PALS/ patient feedback. National survey results.
PE 3.3	Implement an effective electronic feedback system for patients with sampling rate of at least 20%.	Speed of acknowledgement of complaints. Quality of communication with complainants. Effective feedback to staff.	99% of complaints are acknowledged within 3 working days. At least 80% of complaints are responded to within a timeframe agreed with the complainant. At least 80% of complainants who provide a phone number and request a call, get a call within 3 working days of making a complaint.	Complaints process monitoring at committee level. Annual and quarterly reporting. Satisfactions levels shown through survey.
4. Staff Experience Priorities				
SE 4.1	Improve staff experience.	To improve morale and reduce turnover of staff.	Lower turnover Lower temporary staff costs Lower recruitment costs	National and local surveys.
SE 4.2	Ensure that the Trust's Vision and Values are embedded among the workforce.	Increase number of staff being trained in Trust's Vision and Values.	A rise in the number of staff receiving training from the current level of 61% to a minimum of 70%.	Regular reports to the Board.
SE 4.3	To provide improved development and career progression.	Staff retention resulting in improved continuity of care for patients.	Core training rates improved. More internal promotion.	Regular workforce reports to Performance and Finance Committee.

		Improved skills delivering a more flexible workforce.		

Monitoring of performance will be scrutinised through each sub-committee of the Board and reported at monthly Trust Board meetings over the course of the year.

2.2 Development and Performance during the Year

2.2.1 Mortality review

The statistical markers for mortality have been lower than expected for the reported period of 2015-16. The ranking of the Trust regionally and nationally remains in a favourable position.

Hospital Standard Mortality Ratios (HSMR)

The HSMR for February 2015 to January 2016 was 84.65 and statistically 'lower than expected'. This has been 'as expected' or 'lower than expected' for over a year. There is a significant difference for weekday (lower than expected) and weekend (within expected) HSMR for emergency admissions but neither is higher than expected.

The HSMR has fallen for the last 4 years from higher than expected 2011/12 to as expected in 2013/14 to now lower than expected. Nationally the ranking of PAH for HSMR has moved to the upper decile.

Standard Mortality Ratio (SMR)

All diagnosis SMR for February 2015 to January 2016 was 84.0 and statistically lower than expected. This has been as expected or lower than expected for over a year.

Patient Safety Indicators

These are adapted from a set of 20 devised by the Agency of Healthcare Research and Quality (AHRQ) in the USA. Two of these are related to mortality:
Deaths after surgery: within expected range
Deaths in low risk diagnosis groups: lower than expected

Standard Hospital-level Mortality Indicator (SHMI)

The SHMI for October 14 to September 15 was 103.3 and is as expected.

2.2.2 Infection prevention and control (IPC)

Continued and sustained commitment by clinical and management staff to patient safety and infection prevention and control, means the Trust has for another year maintained excellent control of both health care associated infections (HCAI) and antimicrobial resistance.

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

(DoH) in 'Start Smart then Focus 2011' and the 'UK 5 Year Antimicrobial Resistance Strategy 2013 – 2018'.

IPC is a Board to ward priority, with the Chief Nurse leading as Director of Infection Prevention and Control. Staff across the organisation are trained, audited and engaged in IPC measures, and the team are well supported in ensuring IPC remains 'Everybody's business'. All staff remain focused on the prevention of a range of HCAIs, and preventing the emergence and spread of antimicrobial resistance, the latter being a national and global threat to the modern day practice of medicine. The Trust IPC indicators and standards are benchmarked and monitored via the national Public Health England (PHE) mandatory surveillance system and local CCGs, and comply with all five strategic goals of the Trust.

The Department of Health has set national non-negotiable targets for each NHS Trust with regard to MRSA bacteraemia and Clostridium difficile infections. Trusts are set individual trajectories annually:

Clostridium Difficile (C.difficile)

The Trust's infection prevention and control strategy means we have performed increasing and consistently well over the years, leading us to have one of the lowest targets set for C.difficile nationally, in recognition of our sustained low rates of C.difficile disease.

Having met last years target of 16 cases our Trust trajectory was set at 10 for 2015/16, much lower than neighbouring district general hospitals and similar to paediatric and specialist hospitals such as orthopaedic and maternity hospitals. As our hospital serves a large elderly population - the common age group for C. difficile - it was recognised from the outset including by the CCG that an annual target of 10 Trust apportioned C.difficile cases would be a challenging target.

20 cases were reported by our Trust for 2015/16 on the national HCAI data capture system. The CCG appeals panel for contractual purposes are considering only 6 of the 20 cases as the Trust had evidence of following all IPC procedures and only 6 cases were deemed avoidable. This is because C.difficile is recognised as an unfortunate consequence of the use of antibiotics (which often can be lifesaving) and there were no lapses in care associated with the 14 cases.

Bacteraemia

Since July 2014 we are proud of our performance in having no Trust apportioned MRSA bacteraemia; the Trust has been one of the top performing Trusts nationally in regards to our MRSA bacteraemia rates (as well as C.difficile).

West Essex and East and North Hertfordshire CCGs together had 5 CCG attributable cases of MRSA bacteraemia. These patients presented to the PAH A&E department, and were found at the point of presentation to have MRSA bacteraemia. Detailed multi-agency root cause analyses were carried out for all five cases, chaired by CCG IPC leads, with full co-operation and support from the Trust ICT and clinicians. Action plans and remedial work were presented to CCG Committees by the CCG Lead Nurses, as well as other forums and committees, to ensure shared learning across the organisation.

However, 2016/17 will not be without challenges and we cannot allow for complacency. The C.difficile trajectory for next year remains at 10 cases. In addition to further reducing our C.difficile cases and achieving zero cases of MRSA bacteraemia, we face other difficult challenges as there is increasing global concern pertaining to multi-resistant organisms.

2.2.3 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 2015/16, a total of 9,596 incidents were reported on the Trust's Datix incident management system, an increase in incident reporting this year compared with 8,529 over the same period last year. This represents a 12% increase placing the Trust in the top quartile in the country for recognising and reporting incidents. An increase in incident reporting is viewed as an indicator of a good and effective safety culture as it allows the Trust to identify and address any areas requiring improvement. Further, there has been a significant decrease in the severity of incidents across the Trust. The majority of incidents reported were no harm incidents (5,868) representing 61% of the total incidents for this period. Approximately 87% of reported incidents during this period were a combination of no harm (5,868) or minor harm (2,505).

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.

2.2.4 Themes of Serious Incidents

There have been 61 PAH serious incidents (SI's) for 2015/16. This excludes SI's 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 140 SIs in the same period last year although with similar themes. This is due to an increasing focus on safety by the organisation, the vigilance of staff and changes to the national SI reporting framework. This reduction in harm severity is further supported by the improvements in the mortality ratios for the Trust.

In addition to increasing focus on safety across the organisation, national reporting requirements and categories changed in March 2015 and were implemented in May 2015 locally. The new framework encourages the discussion and review of incidents on a case by case basis and a discussion of the level/ degree of harm caused.

Although incident reporting has increased overall, seen as a sign of a positive safety culture, the severity of reported incidents has decreased. It should be noted, however, that direct comparisons and conclusions across periods should be drawn with caution due to the changes in the national reporting framework introduced in April 2015.

The most frequently reported SIs during this reporting period are Hospital Acquired Pressure Ulcers Grade 3 (10), with the numbers reported including both avoidable and unavoidable events, falls (5) and suboptimal care of the deteriorating patient (5). There are on-going safety initiatives focused on the themes and the number of incidents associated with these categories of SI fell in the latter part of the year.

Never Events

There were two reported Never Events in 2015/16. These occurred in April 2015 (wrong site surgery – the removal of the wrong skin lesion) and March 2016 (wrong surgical implant used).

Comprehensive Root Cause Analysis (RCA) investigations were initiated and improvements have and continue to be made. Some of the immediate changes made include:

- The World Health Organisation (WHO) checklist for safe site surgery has been adapted to include a body map.
- Introduction of a new induction/orientation pack to support bank and agency staff.
- Increase in the clinic time per patient (from 20 minutes to 30 minutes).
- Procedure for checking implants prior to implantation has been reviewed and changed. With immediate effect there will be a pause in surgery to enable a verbal as well as visual check of the implant (Pause for Prosthesis).
- Prosthesis manufacturer alerted to recommend improvement to product marking/packaging.

A re-audit of notes is being undertaken to ascertain whether the WHO surgery checklist is being used and to ensure that procedures for identification of site for surgery are being followed in all cases.

All identified actions on both reports have been completed.

Sharing the Learning (STL) Event

The Trust's central Patient Safety & Quality Team working with relevant experts have held one STL event during 2015/2016.

This was held in June 2015 and focussed on the Deteriorating Patient, and Sepsis 6 Care Bundle. Newsletters were also released in that month and in September 2015 which provided links to further information on the Deteriorating Patient, Sepsis, Sign Up to Safety and Duty of Candour.

The Sign Up To Safety campaign was widely publicised throughout the Trust through communications and events. The Trust wide launch took place in April 2016 with clinical events and workshops occurring throughout the week. The launch was well received by staff and patients alike with 55 people attending the main launch and many more attending the information stands throughout the week. The three focal areas are:

- Acute Kidney Injury
- Sepsis 6 care bundle
- End of Life Care

These are known as the Big Three Dot items and are endorsed by the Trust Board and will continue for 2016-2017.

Duty of Candour has been a continued focus as part of the open and transparent approach of the organisation. Posters designed and printed by the central PSQ Team can be seen placed in different areas across the Trust, reinforcing the Trust's commitment to transparency and candour. A Duty of Candour flowchart has been developed to guide individuals into ensuring all processes are followed with Being Open with patients and their families.

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

Safety Improvement 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. Sessions were scheduled for November 2015 to March 2016.

RCA training has been provided and attended by a further 80 staff this financial year bringing the total staff trained to 136 (recorded from 2014 – current). Feedback received from staff for these sessions was positive, and the staff were supported in undertaking RCA investigations for the Trust.

2.2.5 On-going Quality improvements at the Trust

The detailed list of priorities for quality improvement is in the relevant section of the Quality Account and includes:

- Focus on improving care for patients with Learning Disabilities and Autism
- Focus on improving dementia care
- Focus on the Tissue Viability Service
- Focus on Falls improvement

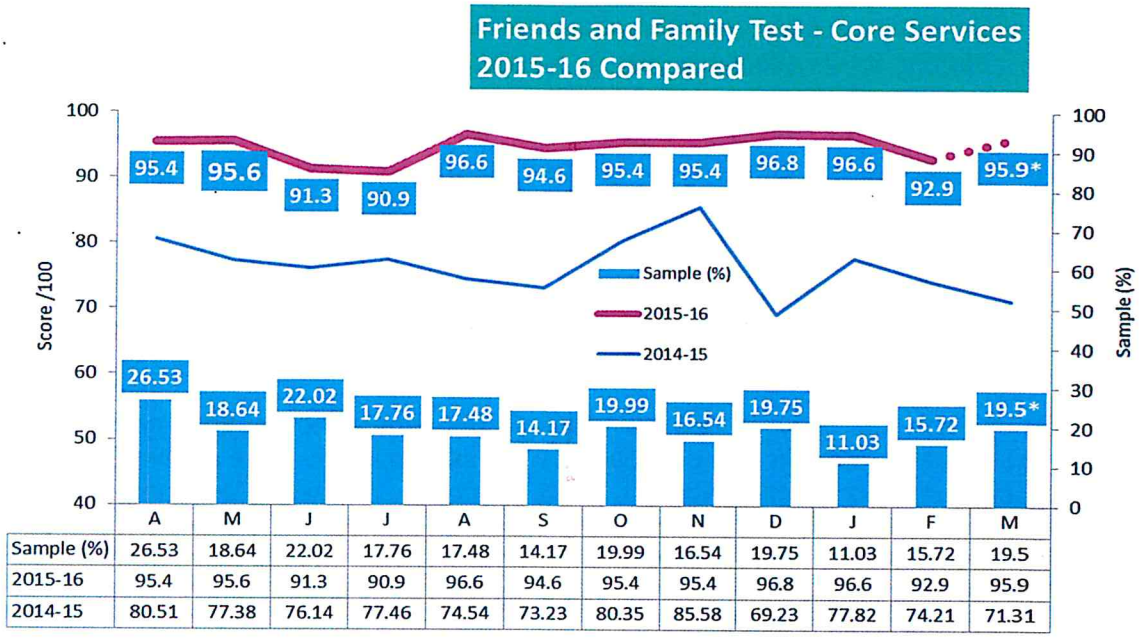
2.2.6 Friends and Family Test

The Friends and Family Test is a national measure that asks the question: "would you recommend this service to your friends or family were they to need similar care or treatment",

The test has continuously expanded and evolved, with a new form of the test being piloted over the 2015/16 period where we gather qualitative data as well as counting the numbers of people rating their care positively.

During 2015/16 thousands of patients voted in our Friends and Family Test, with 25,476 people voting to tell us about their quality of care, of whom 23,818 would come back and recommend our services to others. That equates to 93.5% of our patients.

The Ombudsman also published data showing that the Trust had the least number of cases upheld in Essex which is a direct result of continued focus on improving patient experience, listening and responding where care has been less than expected.



	A	M	J	J	A	S	O	N	D	J	F	M
Sample (%)	26.53	18.64	22.02	17.76	17.48	14.17	19.99	16.54	19.75	11.03	15.72	19.5
2015-16	95.4	95.6	91.3	90.9	96.6	94.6	95.4	95.4	96.8	96.6	92.9	95.9
2014-15	80.51	77.38	76.14	77.46	74.54	73.23	80.35	85.58	69.23	77.82	74.21	71.31

2.2.7 Emergency Department

The Trust has been working hard to mitigate the increased pressures on our A&E service, particularly over the past winter. Our own situation is a reflection of the national picture which has seen emergency admissions increase by 47% in the last 15 years. In the past year we have seen 102,833 A&E attendances with 28,782 patients being admitted.

Below, we outline some of the challenges the Trust is facing and the specific steps we are taking to address these in collaboration with our local health partners. You can read more about the measures we are taking in the Trust's Quality Accounts.

The National Emergency Access Target (NEAT) requires the A&E to treat, admit or discharge 95% of attending patients within four hours. The Trusts performance has fallen below this standard, and also the Trust's agreed trajectory for this financial year 2015/16. The key reasons can be seen within two areas; external pressures and internal pressures:

External pressures

- Primary care services in the local area have struggled to deal with the increase in demand and ambulance conveyances have increased.
- Out-of-area ambulance conveyances (where PAH is not considered to be the nearest hospital) have increased. 15% of the Trusts adult A&E attendances are over 75. This patient group has a higher rate of admission due to complex needs and exacerbation of longer term conditions.
- Delayed transfers of care remain above 3.5% threshold.

Internal pressures

- Mismatch of A&E demand and capacity specifically relating to patients conveyed by ambulance resulting in delayed handovers and overcrowding in A&E.
- Increase in patient acuity as demonstrated through recent audits completed at PAH.
- Delays in patient discharges.
- Delayed transfers of care.

- Increased patient admissions to hospital.
- Reduction in capacity of Ambulatory Care Unit due to building works.
- Continued use of escalation capacity to maintain patient safety.
- Staffing levels affecting ability to open escalation areas.

Review of our Emergency Department (A&E)

The Trust has recognised the pressures on A&E and has been working in close partnership with our CCGs, and the TDA to provide a detailed review and recommendations to enhance our overall A&E performance.

The Trust piloted the Rapid Assessment and Treatment model (RAT) for all ambulance arrivals to support 'early senior review'. The ability to adopt this model 24/7 is dependent upon staffing levels within ED.

To support the flow of patients through the emergency patient pathways additional administrative support was provided to ward staff to improve the admission and discharge processes. The Trust is working in collaboration with health and social care teams to develop a model of care that will see patients who require a further period of assessment being assessed at home rather than in hospital. This will support improved accuracy of assessment as patients will not be affected by environmental factors, resulting in a reduction in associated delay.

The Trust held a 'break the cycle' event in March working with system partners to implement the SAFER model, the red green day measure and also held a Multi-Agency Discharge Event (MADE).

The Trust runs a rolling recruitment programme for nurses and is actively recruiting for Consultants within A&E 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 our patients. With the support of local stakeholders the Trust has gained valuable insight into areas that can be improved.

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.

The Trust developed and refreshed the key recovery and action plans and launched the new programme "Every Minute Matters" to support a return to delivering better patient experience across the emergency pathway.

2.2.8 Maternity Services

During 2015/16 the Trust supported the birth of 4216 babies in hospital or at home and also focused on ensuring that the organisation was compliant with the 18 recommendations from the Morecambe Bay investigation (Kirkup, 2015).

In November the maternity survey was published which highlighted PAH being the 9th best performing out of 64 Trusts and the second best performing Trust since 2013.

Following the CQC inspection in July of last year, Maternity and Gynaecology were awarded a 'Good' overall rating with maternity getting an 'outstanding' for care. This has made a difference to women wanting to give birth at PAH.

The Trust again made a successful bid to the DoH and the unit has been fortunate in previous years too. The unit was awarded £20,000 to improve the birthing experience of women accessing the Maternity Unit.

The maternity unit has also been successful in a bid through Health Education in becoming an early adopter of Maternity Safety training and received an innovation fund of £10,000. This is going to be used to purchase training techniques for the use of Midwives, Obstetricians, Anaesthetists and Allied Health Care Professional's together in the clinical area. Staff will then be equipped with the knowledge and skills to disseminate the knowledge and be in a position to train the trainers. The preferred mode for training is through simulation known as PROMPT who provide the necessary training and materials.

Our stillbirth rate at 1.45 per 1,000 births remains exceptionally low, compared to the national rate of 4.2 per 1,000 births.

2.2.9 Discharge Planning

Effective Transfer planning should ensure that patients are transferred from the acute hospital when the acute phase of their clinical condition has been resolved. This requires coordination both internally and externally to deliver a safe discharge. The transition of care from an acute setting is supported by the transfer of treatment information provided to GPs or other key stakeholders at the point of discharge.

Any delays in transfer pose an increased risk to patient safety and impact directly on the availability of capacity to manage new patients requiring an acute episode of care. The increased pressures on acute hospital capacity means there is an increased need to be able to effectively plan and discharge patients to their own home or other care setting across the whole week and not just Monday to Friday to ensure capacity is maintained within the whole system.

The current arrangements which aim to steer patients through their clinical journey from admission through to discharge from hospital and beyond can be less than seamless. Delays are often caused by the requirement to negotiate between different agencies and organisational entities, or the need to coordinate complex discharge issues requiring effective working between different professional groups.

In 2015/16 the Trust engaged with system partners to undertake a number of key improvements which included running a multi-agency Transfer of Care Event. The output of this event will provide actions for the 2016/17 year to improve performance.

2.2.10 Targets and standards including Referral to Treatment (RTT) and cancer

Progress has been made with the Trust plan to improve data quality and for pathway validation. Reporting on RTT was resumed in November 2015 based on October performance data and an agreed trajectory to deliver 90.7% by the end of March 2016. Sustained progress has been made in delivering the national RTT standard. March position whilst missing the agreed trajectory increased to 86.1%.

During the year we addressed a number of patients who had been identified as waiting over 52 weeks. This number was reduced to 0 by the beginning of December. All patients were reviewed and no clinical harm was identified.

Whilst there has been significant improvement in the Trust's ability to report and monitor RTT pathways, this is dependent on high levels of validation in excess of a business-as-usual model. External resources are in place to support on this on-going pathway validation,

but the Trust have agreed a structure and plans for an internal validation team with the ambition of having the new team in place by early quarter one, 2016/17.

Patient Treatment Lists (PTLs) are monitored at local and Health Group level to ensure visibility of pathways. While there are still some data quality issues due to both user error and 'bugs' in our EPR system 'COSMIC', these are subject to on-going work and improvement plans for the system.

Cancer performance has been challenging in 2015/16. With the exception of the 31 day care standard, all national cancer standards were achieved in 15/16. In year, timed cancer pathways have been agreed and the capacity and demand work to support these is progressing as part of business planning. Work is underway at speciality level on RTT pathways to develop and agree timed pathways, as well as a map of the capacity and demand required to deliver these.

New trajectories for RTT, Cancer and Diagnostics have been agreed for 2016/17 and will be used to monitor performance.

2.2.11 Developing more effective patient pathways

In partnership with West Essex CCG the Trust is continuing a programme of clinical pathway review and redesign for our local health system.

The national and local healthcare system is challenged with increasing demand and limited resources so it is important we deliver services that provide the biggest improvements in health outcomes and resource utilisation while ensuring we meet our patient's needs.

In 2015/16 we have also reviewed our pathways in Urology, Gynaecology, and Gastroenterology and continued to make significant service improvements.

2.2.12 Information, Communication and Technology (ICT)

With the increasing pressure on NHS services and reductions in available funding the Trust has experienced its most challenging year to date. The ICT department continues to play a vital role in improving service efficiency, delivering new and innovative technology solutions whilst driving down its operational costs.

The Trust is now two years into a 10 year strategy to deliver Electronic Patient Records (EPR) which is core to realising the government's ambition for a paperless NHS. The on-going development programme is currently focused on five key schemes:

- **EPR System** - A modern EPR system based on Swedish solution provider Cambio's COSMIC EPR system.
- **Electronic Medicine's Management** - Implementation of a suite of functionality based on established provider JAC.
- **Integrated Care Records Portal** - Based on the successful Graphnet CareCentric solution the Trust is developing a shared records portal which will provide a single point of access to all provider care records.
- **Modern Laboratory Information System (LIMS)** - The Trust is upgrading its established Technidata LIMS system to accommodate enhancements to Order Communications systems (OCS) and integration with its EPR solution.
- **Electronic Early Warning System (EWS)** – Based on the established NerveCentre software suite, the new EWS system will provide significant enhancements to patient care by replacing paper care records with an electronic tablet based system.

The programme is based in the main on market leading technology but has not been without its challenges both in terms of proving technology but also service transformation. System testing and configuration has taken longer than planned leading to delays and cost over runs however the Trust remains committed to its modernisation goals and it is envisaged that these schemes will provide the foundation for the Trust's agenda of a future paperless hospital.

EPR System

The proposed development programme for the Trust's EPR system, COSMIC prove challenging with continuing significant issues with the Referral to Treatment (RTT) pathways and general process compliance throughout the hospital. Whilst the RTT project has succeeded in improving data quality and resolving activity reporting, this has been achieved by significant workarounds and manual processes which have had a substantial impact on the Trusts capital programme in respect of resourcing the project. The ICT team are engaged with the highest levels of authority within Cambio to resolve outstanding issues with the COSMIC product

Despite these challenges the development of the product is progressing on several fronts and has achieved these specific milestones:

- The Trust returned to national reporting of their diagnostic position in July 2015.
- The Trust returned to national reporting of our RTT position in November 2015.
- Electronic Discharge Summaries are delivered electronically to West Essex and East & North Herts CCG, and extended to Redbridge CCG in January 2016.
- Clinic outcome process redesigned and implemented in December 2015.
- Improvements in the recording of the maternity pathway.
- Upgrade to ICD10 5th Edition.
- Implementation of Medicode in Outpatient clinical coding function.
- Continued to develop and implement enhanced reporting.

ICR Graphnet Care Centric: The CareCentric Portal is now live and in early pilot testing with the regional Medical Interoperability Gateway (MIG) which provides access to Primary Care Records.

E-Prescribing – JAC Medication Management: Phase one: Pharmacy stock control went Live in December 2015 following an 8 week implementation plan. The team were applauded by the Supplier for their commitment to the delivery timeline; Phase two: Chemotherapy Management System (First of type in UK) taken into operational pilot phase.

Electronic Observation System: Nerve Centre: The solution was procured and deployed within a challenging timescale. The system is now integrated with the Trust EPR and being tested ready for pilot on three adult wards in May 2016.

Laboratory Information System (LIMS) upgrade from version 3 to 11; Histology upgrade completed, Cytology upgrade completed, Blood Bank upgrade completed.

ICT Plans for 2016/2017

The Trust Board remain committed to investing in technology to support the delivery of the highest standards of care and efficiency in patient care. This is reflected by sustained high levels of investment even in the face of a challenging financial environment.

Confirmed Capital Projects

Project	Description
EPR	Further development of the Trust Cosmic EPR system .
Medicines Management	Completion of Further development of the Trusts JAC Pharmacy system will see Trust wide deployment of Chemotherapy care management and Electronic Prescribing/Medicines Management.
LIMS Pathology upgrade	Completion of the Trusts established Technidata LIMS system.
Electronic Observations/ Early Warning System (EWS)	Trust wide deployment of the established Nerve Centre system.
Integrated Care Record	Continuing development of the Graphnet CareCentric Clinician Portal.
Single Sign on	Trust wide deployment of Impravata OneSign to all Clinical areas.
Ormis Theatre System and Scantrack	Implementation of new Theatre and Instrument tracking functionality.
Outpatient and ED Kiosks	Introduction of self-service check in kiosks to the Trust Outpatient and Emergency Department (A&E).
Patient wifi	Provision of patient and guest wifi services to all areas.
NHS Mail	Migration to the new NHSmail service.
Enhanced IT disaster recovery facilities	Further enhancement to the Trust's IT disaster recovery facilities.

2.2.13 Responding in an emergency

As an organisation we recognise that the ability to respond to emergencies is not just based on our internal plans and processes, but reliant on our ability to forge partnerships with external organisations, to enable us to respond to emergency planning, resilience and response events whatever they may be. The Trust has demonstrated that through its close partnerships with our health and social care system partners we have continued to provide services and respond to the needs of the community.

We have continued to ensure that we play a role in planning for and responding to events across the Essex Area, and have been actively involved in the work of the Local Resilience Forum (LRF by both attending and delivering sessions to develop multi-agency plans such as the identification of vulnerable people in an emergency, and the management of evacuation of healthcare facilities.

We have updated many of our emergency plans to ensure that we can meet the requirements set upon us by the Civil Contingencies Act and the Department of Health. The updating of these plans has led to validation through exercises. Plans that have recently been validated include the Pandemic Influenza Plan, which was exercised with members of

the Executive and infection control team as part of an Essex Wide event, and the Child Abduction Response plan, which saw members of all Health Groups come together to work through the response to this worst case scenario.

Within the Health Groups, work has been done to update and improve business continuity arrangements, so the Trust can continue to deliver the most critical services, in time of challenge.

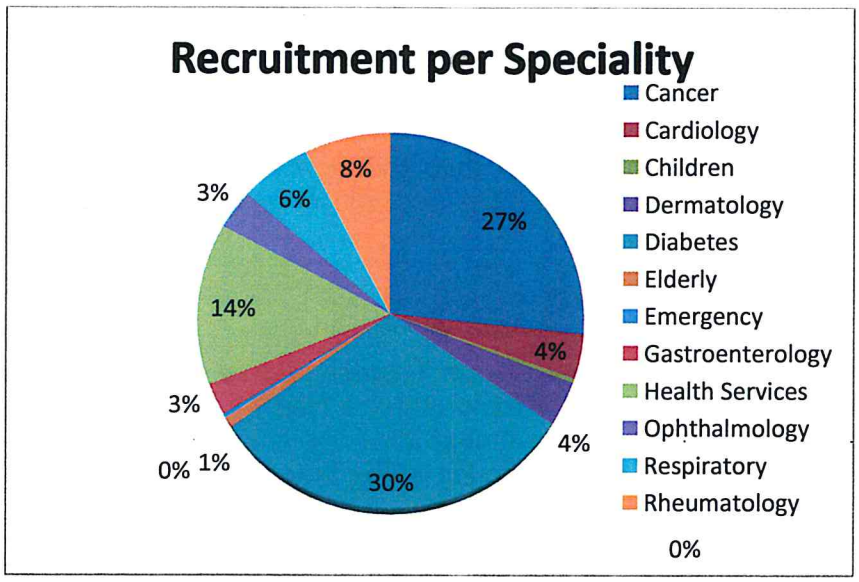
2.2.14 Research, innovation and clinical trials

At the beginning of 2015/16 it was agreed with North Thames Clinical Research Network that the Trust would recruit a target of 370 patients into the National Institute for Health Research (NIHR) portfolio adopted trials. In November 2015 the Trust reached the agreed target and continued to recruit across all Health Groups during the remainder of the financial year 2015/16.

As of 31 March 2016, the Trust have recruited 547 patents into clinical trials, however complete close is 21.04.2016, to date we have recruited a further 13 patients bringing the grand total to 573.

Recruitment per Speciality

Speciality	Recruitment
Cancer	146
Cardiology	21
Children	2
Dermatology	21
Diabetes	165
Elderly	5
Emergency	2
Gastroenterology	15
Health Services	76
Ophthalmology	19
Respiratory	34
Rheumatology	41



Research

- PAHT randomized the first UK patient for the Pharmacyclis PCYC-1130 UK study, which is a global study.
- We held a successful International Clinical Trials Day on 21 May 2015.
- Funding was received from the National Institute for Health Research (NIHR) for a Research Nurse to take on Rheumatology studies after appointing a Lead Research Nurse.
- £25,000 received of Research Capability Funding for approving and delivering on nation high level objectives for 7 commercial studies in the last year.
- Ranked 3rd across North Thames for the BADBIR Study.
- The Trust had the lowest mean number of days between VRA (Valid Research Application) and First Patient at 19.0 days, and also the lowest mean duration between NHS Permission and First Patient at 15.9 days in the UK.
- The Trust are leaders for Quintiles (Commercial Company) regionally.
- Confirmation from the NIHR that all contracts can be renewed for the next financial year.
- The Trust became research active in 3 new specialities (Respiratory, Sexual Health & Urology).

Approved Studies

Approved Studies 2015/16	
Commercial	7 or 16%
Academic	38 or 84%

2.2.15 Sustainability

For the third year running the Trust submitted its Carbon Reduction Commitment report to the Department of Health. This is a government reporting requirement for any business which uses 6 megawatts of power annually.

The Trust is continually installing LED Lighting in all refurbishments to offices, wards and departments, which is both cheaper to run and requires less maintenance.

Phil Morley
Chief Executive

The Accountability Report 2015/16

3. Corporate Governance Report

3.1 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 the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3.1.2 Members of the Trust Board

Name	Position	Voting	From	To
Executive Directors				
Phil Morley	Chief Executive Officer	Y	07/07/14	
Trevor Smith	Chief Financial Officer	Y	15/07/13	
Dr Andy Morris	Chief Medical Officer	Y	01/03/15	
Stephanie Lawton	Chief Operating Officer	Y	1/03/15 (interim) and 07/03/16 (substantive)	
Nancy Fontaine	Chief Nurse	Y	01/11/12	
Gloria Barber	Chief of Workforce and OD	N	05/12/12	13/10/15
Marc Davis	Director of Pathways and partnerships	N	01/10/12	
Liz Booth	Director of HR	N	15/09/15	
Non-Executive Directors				
Douglas Smallwood	Chairman	Y	01/04/13	
Philip Wilson	NED	Y	16/08/12	31/08/15
Sarah Coffey	NED	Y	04/09/13	31/08/15
Neil Goulden	NED	Y	01/07/14	
Andrew Holden	NED	Y	01/01/15	
Christopher (Mike) Roberts	NED	Y	01/02/15	
Pam Court	NED	Y	28/09/15	
James Anderson	NED	Y	28/09/15	

3.1.3 Attendance at Board Meetings

Number of Board members present at Board meetings:

30/04/15	28/05/15	25/06/15	30/07/15	08/15	24/09/15	29/10/15	26/11/15	21/12/15	28/01/16	25/02/16	30/03/16
PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	No meeting held	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED	PUBLIC AND CLOSED
11/11	11/11	8/11	10/11		6/9	12/13	12/13		9/13	11/13	10/13
11/11	11/11	7/11	10/11		6/9	12/13	11/13	10/13	9/13	11/13	10/13

3.1.4 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.

3.1.5 Statement of Board Member's Interests

NAME	TITLE	INTERESTS/MEMBERSHIPS DECLARED
James Anderson	Non-Executive Director	Managing Director of Anglia Ruskin Health Partnership (Not for Profit Organisation)
Gloria Barber	Chief of Workforce and Organisational Development	None
Liz Booth	Director of Human Resources	• Trustee, SENSE, The National Deaf Blind and Rubella Association
Sarah Coffey	Non-Executive Director	• Audit Committee for Herts Chief Constable and Police and Crime Commissioner • North and East Herts Magistrate (Voluntary) • Mr Peter Coffey (Spouse) Chartered Accountant for Department of Transport • Member of BUPA • Member of GP Patient Participation Group at own GP Surgery • Member of the Hertfordshire Partnership University NHS Foundation Trust • Member of Diabetes UK • Deputy Lieutenant for Hertfordshire
Pam Court	Non-Executive Director	• Chief Executive Officer of Saint Francis Hospice
Marc Davis	Director of Pathways and Partnerships	• Seres GIFTS Limited (Spouse's Company) • Governor - Sir Charles Kao UTC • Own GP Surgery • Own Dental Surgery • Own Optician Surgery
Nancy Fontaine	Chief Nurse	• Professor of Nursing at Anglia Ruskin University and University of Essex • Chair of Adult Safeguarding Performance and Audit Committee for Essex
Neil Goulden	Non-Executive Director	• 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	• Treasurer of the Scout Association • Liaison Financial Services • Member of the Ernst & Young Item Club (Economic Forecasts)
Stephanie Lawton	Chief Operating Officer	• On Secondment from Basildon & Thurrock University Hospital NHS Trust
Jules Martin	Chief Operating Officer	• None
Phil Morley	Chief Executive	• Director – Anglia Ruskin Health Partnership
Christopher (Mike) Roberts	Non-Executive Director	• Consultant Physician Barts Health • Queen Mary University of London • Director of Comorbidities programme UCL Partners • Director of Education and Capability for UCL Partners • Associate Director Clinical Effectiveness Unit Royal College of Physicians • Interim Medical Director at Barts Health for a period of six months from 1 March 2015
Andy Morris	Chief Medical Officer	• Consultant Anaesthetist
Douglas Smallwood	Chairman	• Chairman, Headway Hertfordshire (Registered Charity) • Member of Diabetes UK • Member of Crohns and Colitis UK
Trevor Smith	Chief Financial Officer	• Spouse is a Director of Salonica Consulting Limited • Auditor, Windmill Ladies Probus Society
Philip Wilson	Non-Executive Director	• Director of TRS Advice Limited

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

3.2 The Statement of Accounting Officer's responsibilities

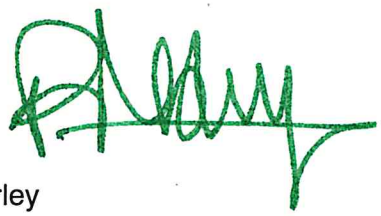
The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development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

Phil Morley
Chief Executive
Date 2/6/16.

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 ended 31.03.16 and up to approval of the annual report and accounts.

The Governance Framework of the Organisation

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

Trust Board – Membership and Committees

The Trust Board consists of:

- A Chairman
- Five other Non-Executive Directors
- A Chief Executive
- Six Executive Directors (including a Chief Financial Officer, Chief Medical Officer, Chief Operating Officer (on secondment until appointed substantively in March 2016) and Chief Nurse all of whom have voting rights and two further Executive Directors who do not have voting rights; namely the Director of HR and the Director of Pathways and Partnerships.

During 2015/16 two Non-Executive Directors left the Trust and two new Non-Executive Directors were appointed.

The Chief of Workforce and Organisational Development retired and a new Director of HR was appointed in September 2015.

Attendance at Board and Committee meetings throughout 2015/16 has been monitored and recorded. Full details are in section 2.1.1.

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

- Audit Committee
- Quality & Safety Committee
- Performance and Finance Committee
- Remuneration & Nominations Committee
- Charitable Funds Committee.
- Strategy Committee (constituted in November 2015, met in January 2016, thereafter it was agreed to disband the Committee and have a standing item on the Board agenda for strategy).

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. Trust Board meetings are reviewed on a quarterly basis.

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

In May 2015 the Board held a workshop on the Well-Led Framework for Governance Reviews and prepared a self-assessment against the requirements and four different domains:

- Strategy and planning
- Capability and culture
- Process and structures
- Measurement

The self–assessment is reviewed and updated by the Board on a quarterly basis.

In June 2015 Board members attended a two day Board Quality and Safety Programme delivered by the Eastern Academic Health Science Network.

The objectives of the programme were:

- To understand the Board's role in leadership for quality and safety.
- To consider how Boards can best adopt the Measurement and Monitoring Framework for Safety.
- To support Boards to develop their own action plan for Improvement.

The Programme provided opportunities for Boards to learn from each other, reflect and develop their own plans with support from Faculty members.

At the Board's strategic workshop event held in March 2016 the Board agreed five strategic corporate objectives for 2016/17:

- Quality and patient safety: delivering great patient outcomes and personalised care.
- Operational performance: delivering all regulatory and national operating standards.
- Managing our resources: delivering value through improved efficiency and increased productivity.
- Engaging with and developing our people: delivering great opportunities through learning, research and innovation.
- Planning our future with partners: delivering on our commitments and ensuring an organisation fit the future.

Organisational Development

During 2015/16 the Trust identified the need to specify Organisational Development as an area of priority requiring support and focus. In September 2015 the Board approved the creation of an Executive led Improvement Board with 5 areas of focus:

- Business Delivery
- Quality Improvement
- Service and System Improvement
- Leadership Development
- Staff Engagement

An Executive lead has been assigned to each of the areas mentioned above; this is in addition to their respective portfolios. In January 2016 the Board received an update on progress as well as the direction and commitment of each workstream for the next 1-3 years. The ultimate goal of the programme is to establish an Improvement Academy.

Quality Governance Arrangements

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

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

Throughout 2015/16, the Quality & Safety Committee received regular reports on themes identified from serious incidents and complaints and a "deep dive" on specific SI's and complaints was conducted to consider the follow-up actions and resulting learning. 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 was also circulated more widely to parties 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 on-going challenge throughout 2015/16 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 on-going basis.

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.

Two never events were reported in 2015/16, the first occurred in April 2015 and the second in March 2016. Both events were reported through the Trust's incident reporting processes and declared externally as required. The Trust has implemented the recommendations from the first report and internal review of process and progress continues. The second never event has been reported as a potential event and confirmation of its status is awaited.

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 Trusts annual quality account. This annual report tracks progress for the year against selected quality improvements and described priorities for the year. Our priorities remain the improvement of services for patients and are identified under the four domains of quality:

Patient Safety

- Improving the identification and treatment of patients with Acute Kidney Injury.
- Improving the identification and treatment of patients with Sepsis.
- To improve Trust wide antibiotic stewardship by reviewing antibiotic prescriptions, duration of treatment and rationale in accordance with best practice.

Clinical Effectiveness

- Continue to enhance the care people receive at end of life while in hospital.
- Continue to improve the care received by people living with dementia in accordance with the Alzheimer Society Report.
- Successful introduction of Hospital at Night to facilitate seamless and equitable care 24 hours a day for acutely unwell patients.

Patient Experience

- Improvement in discharge and transfers of care as detailed by 7 areas for improvement in the National Inpatient Survey.
- Achieve at least 3 areas in the top 20% for ED and Inpatient Surveys for 2016.
- Implement an effective electronic feedback system for patients with sampling rate of at least 20%.

Staff Experience

- Create a better working environment that improves staff morale.
- Ensure that the Trust's Vision and Values are embedded among the workforce.
- To provide the kind of working environment and career progression that will encourage staff to stay at the Trust.

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 at the Committee. The full BAF is also regularly reviewed at the Trust Board. There are currently 13 risks reflected on the BAF:

- Failure to achieve great outcomes in clinical quality, safety and patient experience.
- Failure to achieve Trust Access targets & National Delivery standards - 18 weeks, RTT, ED targets, Cancer, Stroke.
- Concerns around data quality including misuse and compliance with system as well as forward compatibility as Trust moves towards having Integrated Care Records.
- Coding issues (including clinical) within the Trust impacting on patient safety, finances and operational delivery.
- Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.
- Concerns that the Trust does not address issues of staff capability and performance management processes are not consistently applied.
- Inconsistent clinical leadership & engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.
- Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.
- Concerns around failure to meet financial plan including cash.
- Concerns about the state of the Trust's Estate & Infrastructure and capacity of the current team to deliver the modernisation agenda in the required timescale.
- Concerns around the ability of the health system to deliver a sustainable Integrated Care model.
- Concerns around organisational resilience and ability to sustain improvements.
- 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) in 2015/2016. The first related to a patient having been handed another patient's discharge summary in error. The ICO's response to this declaration was as follows:

"We have considered the information you have provided about this incident and have decided that no further action is necessary on this occasion. This is because while there was a disclosure of personal and sensitive personal data, the nature of it was fairly limited, the incident was contained and it appears unlikely that the incident caused substantial detriment. Therefore, 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 patient having been discharged with discharge paperwork relating to another patient. The ICO's response to this declaration is awaited.

The Risk and Control Framework

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

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:

- A Risk Management Strategy (for the effective management of clinical and non-clinical risk)
- A Committee structure with clear reporting mechanisms to the Board
- Monitoring systems for incidents and complaints.
- A Chief Executive Officer report to Board

The Trust's Risk Management Strategy 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 Group 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 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.

In February 2016 the Board approved a revised risk appetite statement:

"The Trust's highest objective is to deliver excellence in the delivery of seamless high quality, safe and effective care; delivered efficiently and within the confines of both regulation and the resources made available to us. We will never accept risks that materially impede, negate or impact on this prime objective. We will always look to mitigate risks that may negatively impact upon our reputation or ability to so deliver. We will never compromise on safety or on delivering compassionate care."

In addition, the reasonable assurance framework rating was revised and the following was approved:

- Blue – Effective controls are definitely in place and there is sufficient evidence and appropriate reasonable assurances on its effectiveness. The target risk score has been achieved.
- Green – Effective controls are in place and there is sufficient evidence and assurance on its effectiveness. However, the target risk reduction is yet to be achieved.
- Amber – Effective control thought to be in place but assurances on its effectiveness are uncertain and/or insufficient.
- Red – Effective controls are not in place and assurances are not available to the board.

Training

Trust staff receive risk management and related training at induction and updates as required. The training covers topics such as risk assessment, health and safety at work, moving and handling, fire safety, incident reporting, information governance as well as infection prevention and control. In addition to providing staff with skills and knowledge to carry out their work safely, staff are actively encouraged to report incidents and escalate any identified risks in a timely manner. In addition,

thematic learning from incidents is shared through newsletters, internal safety alerts, simulation sessions and/or case scenarios through the Trusts 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 2015/16. The Internal Audit report gave an opinion of limited assurance based on their view that weaknesses in the system of internal controls are such as to put the Trust's objectives at risk. The auditors raised two recommendations:

- The Risk Management Strategy requires review
- All staff should receive risk management training as part of their induction.

Both recommendations have been assigned to senior managers for implementation by August 2016 and the Trust has scheduled a further review of risk management which will commence in May 2016.

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 in place an annual clinical audit programme 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:

- Facilities and Estates
- Health and Safety
- Bank and Agency
- Emergency Planning
- IT (Asset Management)
- Risk Management and Assurance Framework
- Clinical Audit

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. During the year some progress has been made in reviewing and following up outstanding audit recommendations however there are a number of recommendations (including those from previous years) that are still to be fully implemented. Internal Audit in conjunction with the Chief Finance Officer and Head of Corporate Affairs continue to work with senior management to clear these. A focus on the implementation of recommendations will continue to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed. The Trust's Executive and operational management teams are commencing work with the incoming Internal Auditors. The Board has agreed a revised approach whereby mandated areas are supplemented by three to four in-depth audit reviews each year to maximise the value of the activity. There will also be a high focus on improving engagement in the implementation of actions and their follow-up to improve compliance rates. Process changes to support this work will include the use of electronic logging systems.

The Head of Internal Audit Opinion for 2015/16 is that:

"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the Trust'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.

* We were asked to undertake a piece of work around Data Quality which was delayed until April at the request of the Trust. We are aware that there may be significant issues in both time /cost in resolving the issues and financially in respect of potential loss of income due to the Trust. The work is still to be completed and we have not therefore taken this into account when considering our opinion."

The basis for the opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- 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; and
- Any reliance that is being placed upon third party assurances

Care Quality Commission

The Trust is registered with the Care Quality Commission (CQC) and was inspected on the 21st - 23rd July 2015.

CQC judged the quality of care provided by the Trust as:

- Overall rating: Requires improvement
- Urgent and emergency services: Requires improvement
- Medical care: Requires improvement
- Surgery: Requires improvement
- Critical care: Requires improvement
- Maternity and gynaecology: Good
- Services for children and young people: Requires improvement
- End of life care: Requires improvement
- Outpatients and diagnostic imaging: Inadequate

A Quality Improvement Plan has been developed to address the areas requiring improvement and is monitored by both the Executive Management Board and Quality and Safety Committee.

The Trust has been informed that the next inspection will take place in June 2016.

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 is compliant with its legal requirements and currently has no outstanding improvement notices:

- The Trust has submitted annual compliance assessments in relation to MHRA, HTA and CPA/ISO standards.
- The Trust is awaiting the final report following a recent JAG visit and actions identified during informal feedback are being addressed. A further visit is to take place within the next 6 months.
- The radiology department is inspected annually by the Radiation Physics department at St Bartholomew's to ensure compliance with all legislation pertaining to radiation safety including IRMER. The last audit was completed on 13/01/2015 and the outcome was positive.

- The Environment Agency inspected the Nuclear Medicine department on 19th April 2016. The full report has not been issued as yet, but the inspection was positive.
- In May 2015 the HSE undertook a Health and Safety (sharp instruments in healthcare) inspection and no material breaches were found. Some minor recommendations were received and actions are in place to address these.
- The Environmental Health Agency inspected the Trust in April 2015; improvements were required and subsequent regular visits have assured the Environmental Health and a food hygiene rating of 4 has now been awarded.
- Following receipt of an adverse report on Fire Safety Management in 2014 improvements in fire safety have been made over the last 12 months and the Trust is now compliant in all high risk areas, although work continues to ensure full compliance is achieved. The Fire Safety Management and Improvement Plan is monitored by QSC.
- The Trust's aseptic Pharmacy unit was audited against the Quality Assurance of Aseptic Preparation Services Standards (NHS QA Committee 2006) on 21 September 2015. Some concerns were raised about the design of the facility and the risk of breakdown of the air handling unit due to age. The Trust has considered options for replacing the unit with one that meets current standards and has identified funding to progress these plans.

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 in to 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):

Operational Performance

A&E 95 % Clinical Standard

The Trust has not delivered against this standard throughout the year and a revised system trajectory to achieve 90% for the year was agreed. Year to date the Trust achieved 82.62% against the revised trajectory. Key factors driving this underperformance include the number of available urgent care beds, staffing numbers, delayed transfers of care and the impact of system partners' plans.

Recovery plans are in place to address internal issues and a system wide plan to address external issues has been agreed. A programme called "Every Minute Matters" led by senior clinicians from across the emergency care team has identified work streams and actions which support improvements in flow and performance. The Trust is in the process of developing a completely new operating model which will require both internal and external system changes. This will build upon the work started in 2015/16 and contribute to further delivery of the national 4 hour standard.

RTT 18 week operational Standard

The Trust had not been in a position to report delivery of this key operational standard since July 2014, primarily due to the implementation of a new electronic patient reporting system and the subsequent system issues encountered. The Trust came off National Reporting and immediately implemented an RTT Recovery Plan. In November 2015 the Trust returned to national reporting for the incomplete standard and a revised trajectory for delivery of 90.7% by year end and 92% by April 2016 was agreed. Despite considerable effort the March RTT trajectory was not achieved, however the February level of performance was sustained. Plans are in place to ensure delivery of the standard.

Financial Sustainability and Strategic Options

At the beginning of the financial year the Trust set a deficit plan of £28.6m. The Trust's adjusted retained deficit outturn position in 2015/16 was £37.7m. During the year the Trust experienced a significant increase in temporary staffing costs and also incurred unplanned expenditure associated with operational requirements. Furthermore, whilst cost improvements were identified and delivered

in year these were not always as originally planned and the Trust was also subject to a range of fines and penalties from its commissioners. Within the year the Trust introduced a number of successful controls and initiatives to reduce reliance, and expenditure on temporary workforce. During 2015/16 the Trust has been successful with its submission to access a total of £39.1m of interim revenue and cash support to underpin its financial deficit.

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 strategic direction is for the development of an Accountable Care Partnership, working closer with other Health and Social Care providers. Business cases to develop this strategic solution are being taken forward and will include assessment of the longer term financial impact on the Trust. 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 will report this position to the Secretary of State. The purpose of the auditor's report 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 2016/17 the Trust is submitting plans to reduce its deficit position. These plans include further reductions in expenditure on temporary staffing and delivery of a Cost Improvement Programme of £12m, receipt of additional income associated with repatriation of services, provider intentions and a reduction in fines and penalty charges in line with revised national guidance. The Trust is also in discussion with NHS Improvement on its ability to access sustainability and transformation funding. All such actions will assist the Trust in reducing its deficit position.

Estate

The estate and the poor infrastructure, deteriorating building fabric, equipment and engineering plant remains a concern. The result of 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.

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 continuous improvement and enhancement of the systems of internal control.

The Trust has a generally sound system of internal control that supports the achievement of its policies, aims, objectives and statutory duties. The Board remains committed to continuous improvement and enhancement of the systems of internal control.

Phil Morley
Chief Executive

3.3 Remuneration and Staff Report

3.3.1 Background

This report includes details regarding "senior managers" remuneration in accordance with paragraphs 2.28 to 2.49 of the NHS Manual for Accounts 2015/16. The Remuneration Report set out below is subject to audit by our external auditors.

The Trust has established a Remunerations 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.

3.3.2 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 2015/16 was £270k to £275k (2014/15, £260k to £265k). This was 13.0 times (2014/15, restated 12.3 times) the median remuneration of the workforce, which was £21k (2014/15, restated £21k). The 2014/15 comparators of pay multiple and median remuneration are restated as they have been recalculated using the same method as for the 2015/16 respective figures. The 2014/15 pay multiple and median remuneration included in the 2014/15 Annual Report were 11.0 times and £24k respectively. These were calculated using a different method as for the 2015/16 respective figures.
- In 2015/16, no employees received remuneration in excess of the highest paid director (this was the same in 2014/15). Remuneration ranged from the bands £0k-£5k to £270-£275k (2014/15 £0k-£5k to £260k to £265k).
- Total remuneration includes salary, and benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions or severance payments

Reason for Increase in Pay Multiple

The highest paid director in 2015/16 was the Chief Medical Officer who started their post on the 2 March 2015 and had a higher salary banding of £270k -£275k than the highest paid director in 2014/15 which was the interim Turnaround Director who left on the 31 March 2015 and had a salary banding of £260 - £265k.

Consultancy and Professional Services Spend

2015/16 total expenditure on consultancy and professional services was £3,339k (2014/15 £3,916k).

Average Staff Numbers

Average Staff Numbers	Total YTD Number	Permanently Employed Number	Other Number	Total Prior Year Number	Permanently Employed Number	Other Number
Medical and Dental	393	334	59	376	326	50
Ambulance Staff	0	0	0	0	0	0
Administration and Estates	590	553	37	527	496	31
Healthcare Assistants and Other Support Staff	259	256	3	248	247	1
Nursing, Midwifery and Health Visiting Staff	873	802	71	866	801	65
Nursing, Midwifery and Health Visiting Learners	415	292	123	389	300	89
Scientific, therapeutic and Technical Staff	231	208	23	220	202	18
Social Care Staff	0	0	0	0	0	0
Healthcare Science Staff	146	146	0	137	137	0
Other	168	143	25	151	115	36
Total	3,075	2,734	341	2,914	2,624	290
Staff Engaged on Capital Projects (including above)	41	8	33	14	14	0

Staff sickness absence and ill health retirements

	2015/16	2014/15
	Number	Number
Total days lost	20,676	22,028
Total staff years	2,725	2,656
Average working days lost	7.6	8.3
	2015/16	2014/15
	Number	Number
Number of persons retired early due to ill health grounds	1	4
	£000s	£000s
Total additional pension liabilities accrued in the year	0	120

3.3.3 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	140,819	2	74,650	5	214,839
£50,001 - £100,000	1	62,330	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	0	303,836

There were no special payments made in 2015/16

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

There were no exit packages in 2014/15

Redundancy and other departure costs have been paid for in accordance with the provisions of the NHS 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 pension scheme. Ill –health retirement costs are met by the NHS pension scheme and are not included in the table.

Table 2**Exit packages -Other Departures analysis**	**2015/16**		**2014/15**	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000's**	**Number**	**£000's**
Contractual payments in lieu of notice	2	75	0	0
Exit payments following Employment Tribunals or court orders	1	7	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	3	82	0	0

3.3.4 Off payroll arrangements

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

During 2015/16 there were no Executive posts covered by off-payroll arrangements.

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	3
Of which, the number that have existed 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	2
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. For all new off-payroll engagements between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	0
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	0
Of which number that have existed	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Off-payroll engagements of board members, and/or senior officers with significant financial responsibility

	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

3.3.5 Table of salaries

Executive Directors

None of the directors received remuneration other their salary, benefits in kind and pension related benefits tabled below.										
			2015/16				2014/15			
Name	Title	Period	Salary (bands of £5,000) £000	All pensions related benefits (bands of £2,500) £000	Total (bands of £5,000) £000	Period	Salary (bands of £5,000) £000	Benefits in kind (rounded to the nearest £000) £000	All pensions related benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Executive Directors										
Trevor Smith	Chief Financial Officer	All Year	135-140	15-17.5	150-155	All Year	135-140	0	0	135-140
Nancy Fontaine	Chief Nurse	All Year	130-135	227.5-230	360-365	All Year	125-130	0	0	125-130
Jolanta McKenzie	Medical Director	-	-	-	-	01/04/14-08/01/15	210-215	1	-	210-215
Phil Morley	Chief Executive	All year	175-180	-	175-180	07/07/14-31/03/15	130-135	0	-	130-135
Gloria Barber	Chief of Workforce	01/04/15-13/10/15	40-45	-	40-45	All Year	95-100	0	-	95-100
Marc Davis	Director of Pathways and Partnerships	All Year	95-100	37.5-40	135-140	All Year	95-100	0	2.5-5	95-100
Jim McLeish	Interim Chief Operating Officer	-	-	-	-	18/12/14-31/03/15	90-95	0	2.5-5	90-95
Stephanie Lawton	Interim Chief Operating	All Year	125-130	175-177.5	305-310	02/03/15-31/03/15	10-15	0	-	10-15

	Officer									
Andrew Morris	Chief Medical Officer*	All Year	270-275	730 -732.5	1,000-1005	02/03/15-31/03/15	20-25	0	-	20-25
Elizabeth Booth	Director of Human Resources	15/09/15-31/03/16	50-55	10-12.5	60-65	-	-	-	-	-
Chris Bown	Interim Chief Executive Officer*	-	-	-	-	07/04/14-04/07/14	120-125	0	-	120-125
Obi Hassan	Turnaround Director*	-	-	-	-	16/06/14-31/03/15	260-265	0	-	260-265
Jules Martin	Chief Operating Officer*	-	-	-	-	01/03/14 – 31/12/15	110-115	0	0	110-115

* £94k of the salary within the total £270k-£275k salary banding disclosed for Andrew Morris, Chief Medical Officer, is for their clinical role. The 2014/15 comparator of all the pensions related benefit amount for Andrew Morris has not been disclosed as it was unavailable.

In 2014/15 the Trust appointed an Interim Chief Executive Officer, Chris Bown from 7th April to 4th July 2015, whilst in the process of appointing a permanent Chief Executive Officer.

In 2014/15 the Trust appointed a Turnaround Director, Obi Hassan, on an interim basis from the 6th June 2014 to the 31st March 2015.

Jules Martin was seconded to Barts Health NHS Trust from 1st January 2015 prior to their leaving Princess Alexandra NHS Trust on 31/12/15.

The 2014/15 salary comparator for Nancy Fontaine has been restated to £125k to £130k in the above table, as it was incorrectly disclosed in last year's Annual Report and Accounts as £100k to £105k

When the calculation of all pensions related benefits returns negative values, a zero is disclosed.

Non-Executive Directors

			2015/16				2014/15	
Name	Title	Period	Salary (bands of £5,000) £000	Other Remuneration £000	Benefits in kind (rounded to the nearest £000) £000	Period	Salary (bands of £5,000) £000	Benefits in kind (rounded to the nearest £000) £000
Non-Executive Directors								
Douglas Smallwood	Chairman	All Year	25-30	0	0	All Year	20-25	0
Neil Goulden	Non-Executive Director	All Year	5-10	0	0	01/08/14-31/03/15	0-5	0
Mark Devonshire	Non-Executive Director	-	-	-	-	01/03/14 – 31/01/15	5 - 10	0
Renata Drinkwater	Non-Executive Director	-	-	-	-	01/04/14-31/12/14	0-5	0
Andrew Holden	Non-Executive Director	All Year	5-10	0	0	01/01/15-31/03/15	0-5	0
Mike Roberts	Non-Executive Director	All Year	5-10	0	0	-	-	-
Philip Wilson	Non-Executive Director	01/04/15-31/08/15	0-5	0	0	All Year	5 - 10	0
Sarah Coffey	Non-Executive Director	01/04/15-31/08/15	0-5	0	0	All year	5-10	0
Claire Feehily	Non-Executive	-	-	-	-	01/04/14-30/06/14	0-5	0

Claire Feehily	Non-Executive Director	-	-	-	-	01/04/14-30/06/14	0-5	0
James Anderson	Non-Executive Director	28/9/15-31/3/16	0-5	0	0	-	-	-
Pam Court	Non-Executive Director	28/9/15-31/3/16	0-5	0	0	-	-	-

Salary pension entitlement of Senior Managers

Name	Title	Real increase in pension at pension age (bands of £2500) £000	Real increase / (decrease) in lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age as at 31 March 2016 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Real Increase in Cash Equivalent Transfer Value £000
Executive Directors								
Trevor Smith	Chief Financial Officer	0.0-2.5	(0.0-2.5)	50-55	145-150	840	811	20
Nancy Fontaine	Chief Nurse	10.0-12.5	25.0-27.5	40-45	115-120	711	521	184
Marc Davis	Director of Pathway and Partnership	0.0-2.5	2.5-3.0	15-20	55-60	341	303	34
Stephanie Lawton	Interim Chief	7.5 -10	25-27.5	35-40	105-110	504	377	122

	Operating Officer							
Andrew Morris	Chief Medical Officer	32.5-35.0	92.5-95.0	80-85	240-245	1,442	830	602
Elizabeth Booth	Director of Human Resources	0.0-2.5	0	0-5	0	11	0	11

- There are no entries in respect of pensions for Non-Executive members as they do not receive pensionable remuneration.
- Cash Equivalent Transfer Value (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.
- On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.
- Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and uses common market valuation factors for the start and end of the period..

3.3.6 Staff Survey and Staff Family and Friends Test Results

The Staff Survey and 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. The key strengths identified in the last Staff Survey (2015) were:

Compared with other NHS hospitals, staff told us

- There were fewer experiences of harassment, bullying and abuse that has gone unreported
- Appraisals/ Performance Reviews discussed organisational values
- They receive regular updates on patient/service user feedback in their Health Groups/Departments
- Feedback from patient/service users is used to make informed decisions within Health Group/Department
- Senior managers try to involve staff in important decisions

The areas that have improved the most since last year include:

- More staff receive regular updates on patient/service user feedback in their Health
- Group/Department
- More staff are satisfied with their level of pay
- Fewer staff saw errors, near misses or incidents that could hurt staff
-

Five key weaker issues have been identified:

- Fewer staff had an Appraisal/Performance Review
- People feel there are not enough staff for them to do their job properly
- More experiences of physical violence have gone unreported
- Fewer staff had non-mandatory training, learning and development in the last 12 months
- More staff felt pressure from colleagues to come to work despite not feeling well enough

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

On the Staff Family and Friends Test in Quarter 4 (Jan-Mar 2016) 72% of staff said they would recommend the Trust to family and friends if they needed care or treatment here. This is 5% above the target of 67% set by the Department of Health. 54% of staff said they would recommend PAHT as a place to work, which is below our Department of Health target of 61%.

3.3.7 Our staff breakdown

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

2015/16 Staff Composition	Numbers	Numbers
	Male	Female
Executive Directors	4	4
Other Employees	701	2,543
Total	**705**	**2,547**

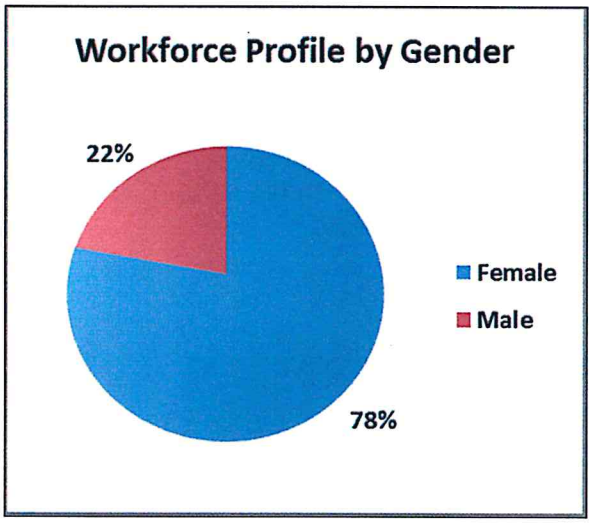
Turnover rate

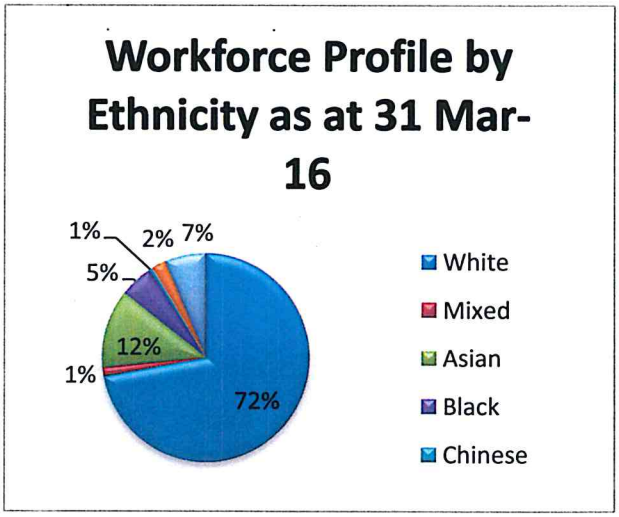
Turnover Rate 2015/16	
2015/16	2014/15
Overall Staff Turnover Rate 20.00%	18.9%
Voluntary Turnover Rate 15.7%	13.9%

Our voluntary turnover rate has increased compared to the previous financial year due to recruitment and retention difficulties in Nursing & Midwifery. However, actions to improve Staff Retention are being developed to address this, including an enhanced on-boarding experience.

Equality and diversity

The Trust regularly monitors the equality profile of its workforce using both external and internal comparators. We employ a greater proportion of staff from ethnic minorities compared to the equivalent demographic for the East of England region. The ratio of male and female employees remains the same compared to previous year.





Policy in Relation to Disabled Employees

The Trust has in place a robust Attendance Management Policy that has recently been reviewed, 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 while 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.

1.7% of our employees have indicated that they have a disability.

Phil Morley
Chief Executive

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 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 33. 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 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 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 44 to 47;
- the table of pension benefits of senior managers and related narrative notes on page 47 to 48;
- the tables of exit packages and related notes on page 42;
- the analysis of staff numbers on page 41; and
- the table of pay multiples and related narrative notes on page 40.

This report is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

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 54 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.

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 2015, 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 2016.

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.

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 2016 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.

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 the NHS Trust Development Authority'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:

- **Referral to the Secretary of State**

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 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

The Trust planned for a £28m deficit but reported a deficit of £37.7 million in its financial statements for the year ending 31 March 2016, after reporting deficits in the

previous two financial periods. Therefore it has breached its duty, under paragraph 2 (1) of Schedule 5 the National Health Service Act 2006, to break even.

It has not succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £42.2 million for 2016/17. The Trust has previously undertaken a Financial Sustainability Review which concluded that it is not financially sustainable in its current form. It is aiming to progress either towards an Integrated Care Organisation or Accountable Care Organisation, but at present there is no defined timetable. With the lack of clear vision there is no articulation of the financial impacts of the potential future arrangements, and how this may address the cumulative financial deficit.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion (Adverse)

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 Trust] put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

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

Kevin Suter
for and on behalf of Ernst & Young LLP
Luton
2 June 2016

The Princess Alexandra Hospital NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

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.....  .....Chief Executive

Date.....21/6/16.....

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

2/6/16 .....Date.....  .....Chief Executive

2/6/2016 .....Date.....  .....Chief Financial Officer

Statement of Comprehensive Income for year ended 31 March 2016

	Note	2015/16 £000's	2014/15 £000's
Gross employee benefits	8.1	**(148,150)**	(135,673)
Other operating costs	6	**(82,125)**	(73,486)
Revenue from patient care activities	3	**184,461**	178,689
Other operating revenue	4	**11,663**	11,789
Operating deficit		**(34,151)**	(18,681)
Investment revenue	10	**21**	20
Finance costs	11	**(326)**	(247)
Deficit for the financial year		**(34,456)**	(18,908)
Public dividend capital dividends payable		**(3,498)**	(3,366)
Retained deficit for the year		**(37,954)**	(22,274)

Other Comprehensive Income

	2015/16 £000's	2014/15 £000's
Net gain/(loss) on revaluation of property, plant & equipment	**9,108**	15,166
Total Other Comprehensive Income	**9,108**	15,166
Total Comprehensive Income for the year	**(28,846)**	(7,108)

Financial performance for the year

Retained deficit for the year	**(37,954)**	(22,274)
Impairments (excluding IFRIC 12 impairments)	**171**	271
Adjustments in respect of donated gov't grant asset reserve elimination	**69**	5
Adjusted retained deficit	**(37,714)**	(21,998)

The notes on pages 59 to 84 form part of these Accounts.

Statement of Financial Position as at 31 March 2016

	Note	31 March 2016 £000's	31 March 2015 £000's
Non-current assets:			
Property, plant and equipment	12	**127,916**	118,637
Intangible assets	13	**13,649**	13,044
Total non-current assets		**141,565**	131,681
Current assets:			
Inventories	17	**4,407**	4,522
Trade and other receivables	18	**15,681**	12,992
Cash and cash equivalents	19	**1,524**	1,708
Total current assets		**21,612**	19,222
Total assets		**163,177**	150,903
Current liabilities			
Trade and other payables	20	**(28,527)**	(21,657)
Provisions	24	**(1,336)**	(3,235)
Borrowings	21	**(238)**	(499)
DH revenue support loan	21	**(300)**	(600)
Total current liabilities		**(30,401)**	(25,991)
Net current assets/(liabilities)		**(8,789)**	(6,769)
Total assets less current liablilities		**132,776**	124,912
Non-current liabilities			
Provisions	24	**(1,037)**	(1,058)
Borrowings	21	**(286)**	(505)
DH revenue support loan	21	**(39,054)**	(300)
Total non-current liabilities		**(40,377)**	(1,863)
Total assets employed		**92,399**	123,049
FINANCED BY:			
Public Dividend Capital		**122,912**	124,892
Retained earnings		**(78,623)**	(40,683)
Revaluation reserve		**48,110**	38,840
Other reserves		**0**	0
Total Taxpayers Equity		**92,399**	123,049

The notes on pages 59 to 84 form part of these Accounts.

The financial statements on pages 55 to 58 were approved by the Board on 2 June 2016 and signed on its behalf by Chief Executive.

Chief Executive: **Date:** 2/6/16

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000's	£000's	£000's	£000's
Balance at 1 April 2015	**124,892**	**(40,683)**	**38,840**	**123,049**
Changes in taxpayers' equity for 2015/16				
Retained surplus/(deficit) for the year		(37,954)		**(37,954)**
Net gain / (loss) on revaluation of property, plant, equipment			9,108	**9,108**
Transfers between reserves		14	(14)	**0**
Reclassification Adjustments				
Permanent PDC received - cash	1,020			**1,020**
Permanent PDC repaid in year	(3,000)			**(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**
Balance at 1 April 2014	**98,682**	**(18,409)**	**23,674**	**103,947**
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained surplus/(deficit) for the year		(22,274)		(22,274)
Net gain / (loss) on revaluation of property, plant, equipment			15,166	15,166
Reclassification Adjustments				
New temporary and permanent PDC received - cash	45,091			45,091
New temporary and permanent PDC repaid in year	(18,881)			(18,881)
Net recognised revenue/(expense) for the year	**26,210**	**(22,274)**	**15,166**	**19,102**
Balance at 31 March 2015	**124,892**	**(40,683)**	**38,840**	**123,049**

Statement of Cash Flows for the Year ended 31 March 2016

	Note	2015/16 £000's	2014/15 £000's
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**(34,151)**	(18,681)
Depreciation and amortisation	12	**6,831**	5,992
Impairments and reversals	14	**171**	271
Interest paid		**(326)**	(247)
PDC Dividend (paid)/refunded		**(3,558)**	(3,186)
(Increase)/Decrease in Inventories		**115**	(256)
(Increase)/Decrease in Trade and Other Receivables		**(2,689)**	5,946
Increase/(Decrease) in Trade and Other Payables		**8,984**	780
Provisions utilised		**(1,865)**	(1,570)
Increase/(Decrease) in movement in non cash provisions		**(69)**	391
Net Cash Inflow/(Outflow) from Operating Activities		**(26,557)**	(10,560)
Cash Flows from Investing Activities			
Interest Received		**21**	20
(Payments) for Property, Plant and Equipment		**(8,126)**	(13,370)
(Payments) for Intangible Assets		**(1,516)**	(20)
Rental Revenue		**0**	132
Net Cash Inflow/(Outflow) from Investing Activities		**(9,621)**	(13,238)
Net Cash Inform / (outflow) before Financing		**(36,178)**	(23,798)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		**1,020**	45,091
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**(3,000)**	(18,881)
Loans received from DH - New Revenue Support Loans		**54,754**	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(16,300)**	(600)
Other Loans Repaid		**(256)**	(369)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(224)**	(246)
Net Cash Inflow/(Outflow) from Financing Activities		**35,994**	24,995
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(184)**	1,197
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,708**	511
Cash and Cash Equivalents (and Bank Overdraft) at year end	19	**1,524**	1,708

NOTES TO THE ACCOUNTS

1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Group Manual for Accounts 2015-16 issued by the Department of Health. 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 Going Concern

IAS 1 requires management to assess, as part of the Accounts preparation process, the Trusts ability to continue as a going concern. The HM Treasury Financial Reporting Manual directs that in 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 Trusts 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 Trusts Commissioning organisations have not informed the Trust of any plans to cease Commissioning service and 2016/17 contracts with Commissioners have been agreed in order to continue services provisions. The Trust is working with partnership organisations to potentially develop a future Accountable Care Partnership. If this Partnership is developed it will potentially involve the transfer of services to provide an integrated provision of services in a single entity.

- The Trust has submitted Long Term Financial Model to its regulator (formerly NHS Trust Development Agency now NHS Improvement). This model supported the Trust's loan applications and as part of this process long term loans were approved during 2015/16.

- The Trust has also submitted it's 2016/17 Operational plan to NHS Improvement. This plan includes a deficit plan of £42.2m in 2016/17 together with details of the cash financing requirements. The Trust's deficit plan is underpinned by delivery of a cost improvement programme.

- The Trust received a letter from NHS Improvement dated 19 May 2016 which confirms it is reasonable for the Board of Directors to assume that sufficient cash financing will be available over the next twelve months to enable the Trust to meet its current liabilities. The letter supports the Trusts position that the Accounts have been prepared on a going concern basis.

The Board of Directors therefore has a reasonable expectation that the trust will continue to have access to adequate cash financing to meet its liabilities in the foreseeable future. On that basis the Board of Directors considers it is appropriate to prepare the 2015/16 Accounts on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 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.

1.4 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 are 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.

1.5 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.

NOTES TO THE ACCOUNTS

1.5.1 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 IAS 17. 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.

1.5.2 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 to be considered to be relevant. Actual results may differ from those estimates and these estimates and assumptions are periodically reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised. If the revisions affects current and future periods the estimate will be updated to impact both current and future provision.

The following are key areas where estimation uncertainty at the end of the reporting period which 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 IAS 37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

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

Receivables

Included in the receivable are estimates made for bad debts and accrued income for partially completed spells. The Trust has adhered to guidance stipulated in the NHS Manual for Accounts 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 of the Accounts. Actual outcomes may differ from these estimates.

1.6 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 Pension's 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.

NOTES TO THE ACCOUNTS

1.7 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 NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable the Trust to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the 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.

1.8 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.

1.9 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
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have 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; or
- 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. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations 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. Fair values are determined as follows:

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

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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

NOTES TO THE ACCOUNTS

1.9 Property, plant and equipment (Continued)

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.

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.

1.10 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 fair value. Software that is integral to the operating 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
- 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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS 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 their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, 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.

NOTES TO THE ACCOUNTS

1.11 Depreciation, amortisation and impairments (Continued)
The following summarises the range of minimum and maximum useful lives applied by asset category :

	Min-Max Life (yrs)
Buildings and Dwellings	3 - 57
Plant & Machinery	0 - 11
Transport Equipment	0 - 5
Information Technology	0 - 12
In house Information Technology & third party software	0 - 4
Development expenditure	4 - 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 should be 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.

1.12 Donated assets
Donated non-current assets are capitalised at their fair 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 as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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 on 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.

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.

1.14 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.

1.15 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.

NOTES TO THE ACCOUNTS

1.16 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 NHS 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 rate as follows :

Rate	Real Rate
Short Term (zero and up to and including five years)	Minus 1.55%
Medium Term (after five years and up to and including ten years)	Minus 1.00%
Long Term (exceeding ten years)	Minus 0.80%

Post employment benefits provisions have been discounted at an applicable rate of 1.37%.

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.

1.17 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.

1.18 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 NHS 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.

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 NHS 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.

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 which occurred after the initial recognition of the asset and which has 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 Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

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 currency 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. 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

The Trust does not have assets belonging to third parties (such as money held on behalf of patients).

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 Department of Health 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 Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

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 their 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 2015-16. 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 for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, 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 an NHS Trust, all services are subject to the same regulatory environment and standards set by our external performance managers. Accordingly, the Trust operates one segment.

3. Revenue from patient care activities

	2015/16 £000's	2014/15 £000's
NHS Trust's	**1,200**	1,203
NHS England	**14,921**	14,804
Clinical Commissioning Groups	**159,656**	157,227
Foundation Trusts	**177**	120
Department of Health	**4**	0
NHS Other (including Public Health England and Prop Co)	**0**	3
Additional income for delivery of healthcare services	**3,000**	0
Non-NHS:		
Local Authorities	**2,248**	1,935
Private patients	**276**	294
Overseas patients (non-reciprocal)	**46**	44
Injury costs recovery	**740**	724
Other	**2,193**	2,335
Total Revenue from patient care activities	**184,461**	178,689

4. Other operating revenue

	2015/16 £000's	2014/15 £000's
Patient transport services	**0**	574
Education, training and research	**5,729**	5,220
Receipt of donations for capital acquisitions - Charity	**0**	60
Non-patient care services to other bodies	**2,789**	2,700
Income generation (Other fees and charges)	**2,166**	2,209
Rental revenue from operating leases	**132**	132
Other revenue	**847**	894
Total Other Operating Revenue	**11,663**	11,789
Total operating revenue	**196,124**	190,478

5. Overseas Visitors Disclosure

	2015/16 £000's	2014/15 £000's
Income recognised (invoiced amounts and accruals)	**46**	44
Cash payments received in-year realting to receivables at previous year end	**19**	25
Cash payments received in-year relating to invoices issued in the year	**42**	15
Amounts added to provision for impairment of receivables relating to invoices issued in the year	**47**	0

6. Operating expenses

	2015/16 £000's	2014/15 £000's
Services from other NHS Trusts	951	704
Services from CCGs/NHS England	0	0
Services from other NHS bodies	522	1,192
Services from NHS Foundation Trusts	816	1,164
Total Services from NHS bodies *	2,289	3,060
Purchase of healthcare from Non-NHS bodies	4,681	3,070
Trust Chair and Non-executive Directors	53	55
Supplies and services - clinical	35,748	34,122
Supplies and services - general	3,671	3,138
Consultancy and professional services	3,339	3,916
Establishment	1,901	2,011
Transport	187	758
Business rates paid to local authorities	932	905
Premises	9,177	8,129
Impairments and reversals of receivables	1,209	89
Inventories write down	65	5
Depreciation	6,382	5,985
Amortisation	449	7
Impairments and reversals of property, plant and equipment	171	271
Internal Audit Fees **	55	
Audit fees	66	89
Other Auditor's remuneration ***	12	0
Clinical negligence	9,821	6,837
Education and Training	610	314
Other	1,307	725
Total Operating expenses (excluding employee benefits)	82,125	73,486
Employee Benefits		
Employee benefits excluding Board members	146,875	134,497
Board members	1,275	1,176
Total Employee Benefits	148,150	135,673
Total Operating Expenses	230,275	209,159

* Services from NHS bodies does not include expenditure which falls into a category below.
** Internal Audit fees in 14/15 totalled £104k.
*** Other Auditor's remuneration relates work associated with the audit of the Trust's Quality Accounts for 2015/16. (£12k : 2014/15)

7. Operating Leases

7.1 The Trust as a lessee

	Land £000's	Buildings £000's	Other £000's	2015/16 Total £000's	2014/15 £000's
Payments recognised as an expense					
Minimum lease payments		2,091	86	2,177	2,028
Contingent rents				0	0
Total		2,091	86	2,177	2,028
Payable:					
No later than one year	0	877	94	971	1,845
Between one and five years	0	2,754	231	2,985	1,666
After five years	0	2,340	17	2,357	1,266
Total	0	5,971	342	6,313	4,777

7.2 The Trust as a lessor

	2015/16 £000's	2014/15 £000's
Recognised as revenue		
Rental revenue	132	132
Contingent rents	0	0
Total	132	132
Receivable:		
No later than one year	132	132
Between one and five years	527	660
After five years	923	660
Total	1,582	1,452

8. Employee benefits and staff numbers

8.1 Employee benefits

	Total £000's	2015/16 Permanently employed £000's	Other £000's
Employee Benefits - Gross Expenditure			
Salaries and wages	**129,295**	97,930	31,365
Social security costs	**8,967**	7,978	989
Employer Contributions to NHS BSA - Pensions Division	**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**

Employee Benefits - Gross Expenditure 2014/15	Total £000's	Permanently employed £000's	Other £000's
Salaries and wages	116,563	94,601	21,962
Social security costs	8,965	8,037	928
Employer Contributions to NHS BSA - Pensions Division	11,005	10,679	326
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	136,533	113,317	23,216
Employee costs capitalised	860	860	0
Gross Employee Benefits excluding capitalised costs	135,673	112,457	23,216

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within salaries and wages.

8.2 Staff Numbers

	Total Number	2015/16 Permanently employed Number	Other Number	2014/15 Total Number
Average Staff Numbers				
Medical and dental	**445**	386	59	376
Administration and estates	**588**	551	37	527
Healthcare assistants and other support staff	**259**	256	3	248
Nursing, midwifery and health visiting staff	**873**	748	125	866
Nursing, midwifery and health visiting learners	**415**	344	71	389
Scientific, therapeutic and technical staff	**231**	208	23	220
Healthcare Science Staff	**146**	146	0	137
Other	**118**	95	23	151
TOTAL	**3,075**	**2,734**	**341**	2,914
Of the above - staff engaged on capital projects	**41**	8	33	14

8.3 Staff Sickness absence and ill health retirements

	2015/16 Number	2014/15 Number
Total Days Lost	20,676	22,028
Total Staff Years	2,725	2,656
Average working Days Lost	**7.6**	8.3

	2015/16 Number	2014/15 Number
Number of persons retired early on ill health grounds	1	4
	£000's	£000's
Total additional pensions liabilities accrued in the year	**0**	120

8.4 Exit Packages agreed in 2015/16

	2015/16					
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**
	Number	**£s**	**Number**	**£s**	**Number**	**£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**

There were no exit packages in 2014/15.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS pension 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.

8.5 Exit packages - Other Departures analysis

	2015/16 Agreements	Total value of agreements	2014/15 Agreements	Total value of agreements
	Number	£000's	Number	£000's
Contractual payments in lieu of notice	2	75	0	0
Exit payments following Employment Tribunals or court orders	1	7	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	3	82	0	0

8.6 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 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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.

9. Better Payment Practice Code

9.1 Measure of compliance

	2015/16 Number	2015/16 £000's	2014/15 Number	2014/15 £000's
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**42,896**	**81,672**	46,349	80,632
Total Non-NHS Trade Invoices Paid Within Target	**14,714**	**28,817**	28,991	45,791
Percentage of NHS Trade Invoices Paid Within Target	**34.3%**	**35.3%**	62.5%	56.8%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,754**	**12,136**	2,203	**12,973**
Total NHS Trade Invoices Paid Within Target	**748**	**4,914**	1,537	**7,252**
Percentage of NHS Trade Invoices Paid Within Target	**42.6%**	**40.5%**	69.8%	55.9%

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

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

	2015/16 £000's	2014/15 £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

	2015/16 £000's	2014/15 £000's
Interest revenue		
Bank interest	**21**	20
Total Investment revenue	**21**	20

11. Finance Costs

	2015/16 £000's	2014/15 £000's
Interest		
Interest on loans and overdrafts	**267**	10
Interest on obligations under finance leases	**4**	11
Total interest expense	**271**	21
Other finance costs	**41**	202
Provisions - unwinding of discount	**14**	24
Total	**326**	247

12. Property, plant and equipment

Land and building assets were valued independently using a modern equivalent asset valuation methodology. A valuation was performed as at 31 March 2016. The valuation was performed by a suitably qualified (MRICS) valuer from Montagu Evans LLP. The valuation methodology is set out in the RICS guidance, the Treasury FReM, Treasury guidance on asset valuations and IFRS (IAS16) guidance.

2015/16	Land	Buildings excluding dwellings	Assets under construction & payments	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	15,428	89,385	0	24,917	170	15,575	1,508	146,983
Additions of Assets Under Construction			110					110
Additions Purchased	0	1,536		1,817	0	3,260	1	6,614
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0		0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0
Disposals other than for sale	0	(8)	0	(1,540)	0	(27)	(21)	(1,596)
Upward revaluation/positive indexation	140	6,174	0	0	0	0	0	6,314
Impairment/reversals charged to operating expenses	0	(163)	0	(8)	0	0	0	(171)
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0	0	0	0	0	0
At 31 March 2016	15,568	96,924	110	25,186	170	18,808	1,488	158,254
Depreciation								
At 1 April 2015	0	0		16,315	156	10,447	1,428	28,346
Reclassifications	0	0		0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0		0	0	0	0	0
Disposals other than for sale	0	(8)		(1,540)	0	(27)	(21)	(1,596)
Upward revaluation/positive indexation	0	(2,794)		0	0	0	0	(2,794)
Impairment/reversals charged to reserves	0	0		0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0		0	0	0	0	0
Charged During the Year	0	2,802		2,193	2	1,367	18	6,382
Transfers to NHS Foundation Trust on authorisation as FT	0	0		0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0		0	0	0	0	0
At 31 March 2016	0	0	0	16,968	158	11,787	1,425	30,338
Net Book Value at 31 March 2016	15,568	96,924	110	8,218	12	7,021	63	127,916
Asset financing:								
Owned - Purchased	15,568	96,924	110	7,837	12	6,984	63	127,498
Owned - Donated	0	0	0	157	0	0	0	157
Owned - Government Granted	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	224	0	37	0	261
On-SOFP PFI contracts	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0
Total at 31 March 2016	15,568	96,924	110	8,218	12	7,021	63	127,916

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	4,658	33,701	0	338	5	45	93	38,840
Movements (specify)	139	9,145	0	(14)	0	0	0	9,270
At 31 March 2016	4,797	42,846	0	324	5	45	93	48,110

Additions to Assets Under Construction in 2014-15

Land	110
Buildings excl Dwellings	0
Dwellings	0
Plant & Machinery	110
Balance as at YTD	220

12.1 Property, plant and equipment prior-year

2014/15	Land	Buildings excluding dwellings	Assets under construction & payments	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2014	17,035	89,858	8,454	24,473	176	13,102	1,526	154,624
Additions of Assets Under Construction			0					0
Additions Purchased	0	3,907		1,683	0	2,581	3	8,174
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	0	0	60	0	0	0	60
Additions Leased (including PFI/LIFT)	0	0		0	0	0	0	0
Reclassifications	0	0	(8,454)	0	0	0	0	(8,454)
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	(1,299)	(6)	(108)	(21)	(1,434)
Revaluation	(1,607)	(4,380)	0	0	0	0	0	(5,987)
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0	0	0	0	0	0	0
At 31 March 2015	15,428	89,385	0	24,917	170	15,575	1,508	146,983
Depreciation								
At 1 April 2014	0	18,346	0	15,496	157	9,263	1,415	44,677
Reclassifications	0	0		0	0	0	0	0
Reclassifications as Held for Sale and Reversals	0	0		0	0	0	0	0
Disposals other than for sale	0	0		(1,299)	(6)	(108)	(21)	(1,434)
Revaluation	0	(21,153)		0	0	0	0	(21,153)
Impairments/negative indexation charged to operating expenses	0	248	0	21	2	0	0	271
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Charged During the Year	0	2,559		2,097	3	1,292	34	5,985
Transfers (to)/from Other Public Sector Bodies under Absorption Accountin	0	0		0	0	0	0	0
At 31 March 2015	0	0	0	16,315	156	10,447	1,428	28,346
Net Book Value at 31 March 2015	15,428	89,385	0	8,602	14	5,128	80	118,637
Asset financing:								
Owned - Purchased	15,428	89,385	0	7,943	14	5,017	80	117,867
Owned - Donated	0	0	0	226	0	0	0	226
Owned - Government Granted	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	433	0	111	0	544
On-SOFP PFI contracts	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0
Total at 31 March 2015	15,428	89,385	0	8,602	14	5,128	80	118,637

13. Intangible non-current assets

13.1 Intangible non-current assets

2015/16

	IT - in-house & 3rd party software	Computer Licenses	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's
At 1 April 2015	37	0	13,036	13,073
Additions Purchased	6	0	1,048	1,054
Additions Internally Generated	0	0	0	0
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0
Reclassifications	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0
Disposals other than by sale	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0
At 31 March 2016	43	0	14,084	14,127
Amortisation				
At 1 April 2015	17	0	12	29
Reclassifications	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0
Disposals other than by sale	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0
Impairment/reversals charged to reserves	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0
Charged During the Year	1	0	448	449
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0
At 31 March 2016	18	0	460	478
Net Book Value at 31 March 2016	25	0	13,624	13,649
Asset Financing: Net book value at 31 March 2016 comprises:				
Purchased	25	0	13,624	13,649
Donated	0	0	0	0
Government Granted	0	0	0	0
Finance Leased	0	0	0	0
On-balance Sheet PFIs	0	0	0	0
Total at 31 March 2016	25	0	13,624	13,649

Development Expenditure relates to the Trust's Electronic Patient Record (EPR) system. During the year the asset was transferred from an asset under construction into operation. Accordingly the asset has attracted depreciation charges with the asset being depreciated over eight years.

13.2 Intangible non-current assets prior year

2014/15	IT - in-house & 3rd party software	Computer Licenses	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's
Cost or valuation:				
At 1 April 2014	17	0	37	54
Additions - purchased	20	0	4,545	4,565
Additions - internally generated	0	0	0	0
Additions - donated	0	0	0	0
Additions - government granted	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0
Reclassifications	0	0	8,454	8,454
Reclassified as held for sale	0	0	0	0
Disposals other than by sale	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0
Impairments	0	0	0	0
Reversal of impairments	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0
At 31 March 2015	37	0	13,036	13,073
Amortisation				
At 1 April 2014	14	0	8	22
Reclassifications	0	0	0	0
Reclassified as held for sale	0	0	0	0
Disposals other than by sale	0	0	0	0
Upward revaluation/positive indexation	0	0	0	0
Impairments charged to operating expenses	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0
Charged during the year	3	0	4	7
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0
At 31 March 2015	17	0	12	29
Net book value at 31 March 2015	20	0	13,024	13,044

14. Analysis of impairments and reversals recognised in 2015/16

	2015/16 Total £000's
Property, Plant and Equipment impairments and reversals taken to SoCI	
Unforeseen obsolescence	98
Loss as a result of catastrophe	0
Other	0
Changes in market price	73
Total charged to Annually Managed Expenditure	171
Total Impairments of Property, Plant and Equipment changed to SoCI	171
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	171
Overall Total Impairments	171

15. Analysis of impairments and reversals recognised

	2015/16 Property Plant and Equipment	2015/16 Non-Current Assets Held for Sale	2015/16 Total	2014/15 Total
	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI	0	0		
Unforeseen obsolescence	98	0	98	23
Loss as a result of catastrophe	0	0	0	0
Other	0	0	0	0
Changes in market price	73	0	73	248
Total charged to Annually Managed Expenditure	171	0	171	271
Total Impairments of Property, Plant and Equipment changed to SoCI	171	0	171	271

16 Commitments

16.1 Capital commitments

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

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	396	425
Intangible assets	116	0
Total	512	425

16.2 Other financial commitments

From 01 April 2015 to 31 March 2016 the Trust has not entered into non-cancellable contract arrangements (which are not leases or PFI contracts or other service concession - 2014/15 Nil).

17. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2015	1,081	3,309	0	111	0	21	4,522	0
Additions	17,087	1,403	0	0	0	15	18,505	0
Inventories recognised as an expense in the period	(16,841)	(1,689)	0	(10)	0	(15)	(18,555)	0
Write-down of inventories (including losses)	(65)	0	0	0	0	0	(65)	0
Balance at 31 March 2016	1,262	3,023	0	101	0	21	4,407	0

18. Trade and other receivables

	Current	
	31 March 2016 £000's	31 March 2015 £000's
NHS receivables - revenue	7,451	3,478
NHS receivables - capital	0	0
NHS prepayments and accrued income	4,243	4,705
Non-NHS receivables - revenue	1,001	618
Non-NHS receivables - capital	0	0
Non-NHS prepayments and accrued income	1,574	1,607
PDC Dividend prepaid to DH	0	0
Provision for the impairment of receivables	(1,625)	(432)
VAT	1,192	564
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0
Interest receivables	2	0
Other receivables	1,843	2,452
Total	15,681	12,992
Total current and non current	15,681	12,992

The majority of trade is with NHS Clincal Commissioning Groups (CCG's). As CCG's are funded by Government to buy NHS patient care services no credit scoring of them is considered necessary.

18.1 Receivables past their due date but not impaired

	31 March 2016 £000's	31 March 2015 £000's
By up to three months	4,208	1,537
By three to six months	4,920	145
By more than six months	2,988	2,414
Total	12,116	4,096

£11,353k of the total £12,116k relates to debts from NHS organisations.

18.2 Provision for impairment of receivables

	2015/16 £000's	2014/15 £000's
Balance at 1 April 2015	(432)	(343)
Amount written off during the year	16	0
Amount recovered during the year	59	0
(Increase)/decrease in receivables impaired	(1,268)	(89)
Balance at 31 March 2016	(1,625)	(432)

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 2016 £000's	31 March 2015 £000's
Opening balance	1,708	511
Net change in year	(184)	1,197
Closing balance	1,524	1,708
Made up of		
Cash with Government Banking Service	1,489	1,650
Commercial banks	25	51
Cash in hand	10	7
Cash and cash equivalents as in statement of financial position	1,524	1,708
Cash and cash equivalents as in statement of cash flows	1,524	1,708

20. Trade and other payables

	Current	
	31 March 2016 £000's	31 March 2015 £000's
NHS payables - revenue	**832**	624
NHS payables - capital	**0**	0
NHS accruals and deferred income	**9,053**	3,477
Non-NHS payables - revenue	**1,420**	2,100
Non-NHS payables - capital	**2,496**	4,610
Non-NHS accruals and deferred income	**11,594**	10,666
Social security costs	**1,264**	47
PDC Dividend payable to DH	**120**	0
Accrued Interest on DH Loans	**44**	
VAT	**251**	0
Tax	**1,309**	9
Payments received on account	**0**	0
Other	**144**	124
Total	**28,527**	21,657
Total payables (current and non-current)	**28,527**	**21,657**
Included above:		
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0
number of Cases Involved (number)	**0**	0
Outstanding Pension Contributions at the year end	**1,454**	1,524

21. Borrowings

	Current		Non-current	
	31 March 2016 £000's	31 March 2015 £000's	**31 March 2016 £000's**	31 March 2015 £000's
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from Department of Health	**300**	600	**39,054**	300
Loans from other entities	**116**	256	**190**	306
Finance lease liabilities	**122**	243	**96**	199
Total	**538**	**1,099**	**39,340**	**805**
Total borrowings (current and non-current)	**39,878**	**1,904**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	Dept of Health £000's	**Other £000's**	**Total £000's**
0-1 Years	300	333	**633**
1 - 2 Years	0	191	**191**
2 - 5 Years	39,054	0	**39,054**
TOTAL	**39,354**	**524**	**39,878**

During the period the Trust took out the following loans :

Loan Type	**Value £000's**	**Rate %**
Revolving Working Capital Loan (Department of Health)	15,317	3.5
Interim Revenue support Loan (Department of Health)	23,737	1.5

All loans have received Board of Directors, NHS Improvement (formerly NHS Trust Development Agency) and Department of Health approval.

22. Deferred income

	Current		Non-current	
	31 March 2016 £000's	31 March 2015 £000's	**31 March 2016 £000's**	31 March 2015 £000's
Opening balance at 1 April 2015	**400**	40	**0**	0
Deferred revenue addition	**152**	360	**0**	0
Transfer of deferred revenue	**(400)**	0	**0**	0
Current deferred Income at 31 March 2016	**152**	400	**0**	0
Total deferred income (current and non-current)	**152**	400		

23. Finance lease obligations as lessee

Amounts payable under finance leases other than land and buildings comprises of :

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2016 £000's	31 March 2015 £000's	**31 March 2016 £000's**	31 March 2015 £000's
Within one year	**124**	247	**122**	243
Between one and five years	**97**	201	**96**	199
After five years	**0**	0	**0**	0
Less future finance charges	**(3)**	(6)	**0**	0
Minimum Lease Payments / Present value of minimum lease payments	**218**	442	**218**	442
Included in:				
Current borrowings			**122**	243
Non-current borrowings			**96**	199
			218	442

The Trust did not have any amounts payable under finance leases in respect of land and buildings (2014/15 Nil).

24. Provisions

	Total	Early Departure Costs	Legal Claims	Other	Redundancy
	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2015	**4,293**	1,086	49	3,158	0
Arising during the year	**1,300**	41	189	971	99
Utilised during the year	**(1,865)**	(76)	0	(1,789)	0
Reversed unused	**(1,369)**	0	0	(1,369)	0
Unwinding of discount	**14**	14	0	0	0
Change in discount rate	**0**	0	0	0	0
Balance at 31 March 2016	**2,373**	**1,065**	**238**	**971**	**99**
Expected Timing of Cash Flows:					
No Later than One Year	**1,336**	77	189	971	99
Later than One Year and not later than Five Years	**357**	308	49	0	0
Later than Five Years	**680**	680	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 2016	52,658
As at 31 March 2015	32,490

Provisions arising during the year include provisions against 2015/16 activity including payments for maternity pathways. The Trust has also provided for contractual obligations, legal and regulatory claims and clinical excellence awards.

25. Contingencies

	31 March 2016	31 March 2015
	£000's	£000's
Contingent Liabilities		
NHS Litigation Authority legal claims	(38)	0
Net value of contingent liabilities	(38)	0

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

The Trust has no contingent assets (2014/15 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 Cash and Treasury Management policy agreed by the Board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

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

Interest rate risk
The Trust borrows from the Department of Health. For capital expenditure, any loans or Public Dividend Capital allocations are subject to affordability as confirmed by NHS Trust Development Agency. 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

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 31 March 2016 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

	Total Loans and Receivables £000's
Receivables - NHS	**7,451**
Receivables - non-NHS	**1,001**
Cash at bank and in hand	**1,524**
Other financial assets	**1,843**
Total at 31 March 2016	**11,819**
Receivables - NHS	3,478
Receivables - non-NHS	618
Cash at bank and in hand	1,708
Other financial assets	2,452
Total at 31 March 2015	8,256

26.3 Financial Liabilities

	Total Other £000's
NHS payables	**832**
Non-NHS payables	**3,916**
Other borrowings	**39,660**
PFI & finance lease obligations	**218**
Other financial liabilities	**144**
Total at 31 March 2016	**44,770**
NHS payables	624
Non-NHS payables	6,710
Other borrowings	1,462
PFI & finance lease obligations	442
Other financial liabilities	124
Total at 31 March 2015	9,362

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 the 2 June 2016.

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 transaction, including any transactions of close family members. The Trust also maintains a hospitailty and decalration of interest register.

Employeee Name / Role	Role/Name of Related Party	Payments to Related Party 01 April 2015 - 31 March 2016 £
Mr James Anderson - Non Executive Director	Anglia Ruskin Health Partnership - Managing Director*	40,000

* Anglia Ruskin Health Partnership is a partnership of nine health and social care organisations in Essex including Princess Alexandra Trust.

The Department of Health is also 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. Consistent with 2014/15 the most significant transactions have been with :-

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

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 Charities objective is to provide support both generally and in certain areas of the Trust's activities. During the year the Charity contributed £463k (unaudited) to the Trust (2014/15 £278k).

29. Losses and special payments

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

The total number of losses cases in 2014/15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	16,850	633
Special payments	80,027	28
Total losses and special payments	96,877	661

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 Breakeven 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
Turnover	136,763	149,202	161,295	172,171	179,388	180,790	184,568	177,739	190,478	**196,124**
Retained surplus/(deficit) for the year	4,408	4,534	3,222	511	415	(4,506)	(63)	(16,498)	(22,274)	**(37,954)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	0	0	4,930	228	5	271	**171**
Adjustments for impact of policy change re donated/government grants assets						37	(43)	90	5	**69**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	0	0	0	0	**0**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	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)**
Break-even cumulative position	**(6,220)**	**(1,686)**	**1,536**	**2,047**	**2,462**	**2,923**	**3,045**	**(13,358)**	**(35,356)**	**(73,070)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, the Trust's financial performance measurement 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 Breakeven 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 %
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**
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**

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.

31. 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%.

32. External financing

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

	2015/16 £000's	2014/15 £000's
External financing limit (EFL)	**36,722**	26,355
Cash flow financing	**36,178**	23,798
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**36,178**	23,798
Under/(over) spend against EFL	**544**	2,557

The Trust underspent against the EFL. Underspends are permitted.

33. Capital resource limit

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

	2015/16 £000's	2014/15 £000's
Gross capital expenditure	**7,778**	12,800
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**0**	(60)
Charge against the capital resource limit	**7,778**	12,740
Capital resource limit	**8,411**	14,002
(Over)/underspend against the capital resource limit	**633**	1,262