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Milton Keynes
University Hospital

NHS Foundation Trust

2019/20

Annual Report and Accounts

Milton Keynes University Hospital NHS Foundation Trust
Annual Report and Accounts
2019/20

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors of Milton Keynes University NHS Foundation Trust on 11 June 2020.

Joe Harrison
Chief Executive

The Annual report can be made available in other languages and formats on request

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Chairman's Introduction

It gives me great pleasure to introduce the Annual Report for the Trust for 2019/20. It has been a very positive and rewarding year – but, at the end, very challenging - with a range of great developments and initiatives to build on the service we provide to patients.

Towards the end of the year, there was an unprecedented time for NHS hospitals across the UK – MKUH included - as the Covid-19 pandemic took hold in late February and March 2020. We rapidly had to devise very different ways of working to ensure the safety of staff, patients and visitors. As suspected cases increased, we took the decision to suspend the majority of non-urgent and elective cases as we rapidly redeveloped and repurposed certain areas of the site to create additional ICU (Intensive Care Unit) space and create separate entrances and workstreams for Covid-suspected patients and non-Covid patients.

2019/20 was a year in which we were again awarded a rating of 'Good' by the Care Quality Commission. The rating followed a series of planned inspections across April and May earlier in 2019 when emergency care, medical, surgical and maternity services were all inspected by the regulator. I was very pleased with the overall 'Good' rating, and that the report recognised the hard work and good practice demonstrated across our clinical services, as well pointing out some areas that we can improve. Our staff can look on the rating as recognition of their hard work and commitment. We all have a collective responsibility now to make sure we improve in the relevant areas highlighted in the report for the benefit of the people of Milton Keynes. To read the full report, please visit the CQC website.

In early March 2020, we opened our fantastic new Cancer Centre which brings all cancer-related services under one roof for holistic treatment and care. The Centre brings significant improvements to the treatment of cancer patients in Milton Keynes and the surrounding areas. While cancer services were previously provided across three locations on the hospital site, the new centre offers oncology, clinical haematology and cancer-related chemotherapy services, inpatient and outpatient services alongside a wellbeing support service, allowing MKUH to significantly improve the quality of its Cancer Services whilst also helping to increase capacity. Facilities include outpatient consultation rooms, procedure rooms and a specialist treatment rooms, a 24-bed inpatient ward (16 single en-suite rooms) including two two-bed bays and a four-bed assessment bay, a Macmillan Suite and the Irene Crosswell Macmillan Wellbeing Lounge.

The building has been supported by Milton Keynes Council, Macmillan Cancer Support and a public fundraising appeal by Milton Keynes Hospital Charity. We were delighted the Charity was named 'Charity of the Year' in the MK Business Achievement Awards and, while fundraising has focused largely on the Cancer Centre Appeal, support has continued for other areas including paediatrics, the Neonatal unit and wards for our patients with dementia. We are extremely grateful to everyone who has contributed to what is a wonderful facility.

On behalf of the Board and as Chairman of the Council of Governors, I would like to thank all of the governors who contributed to ensuring that the hospital has continued to meet the needs of the local community. As a Foundation Trust, MKUH has a Council of Governors which plays a vital role in representing the interests of the hospital's members. We have both staff and publicly elected governors who represent constituencies in Milton Keynes and the surrounding area, and governors who are appointed to represent the interests of certain stakeholders. Their key role in the oversight of services here at the hospital is one for which I am most grateful. It also gives me great pleasure to acknowledge the tireless support of our Non-Executive Directors. We have welcomed Haider Husain and John Lisle to the Board as Non-Executive Directors. We have also said goodbye to Tony Nolan and Parmjit Dhanda and we are extremely grateful for them for the outstanding contribution they have made as members of the Board. We also said farewell to Lisa Knight, our Chief Nurse and Director of Patient Care. Nicky Burns-Muir took over this role as an interim post, and following formal recruitment was substantively appointed to the post. We also welcomed Emma Livesley as Director of Operations.

Our staff are fundamental to our success as a Trust in providing quality care and treatment to patients, and recognition of their contribution was showcased at the MKUH Staff Awards in November 2019, which was our biggest ever with more than 300 in attendance. The ceremony is our opportunity to celebrate staff achievements from right across the hospital, and it is fair to say our staff and the public joined in with over 670 nominations submitted. I would like to say a big well done to the individuals and teams who were either nominated, shortlisted or won although, as Chairman, it would be remiss of me not to single out Samantha Burns, Patient Pathway Manager for ENT (Ear, Nose and Throat) who won my own Chairman's Award for Excellence!

Speaking of staff engagement, in May 2019 we held our annual Event in the Tent which provided an excellent opportunity to further inspire our staff with dynamic presentations from a variety of speakers and activities that provided great motivation and additional perspectives on how to provide excellent care and treatment for our patients. More than 1,400 staff from across the hospital attended the Event during the week, hearing talks by Sir Anthony Seldon, Vice Chancellor of the University of Buckingham, and NHS Patient Champion Ashley Brooks, among others. The 2019 event also saw the new staff benefits package unveiled giving staff free parking at the hospital, among other benefits which were rolled out across the year. Staff fully deserve these benefits for their continued hard work and commitment, and we believe that these assist in retaining and recruiting staff.

> *"I am very confident that the teams here at the hospital will continue to devise the necessary contingency plans and work to the highest levels in an uncertain and changing healthcare climate to deliver the best healthcare for the people of Milton Keynes."*

As I have already indicated, we faced very challenging times towards the end of the year, with the pandemic Covid-19. It is testament to the leadership team and our front-line staff for their dedication and hard work as the Trust adapted our models of care for the very sickest patients who required ventilation and round the clock care. In line with many hospital trusts in the country we have seen all our staff and volunteers doing their utmost to ensure all our patients received the care and treatment they needed, and they deserve our greatest thanks.

All in all, 2019/20 was positive year for the Trust and, looking ahead to 2020/21, while it is clearly difficult to predict the ongoing effects that Covid-19 will have, I am very confident that the teams here at the hospital will continue to devise the necessary contingency plans and work to the highest levels in an uncertain and changing healthcare climate to deliver the best healthcare for the people of Milton Keynes.

Simon Lloyd
Chairman

1. Performance Report

1.1 Overview of Performance

The performance overview provides a summary of the Trust's performance for 2019/20. It includes a statement from the Chief Executive providing his perspective on how the Trust has performed during the year; provides a brief synopsis of the Trust's purpose and activities and on its history and statutory (legal) background. This section also outlines the key risks and issues to the delivery of the Trust's objectives faced by the organisation in 2019/20.

1.1.1 Chief Executive's Statement on Performance

The last months of the 2019/20 financial year have been some of the most arduous and testing we have faced. Writing this at the close of the year, it is almost impossible to imagine the world that existed pre-Covid-19. Our lives, both within the hospital and outside it, have changed immeasurably.

I know this is a burden carried by our whole community, and communities across the country. I thank each and every one of our staff, their families and the residents of Milton Keynes for their courage and fortitude throughout these most challenging of times.

The Covid-19 pandemic has seen us completely restructure the care and services we deliver, providing emergency care for patients in need, and dramatically scaling back our outpatient and non-emergency activity. This annual report therefore looks quite different from previous years, with much more limited performance and quality information than would usually be the case.

I would like to reassure the reader however, that our commitments to the quality of care our patients receive, to their experience, to our operational performance and to our long-term financial health, remain absolute. Whilst it has been necessary for us to operate very differently as a hospital in the last months of the financial year, we have not and will not lose sight of our long-term ambitions and priorities in continuing to improve our care and services.

One of the most significant and visible of these ambitions has been realised this year with the building and opening of our new Cancer Centre. This impressive building brings together our cancer services into one purpose- built location, providing patients undergoing cancer treatment with an environment designed for their specific needs – whether receiving outpatient chemotherapy or acute inpatient care. Fundraising for the Cancer Centre has also united local businesses and members of the community, with their kindness and generosity raising £0.9m in our Cancer Centre Appeal.

We have a firm belief that investing in the health and wellbeing of #TeamMKUH is the right thing to do – with a raft of evidence showing staff who feel happy and valued provide higher quality care. To this end we held an engagement exercise with staff across the hospital to find out what would improve their working lives. We then launched a benefits programme in May 2019, introducing free parking, free tea and coffee and a raft of other measures to make working life easier. We have continued to build on this – including throughout the Covid-19 pandemic, to ensure our staff are as well cared for as our patients.

> *"Our staff, volunteers, governors, members, students, partner organisations and those others in the community who all work together to provide care, services and support for those we are here to serve deserve our thanks and recognition more than ever this year."*

Our operational performance has been in line with our peers throughout the year, with increasing demand on hospital services causing some points of pressure in emergency, cancer and planned care. We have worked hard to maintain our performance and have engaged in a national pilot around elective care waiting times and continued our focus on improving access to timely emergency and planned care and services. You will find detailed performance analysis on page 20 of this report.

Financially, after adjusting for specific items relating to Covid-19 we met our agreed financial control total for the seventh consecutive year. On a control total basis (including funding received through the financial recovery fund and provider sustainability funds), the Trust reported a small surplus of £0.1m which was £0.5m better than the Trust's financial control total and plan of £0.4m deficit.

Finally, I would like to take this opportunity to extend my gratitude to the whole of #TeamMKUH for their dedication and professionalism. Our staff, volunteers, governors, members, students, partner organisations and those others in the community who all work together to provide care, services and support for those we are here to serve deserve our thanks and recognition more than ever this year. The demand that is placed on staff and services is unrelenting and yet, their passion remains undiminished. This never ceases to amaze and inspire me in equal measure.

Looking ahead our focus will remain, whatever challenges we face as a hospital and as a nation, on providing the excellent care and services the people of Milton Keynes expect and deserve.

Joe Harrison
Chief Executive

1.1.2 Purpose and Activities of the Trust

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006. The hospital has around 550 beds, including day acute and neonatal beds and employs around 3,500 staff, providing a full range of acute hospital services and an increasing number of specialist services to the growing population of Milton Keynes and surrounding areas. All in-patient services and most outpatient services are provided on the main hospital site.

The Trust is organised into four clinical divisions (medicine, surgery, women and children and core clinical) and a number of corporate directorates. The executive directors, and clinical service unit (CSU) leadership teams, are responsible for the day-to-day management and running of the hospital's services, with ultimate management accountability resting with the Chief Executive.

1.1.3. Trust objectives

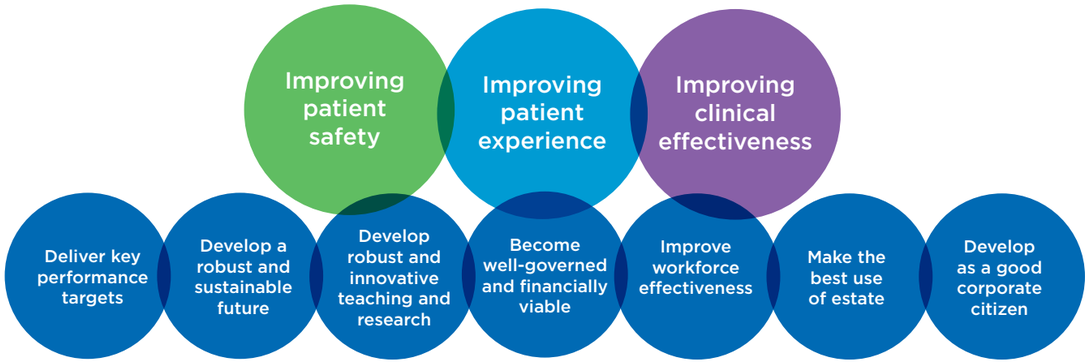
The Trust Board has agreed a process for agreeing and refreshing its objectives each year, ensuring that these remain linked to its vision, values and strategy.

The Trust's vision is set out as:

"Our vision for Milton Keynes University Hospital NHS Foundation Trust is to be an outstanding acute hospital and part of a health and care system working well together"

These are linked to our strategy. This has five key priorities which will help us to be an outstanding acute hospital and part of a health and care system working well together

Underpinning our strategy are our objectives – which describe what we will deliver in the coming year. For the past five years, we have kept the same ten strategic objectives, the most critical being improving patient safety, experience and clinical effectiveness.



MKUH is part of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS), which was formerly known as a Sustainability and Transformation Partnership (STP). The BLMK ICS is one of 44 ICS 'footprints' set up across England under the Five Year Forward View as a new approach to plan and deliver services by place rather than around individual organisations. In June 2017, BLMK was named as one of eight health and social care systems across the country that is to become Accountable Care System (ACS). The continuing development of ACS (now referred to as Integrated Care System) will see local health and care organisations working more closely together to provide joined up and better coordinated care.

1.1.4 History and Statutory Background of the Trust

Milton Keynes Hospital was officially opened in 1984 and is located at Standing Way, Eaglestone, Milton Keynes, MK6 5LD. The acute services provision at that time included operating theatres, an emergency department, maternity services, general and speciality wards, full diagnostic x-ray facilities, and a major pathology department.

Other projects that were completed soon after this major development included a postgraduate education centre and an extended physiotherapy department, including a hydrotherapy pool.

Construction of phase two started in 1988 and focused on the expansion of facilities to support the continued population growth of Milton Keynes (estimated increase from 1984 to 1994 - 40%). The development comprised six additional 28-bed wards, a further suite of operating theatres, extra accommodation for the pathology department and additional accommodation for staff.

Phase two opened in 1992. Milton Keynes General NHS Trust formally came into being on 1 April 1992. Since then, significant changes have included the expansion of postgraduate education facilities, the provision of a new MRI scanning unit and the expansion and re-location of the cardiology unit and coronary care ward. In recent years the site has grown further with the addition of a 28-bed orthopaedic ward, a GP paediatric assessment unit, fracture clinic and refurbishment of the Emergency Department.

Expansion continued with the opening of a £1.5m Macmillan Haematology and Oncology Unit within the main hospital. In January 2005 the biggest single development on the site for ten years, a £12m treatment centre dedicated to day cases and extended day case surgery, was opened with 60 bed spaces and a further four operating theatres. The centre has proved very popular with patients.

During 2006/07 the sexual health centre was refurbished and a new £2.5m angiography unit opened. Construction work on a new multi-storey car park was completed in July 2007 and cardiology services continue to develop. Extra capacity has been added to clinics such as orthopaedics, ophthalmology and a rolling refurbishment of wards and corridors is on-going.

Since becoming an NHS Foundation Trust on 1 October 2007, sustained expansion has continued. During 2008/09 Ward 14, previously run by the local primary care Trust, was fully refurbished and reopened by the hospital. In April 2009 the

hospital opened a new significantly expanded £4.6m state-of-the-art endoscopy unit and a new 22 bed ward.

In response to the number of patients requiring step down facilities rather than acute care, the Trust invested in the conversion of a ward into a therapist-led facility for patients on the road to recovery. The Phoenix Unit, as it was named, opened in 5 November 2012, and has 20 beds.

A new 20-bed surgical ward, Ward 24, opened in February 2017. Ward 24 helps the hospital manage an ever-increasing demand for services throughout the year and is used by elective surgery patients. It is the first building to be opened under the hospital's site development programme. It was followed by the new £5.4m main entrance that opened in May 2017 and the £8.5m Academic Centre opened by HRH the Duke of Kent in February 2018.

The Trust entered into a partnership with the University of Buckingham to establish the first independent Medical School in the country. The first medical students commenced pre-clinical training at the University in January 2015, and in April 2015 the Trust changed its name to Milton Keynes University Hospital NHS Foundation Trust to reflect this status. The first cohort of University of Buckingham medical students began full-time clinical training with the Trust in March 2017. Sixty students will complete their MB ChB course at the hospital over the next six months, with forty students training on site at any one time.

In late 2018, the Trust opened Ward 12, a new eight bed ward to accommodate the increasing need for inpatient beds. The Acorn Suite opened next to the Emergency Department in 2018, increasing clinical assessment space. A dedicated paediatric emergency department, with separate outside entrance during core hours was also opened. This has been welcomed by parents and carers of our younger patients.

In March 2020, we opened our brand new £15m Cancer Centre, which brings all cancer services on the Trust site under one roof in a state of the art, airy dedicated space. This Centre was supported financially with a £10m donation from MK Council, £2m from Macmillan and the rest generated by our hospital charity's cancer centre appeal. It features a 24-bedded ward with single rooms and shared bays, an extensive area for outpatient treatment, a wellbeing area, along with offices and an aseptic suite for the preparation of cancer treatment drugs.

In 2019/20, the Trust recruited over 4,200 patients to participate in research projects, with more data still to be included. It is the Trust's aim that research becomes an embedded feature of the patient journey and that where possible, they will always be offered the opportunity to participate in clinical trials.

Having submitted expressions of interest for several commercial studies, MKUH has been involved in research across a range of different clinical specialities with most speciality areas now research active. This demonstrates the Trust's growing recognition by industry and its success in forging relationships with commercial partners intending to perform quality research.

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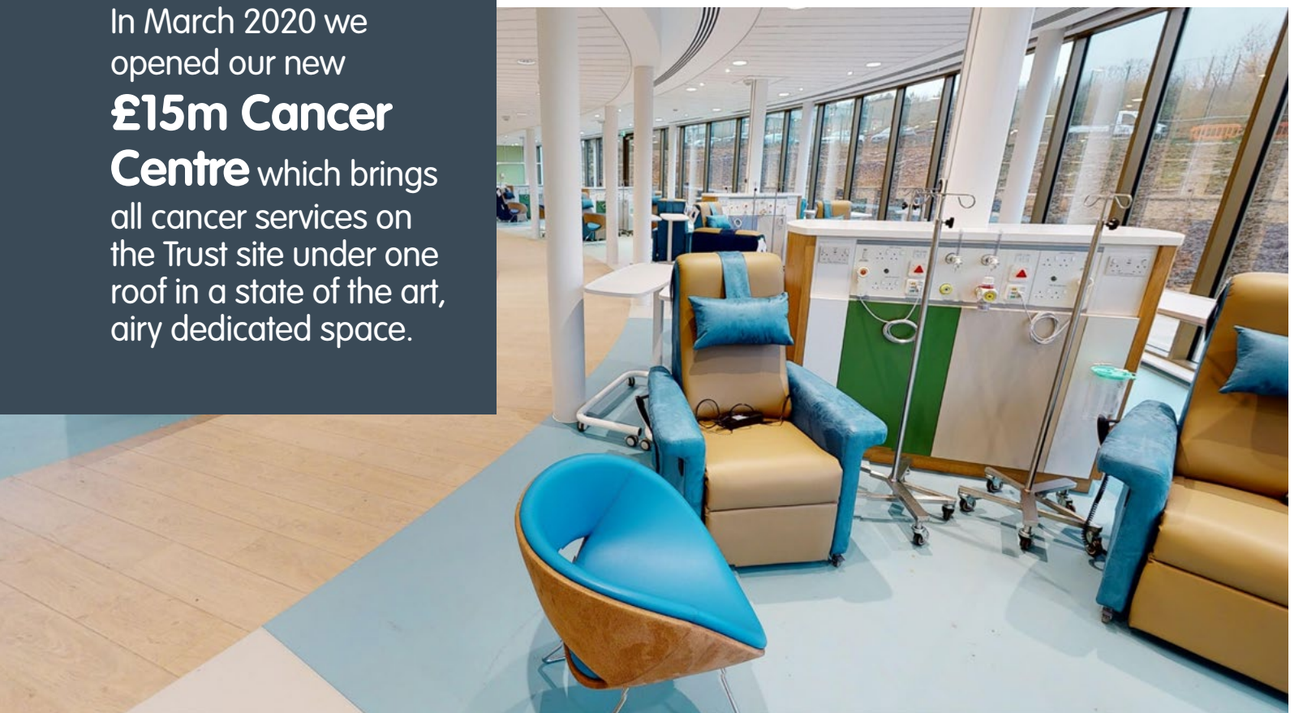


1.1.5 Key Risks and Issues

The Board Assurance Framework reflects the principle risks against the achievement of the Trust's strategic objectives, including clinical and non-clinical risk. These risks are managed through the risk management processes in place in the Trust, with oversight and scrutiny through executive and non-executive chaired boards and committees. The following risks were identified on the Board Assurance Framework at the end of the 2019/20 financial year:

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Quality & Clinical Risk	COO	Strategic failure to manage demand for emergency care	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Tactical failure to manage demand for emergency care	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Ability to maintain patient safety during periods of overwhelming demand	5x4=20	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	Medical Director	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests [Reviewed March 2020]	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	Medical Director	Failure to recognise and respond to the deteriorating patient [Reviewed March 2020]	4x4=16	4x2=8	4x2=8	Avoid
Quality & Clinical Risk	Deputy CEO	Failure to manage clinical risk during significant digital change programmes	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	5x4=20	4x4=16	4x2=8	Avoid
Board of Directors	COO	Ability to cope with the demand for ITU and inpatient care due to the Covid-19 pandemic	5x4=20	5x3=15	5x2=10	Avoid

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Board of Directors	COO	Harm to patients due to the suspension of elective activity during the Covid-19 pandemic	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	Chief Nurse	Failure to achieve improvements in the patient survey	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	COO	Failure to embed learning from poor patient experience and complaints	4x4=16	4x3=12	4x2=8	Avoid
Trust Board	CEO	Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	5x4=20	4x4=16	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Failure to evidence compliance with the annual clinical audit programme	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Failure to embed learning and evidence action plans following clinical audit	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Lack of assessment against and compliance with NICE guidance	3x4=12	3x4=12	3x2=6	Minimal
Executive Management	COO	Failure to meet the 4-hour emergency access standard	4x4=16	4x4=16	4x2=8	Minimal
Executive Management	COO	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	4x4=16	4x4=16	4x2=8	Minimal
Audit	Deputy CEO	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	4x4=16	4x3=12	4x2=8	Minimal
Audit	Deputy CEO	Failure to adequately safeguard against major IT system failure (deliberate attack)	5x2=10	4x2=8	4x2=8	Minimal
Finance & Investment	Deputy CEO	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	5x2=10	4x2=8	4x2=8	Minimal
Executive Management	Deputy CEO	Failure to maximise the benefits of EPR	4x4=16	4x3=12	4x2=8	Minimal
Finance & Investment	DOF	There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trust's capital programme	5x4=20	4x2=8	4x2=8	Cautious
Finance & Investment	DOF	There is a risk that the Trust does not receive timely confirmation that its historical revenue loans due for repayment within 12 months have been refinanced or written off leading to a potential breach of the DHSC loan agreements and/or a going concern/cashflow risk to the Trust.	5x3=15	4x3=12	4x2=8	Cautious
Finance & Investment	DOF	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	5x5=25	3x3=9	3x2=6	Cautious
Finance & Investment	DOF	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	5x4=20	3x3=9	3x2=6	Cautious

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Workforce	Director Workforce	Inability to retain staff employed in critical posts	4x4=16	4x3=12	4x2=8	Cautious
Workforce	Director Workforce	Inability to recruit to vacancies in short term (0-18 months)	4x3=12	4x2=8	4x2=8	Cautious
Workforce	Director Workforce	Inability to recruit to vacancies in medium to long term (19+ months)	4x4=16	4x4=16	4x3=12	Cautious
Quality & Clinical Risk	Medical Director	Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment. [Reviewed March 2020]	4x5=20	4x4=16	4x2=8	Cautious
Workforce	Board of Directors	Ability to maintain a safe working environment during the Covid-19 pandemic	4x4=16	4x3=12	4x2=8	Cautious
Finance & Investment	COO	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	4x3=12	4x3=12	4x2=8	Cautious
Charitable Funds	Director Corp Aff	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	4x2=8	4x2=8	4x2=8	Cautious
Board of Directors	CEO	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	4x3=12	4x2=8	4x2=8	Cautious
Board of Directors	COO	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	5x2=10	5x2=10	5x2=10	Avoid

Further detail on risk management is contained within the Annual Governance Statement from page 92 onwards.

1.1.6 Going Concern Disclosure

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The economic environment for all NHS trusts and NHS foundation trusts continues to be challenging with on-going internal efficiency gains necessary; cost pressures in respect of national pay terms and conditions; and non-pay and drug cost inflation. In addition, as a result of the Covid-19 pandemic (declared by the World Health Organisation on 11 March 2020) there is, and remains, significant uncertainty about the likely demand for hospital services and the impact Covid-19 will have on the costs incurred by NHS organisations. In response the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) have announced a series of measures to ensure the continuity of services, including the provision of additional funding to NHS trusts and foundation trusts to cover additional costs relating to the Covid-19 pandemic.

In its internal planning, the Trust had assumed it will receive at least £19.8m of Financial Recovery Funding (FRF) and £3.2m of Marginal Rate Emergency Tariff (MRET) funding in 2020/21 in accordance with the Trust's original allocations. However, as a result of the Covid-19 pandemic, the Trust expects the changes to the funding regime to result in additional payments by way of a national 'top-up' fund in order to maintain the Trust's planned breakeven position. At present, these additional payments are not expected to be contingent on achievement of a financial control total as would have been the case in the pre-Covid-19 regime.

The Trust expects this to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue operating until adequate plans are in place to achieve financial sustainability for the Trust without reliance on Financial Recovery Funding. Whereas in previous years there were material uncertainties that cast significant doubt over whether the Trust would continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business, the Directors of the Trust believe that there is no longer a material uncertainty regarding Trust's ability to continue as a going concern.

The Directors have considered the following matters in reaching this conclusion:

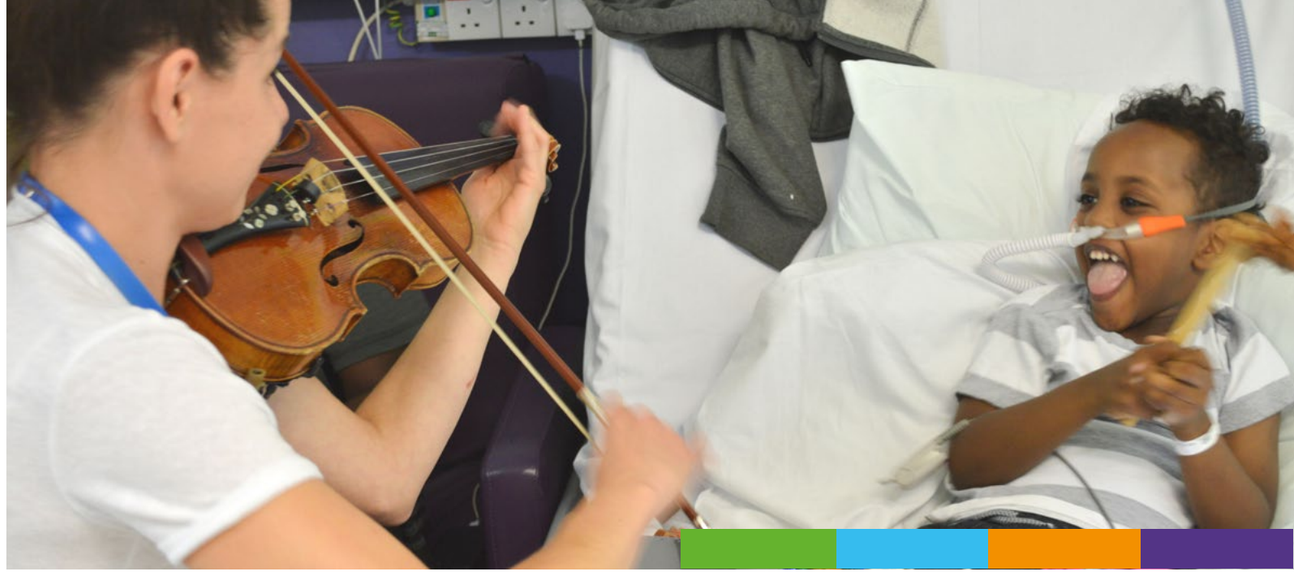
1. The Trust had a financial deficit of £5.124m for the year ended 31 March 2020 (£9.546m deficit in 2018/19); however, the Trust generated cash of £10.1m in 2019/20 (£3.7m in 2018/19) and held a cash balance of £16.3m on 31 March 2020 (£6.2m on 31 March 2019)
2. On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital loans (totalling £130.9m as at 31 March 2020) will be written off as of 1 April 2020 and will be replaced with Public Dividend Capital for which there is no repayment obligation. This announcement has removed the material uncertainty regarding loans that were previous due for repayment within 12 months of the Trust's financial year end;
3. The Trust held a cash balance of £16.3m on 31 March 2020 (£6.2m on 31 March 2019) which provides a reserve to sustain the cashflow of the organisation and support continued investment in the Trust's estate, equipment and infrastructure;
4. Prior to the Covid-19 pandemic the Trust had put in place plans to achieve its control total set by NHS England and NHS Improvement and in doing so secure the Financial Recovery Funding. While the Covid-19 outbreak has led to uncertainties about the deliverability of this plan in its original form, NHS England and NHS Improvement have given assurance that additional costs incurred in respect of Covid-19 will be reimbursed. In addition, the funding regime for the period April 2020 to July 2020 has changed in order to provide a guaranteed income stream to the Trust, with amounts paid in advance in order to protect the Trust's cashflow position. While there remains uncertainty about the funding and contracting regime beyond July 2020, the Directors are of the view that additional resources will be made available centrally in the event that the Trust is not able to operate business as usual plans due to on-going pressures from Covid-19.

For these reasons, the financial statements do not include any adjustments that would result if the going concern basis were not appropriate, not has the Trust identified material uncertainties which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore its ability to realise its assets and discharge its liabilities in the normal course of business.

1.2 Performance Analysis

This section of the report provides a summary of the Trust's key performance indicators and outlines how it monitors performance against these measures. It also provides a detailed analysis and explanation of the development and performance of the Trust during the year using a wide range of data, including key financial information.

This section also provides a summary of environmental matters and some background on social, community and human rights issues, important events and overseas operations.



1.2.1 Activity

The Trust processed 24.2% more GP referrals than it had planned to at the beginning of the year, and demand on the emergency department was 0.9% higher than expected. The impact of Covid-19 affected activity volumes in March 2020. The Trust accommodated 9.3% fewer emergency admissions through the year than planned, which was a decrease of 15.7% compared to 2018/19. This reduction in emergency admissions was influenced by the evolution of the Ambulatory Care pathway. The Trust treated 2.3% fewer elective admissions than planned and when compared to elective activity in 2018/19, this represented a decrease of 3.4%.

The variation in activity during 2019/20 compared to 2018/19 was as follows:

383,764 outpatient attendances, 0.2% more than 2018/19

25,061 elective spells, 3.4% less than 2018/19

28,997 emergency admissions, 15.7% less than 2018/19

90,152 emergency department attendances, 2.4% more than 2018/19

3,571 babies were delivered, 0.6% fewer than 2018/19

1.2.2 Key Performance Measures

The Trust measures performance in key service and quality areas against key national indicators, which each have nationally defined standards. In addition, the Trust has also developed a series of local service quality indicators in conjunction with Milton Keynes CCG, as well as a number of internal indicators of quality and performance that are not required to be reported nationally.

Where possible, relevant and applicable, performance indicators are consistently reported at aggregate Trust level, as well as at Divisional and CSU level to provide a more granular view. This approach provides an insight into performance, and is used to highlight risks and/or uncertainty in specific areas or services. Performance reports and key performance indicators are used as a basis for influencing the agenda at monthly Trust and Divisional Management Board accountability meetings, alongside financial, workforce and other key elements of information about the trust. This 'balanced scorecard' approach allows correlations to be made across a wide range of information about different areas in the trust to drive and inform a culture of continuous improvement.

Despite a continued increase in demand and sustained pressure on the healthcare system, the Trust has worked tirelessly to manage patient waiting times for planned care in 2019/20.

Since August 2019, the Trust has been operating as a pilot site for a new RTT waiting time performance indicator that was identified as part of the NHS England/Improvement Elective CRS review. During this pilot, the Trust has monitored the mean average waiting times for planned elective pathways as opposed to measuring performance using the 92% 18-week target. An initial 'baseline' of 9.2 weeks was used as the starting point for measuring the movement of the mean average waiting times each month since August 2019.

The diagnostic waiting time target was achieved in six of the twelve months. Delivering the national standards for cancer waiting times also proved to be challenging, but the Trust's aggregate performance has consistently been achieved against the national standards and has also been reliably better than the national aggregate performance. The table below summarises performance against key national indicators for 2019/20.

Indicator	Threshold/Target	Trust Performance	
National Requirements			
Clostridium Difficile Infections (hospital associated)	Ceiling: 22	14	Achieved
MRSA Bacteraemia (hospital associated)	Zero Tolerance	0	Achieved
All cancers, 31 day wait for second or subsequent treatment	Drugs treatments: 98% Surgery: 94% Radiotherapy: 94% Palliative Care: 94%	99.5% 95.8% 95.1% 100%	Achieved Achieved Achieved Achieved
All cancers: 62-day wait for first treatment	GP referred: 85% NHS Screening: 90% Consultant upgrade: 85%	82.2% 81.1% 73.5%	Not Achieved Not Achieved Not Achieved
All cancers: 2-week wait from referral to first appointment	All cancers: 93% Symptomatic breast: 93%	92.1% 96.5%	Not Achieved Achieved
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways OR the mean average waiting time for patients in weeks.	92% OR 9.2 weeks	83.9% OR 13.7 weeks (at the end of March 2020)	Not Achieved
Maximum wait of 4 hours in the Emergency Department from arrival to admission, transfer or discharge	95%	88.7%*	Not Achieved
Acute Foundation Trust – Minimum Standards			
Friends and Family Test (Patient Recommend Rate)	None	95.0%	No Threshold
Complaints responded to within the required timeframe	90%	89.5%	Not Achieved

**This figure represents the combined performance of the Trust's Type 1 and Type 3 units.*

1.2.3 Detailed Quality Performance Analysis

1.2.3.1 Referral to Treat (RTT)

Since August 2019, the Trust has been operating as a pilot site for a new RTT waiting time performance indicator that was identified as part of the NHS England/Improvement Elective CRS review. During this pilot, the Trust has monitored the mean average waiting times for planned elective pathways as opposed to measuring performance using the 92% 18-week target. An initial 'baseline' of 9.2 weeks was used as the starting point for measuring the movement of the mean average waiting times each month since August 2019.

The Trust did not meet the 9.2-week baseline consistently. Significant winter pressures meant that the focus, in common with most other NHS Trusts, turned to caring for the large number of very sick patients attending the Emergency Department. The Trust's performance was further hampered by the difficulties encountered in maintaining patient flow through the hospital. In particular, many patients who had been admitted with medical complaints had to be cared for in beds that would normally have been used for elective patients.

Month 2019/20	Baseline (Average Wait in Weeks)	Trust Performance (Average Wait in Weeks)
April	9.2	8.9
May	9.2	9.2
June	9.2	9.3
July	9.2	9.9
August	9.2	9.6
September	9.2	10.1
October	9.2	10.1
November	9.2	10.7
December	9.2	12.0
January	9.2	12.3
February	9.2	11.9
March	9.2	13.7

1.2.3.2 Accident and Emergency 4-hour target

The Trust did not achieve the target of treating 95% of patients attending the Emergency Department within 4 hours. However, its overall performance of 88.7% (all types) for the year placed it among the top 25% of performing trusts with a Type 1 department nationally for this measure.

The Trust reacted positively to increased pressure on services and patient flow throughout the winter months, through effective planning involving the whole hospital, and coordinated with key partners across the local health economy. This meant that additional bed capacity was made available in advance of the winter months. Clinical teams from across the Trust were deployed to provide assistance to the Emergency Department at times of particularly high demand, and the Trust worked collaboratively with primary and social care to help free up capacity and keep the number of delayed transfers of care to a minimum. Continuous steps are taken to promote best practice to reduce length of stay where appropriate and enhance the patient discharge process, with whole health and social care system across Milton Keynes and the surrounding areas.

1.2.4 Development of the Business during the Year

The Trust continued to engage fully in the development of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS). This is a system in which the respective NHS organisations (both commissioners and providers) in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. This collaborative approach to providing care is already leading to better outcomes for local people, including reductions in the length of time that patients need to wait before they can be discharged from the hospital back into community settings.

In addition to the collaboration with ICS partners, the partnership between the Trust and the University of Buckingham Medical School continues with positive results. The first cohort of students trained in the University's Academic Centre on the Trust site and within the hospital's wards and clinical areas graduated in September 2019, with several graduates taking on employment with us. A range of Trust clinicians continue to actively participate in all aspects of training.

The Trust continued the roll out of its Electronic Patient Record (EPR) system, known as eCare. It was first introduced in May 2018. The planned move of several additional areas over to eCare in early 2020 - including Paediatrics – was postponed due to the pressures caused by the Covid-19 pandemic. The aim of eCare is to better utilise technology to increase patient safety and clinical effectiveness with significant benefits already in evidence. We are constantly looking at growing these benefits when further functionalities of the system are realised. It is expected that this system, together with other new technological innovations that the Trust is investing in, will revolutionise the way that care is provided across the hospital.

In 2019/20 the Trust took delivery of a state-of-the-art surgical robot. Clinicians undertook comprehensive training using the robot before going live in theatres. The robot has been used to assist in performing a number of procedures, particularly in the area of colorectal surgery and to date results have been impressive, with both clinical staff and patients giving positive feedback.

1.2.5 Impending Developments and Future Development Trends

The building of our Cancer Centre was completed to budget and it was opened and fully operational in early March 2020. This £15m project brings all cancer services provided on site under one roof in a purpose-built extension to the hospital estate. In the future, the Trust also has plans to develop and build further cancer services on site, including radiotherapy bunkers subject to the agreement of our tertiary providers at Oxford.

During 2020, work will commence on the construction of a new imaging building to enable the Trust to provide increased capacity for MRI (magnetic resonance imaging) and CT (computed tomography) scans. A new PET CT Scanner (positron emission tomography–computed tomography) is already operational on site.

Work has commenced on the development of our new Assessment Unit which will include a 26-bed ward to manage the flow of emergency medical admissions into the Trust. The Unit will take referrals from the Emergency Department, General Practice and from Outpatient clinics.

Patients attending the unit will receive full nursing and medical assessments of their physical and healthcare needs. Treatment options will be discussed and initiated within this area with a plan that either allows them to return home or be admitted to an appropriate medical ward.

The Unit will be managed by a clinical and nursing team consisting of medical consultants, a ward sister and senior staff and supported by a whole range of healthcare professionals.

The Assessment Unit will provide:

- rapid assessment, diagnosis and initial treatment of emergency medical patients
- rapid access for GPs
- rapid access nurse led clinics
- rapid access to diagnostic services
- follow up consultant clinics
- ensure that patients are admitted to the appropriate beds wherever possible.
- enable an informed decision as to whether the patient requires admission or can be discharged home or to residential care with a plan of treatment

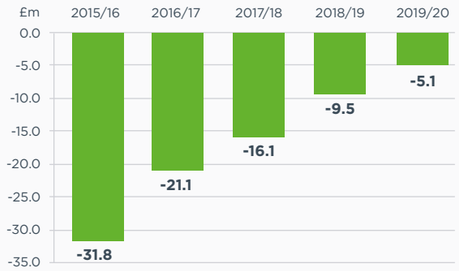
The unit will be part of a Trust wide initiative, working closely with the Emergency Department to create and Acute Care Pathway which is being designed to simplify the patient journey, improve the services we offer and enhance the patient experience.

In December 2019, the Trust was informed that it was going to be the recipient of 'seed funding' from the Department of Health and Social Care's HIP2 (Health Infrastructure Plan) as part of a planned £200m hospital redevelopment programme in Milton Keynes. The first tranche of funding will allow the Trust to develop a comprehensive strategic outline case regarding proposals for the expansion of the site. With the rapid population growth of Milton Keynes predicted to continue, it has been clearly established that there is a need for a dedicated women's and children's unit, along with further theatres and accompanying surgical wards.

1.2.6 Review of Financial Performance

Despite on-going financial pressures across the NHS, during 2019/20 the Trust continued its excellent track record of reducing its financial deficit year on year and meeting or exceeding its agreed financial plan. In 2019/20 it secured a lower (better) deficit of £5.1m (excluding other comprehensive income). This represents a £4.5m improvement on the reported deficit of £9.5m in 2018/19 and a £26.8m improvement compared to 2015/16 when the Trust reported its largest deficit (£31.8m):

Historical reported deficits (before revaluations)



During 2019/20 the Trust benefitted from £24.8m of income from Provider Sustainability Funding (£5.6m), Marginal Rate Emergency Rule income (£3.2m) and through the Financial Recovery Fund (£16.0m) after meeting its financial control total (adjusted for the impact of Covid-19 in March 2020).

The Trust's income continued to grow over the course of 2019/20, with operating income from patient services increasing by £22.4m to £234.9m for the year ending 31 March 2020. This growth in income reflects the continued rise in demand for the hospital's services, as well as the increasing complexity of patients and changes in contracting and pricing arrangements adopted during the year.

As a result of the Covid-19 pandemic (declared by the World Health Organisation on 11 March 2020) the Trust incurred additional costs in March 2020 in order to ensure that the Trust continued to provide safe and effective care and manage the increase in the number of critically unwell patients requiring intensive care. Whilst this adversely affected the Trust's financial performance in month (resulting in adverse variances against plan), the Trust, like other NHS organisations, received additional central funding to manage the additional cost pressures.

During 2019/20 the Trust continued to invest in the hospital's infrastructure through its capital programme. Significant investments in information technology (as part of the Trust's eCare programme) mean that the Trust continues to be one the most technologically advanced trusts in the country. This, combined with investments in the physical estate including a new pharmacy robot and development of a new aseptic unit (used for the manufacture of drugs to support the treatment of cancer and other patients in hospital), will enable the Trust to deliver more effective and efficient hospital services and allow for the significant growth in the population it serves. In addition, in February 2020 the Trust completed its new Cancer Centre, a state-of-the-art facility for the treatment of cancer patients in Milton Keynes and surrounding areas. This investment was made possible by the generous donations of the local community through the Milton Keynes Hospital Charity Cancer Centre appeal.

Total capital expenditure for the year was £24.9m which was funded through a combination of internally generated sources, Public Dividend Capital, donations and capital loans from the Department of Health and Social Care.

Statement of Comprehensive Income

The Trust experienced growth in the demand for its services in 2019/20, with activity volumes increasing by 1% on average. This, combined with increasing complexity of patients and changes in the contracting and payment regime during the year, led to a £22.4m (10.6%) increase in clinical income compared to the previous year. The main elements of the increase in clinical income were as follows:

- Outpatient income: £2.8m (6.6%);
- Non-Elective income: £6.0m (8.5%);
- Other NHS clinical income £8.6m (16.3%) which includes adjustments relating to the Trust's block contract arrangement with Milton Keynes CCG;
- Pension funding (£6.7m). This relates to central funding to cover the additional cost of an increase in the employer pension contribution rate from 14.38% to 20.68%.

Non-clinical income increased by £6.2m following the introduction of the Financial Recovery Fund in 2020/21 which was only partly offset by a reduction in the Provider Sustainability Funding.

Operating expenses increased by £25m (9.6%) on the previous year to £284.9m, of which £17.6m related to increase in staffing costs.

The increase in operating expenses reflects a continued investment by the Trust in its services, with business cases approved in year to support improvements in patient experience, staff health and well-being and clinical safety and effectiveness. These investments included the introduction of the next generation of surgical robot, with the Trust being the first trust to adopt the new technology in England. The increase in operating expenses also includes:

- Additional costs to accommodate the increase in demand for hospital services for which the Trust had to increase its clinical capacity (achieved in part by increasing the number of hospital beds, including those within the new Cancer Centre);
- £6.7m relating to increase pension costs following an increase in the employer pension contribution rate (offset in income);
- The Trust had a revaluation in year which resulted in an impairment of £17.2m, of which £7.4m was recognised as an operating expense.
- A £1.4m increase in Trust infrastructure costs, including IT software support, equipment costs and utility costs;
- A £1.2m increase in education and training staff costs linked to the expansion of the University of Buckingham Medical School.

Statement of Cash Flows and Net Debt

As the Trust is in financial deficit, it is reliant on loan financing from the Department of Health and Social Care (DHSC) to meet its obligations as they fall due. In 2019/20, the Trust received a revenue loan from DHSC of £2.6m to fund the planned financial deficit, and a capital loan of £2.7m. The capital loan allowed the Trust to continue with the implementation of its electronic patient records system (eCare) as well as installing a new pharmacy robot and building a new aseptic unit.

The Trust ended the year with cash and cash equivalents of £16.3m which was £8.8m higher than its plan due to earlier than expected receipts of in-year PSF incentive funding and the timing of capital purchases.

Total Assets Employed

Total assets employed decreased by £11.1m (31.5%) to £24.1m. This was largely due to the reduction in the asset value of £17.3m following the revaluation of the Trust's estate and the additional loans taken on by the Trust in the year.

£m	2019/20	2018/19
Non-Current Assets	160.2	162.0
Current Assets	45.3	39.3
Current Liabilities	-174.0	-112.3
Non-Current Liabilities	-7.4	-53.8
Total Net Assets Employed	**24.1**	**35.2**

Capital Expenditure

The Trust invested £24.9m in capital schemes during 2019/20 which was funded through a combination of internally generated resources, public dividend capital and loan financing (provided by DHSC). The investments in year included:

- £9.3m for the Cancer Centre opened in February 2020;
- £1.8m relating to the Trust's eCare digital investment programme;
- £2.4m for a new pharmacy robot and investment in a new aseptic unit;
- £1.7m funded through the Global Digital Investment programme; and
- £9.7m of investment in the wider hospital estate and infrastructure.

A further expansion of the capital programme is planned for 2020/21 which is expected to include investment in a new ambulatory care and assessment unit (the 'Pathway Unit'). In addition, the Trust is one of the 21 trusts that form part of the national Hospital Infrastructure Plan which will lead to significant investment in the hospital site over the next five years.

1.2.7 Counter Fraud

The Trust has an established counter-fraud policy to minimise the risk of fraud or corruption, together with a whistleblowing policy to be followed in the event of any suspected wrong-doing being reported. This policy also highlights the relevant provisions of the Bribery Act 2010, and the offences for which individual members of staff and the Trust corporately could be liable under this Act. The policy and related materials are available on the intranet and counter-fraud information is prominently displayed across the Trust's premises. The Trust's local counter fraud specialist (LCFS) reports to the Director of Finance and performs a programme of work designed to provide assurance to the Board in regard to fraud, bribery and corruption.

The LCFS attends audit committee meetings to present the programme and the results of counter-fraud work. The LCFS also gives regular fraud awareness sessions for Trust staff and investigates concerns reported by staff. Where these are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

1.2.8 Statutory and Other Declarations

Compliance with HM Treasury Cost Allocation and Charging Guidance

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Cabinet Office public sector information guidance.

Accounting Policies and Other Retirement Benefits

The accounting policies for pensions and other retirement benefits are set out in the accounting policies section of the Financial Statements and the arrangements for senior employees' remuneration can be found in the Remuneration Report.

Political and Charitable Donations

The Trust continues to benefit from charitable donations from its charity, Milton Keynes Hospital Charity, and is grateful for the efforts of fundraisers and members of the public for their continued support. The Trust also continues to benefit from charitable donations made from independent charity The Friends of MK Hospital and Community, which celebrated its 40th anniversary in 2019 and continue to raise funds through profits from its hospital shop and other events in the community.

Board of Directors and Accounts' Preparation

The Annual Report and Accounts have been prepared under a direction issued by NHS Improvement. In support of the Chief Executive, as accounting officer of the Trust, the Board of Directors has responsibilities in the preparation of the accounts.

NHS improvement, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006 directs that the accounts give a fair and true view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial period.

To this end, the Board of Directors are required to:

- Apply on a consistent basis accounting policies laid down by NHS Improvement with approval of the Treasury
- Make judgements and estimates that are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- Keep 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 Act
- Safeguard the assets of the Trust and hence take reasonable steps for the prevention and detection of fraud and other irregularities

Critical Accounting Judgements

There are a range of judgements and estimates that have been made in the preparation of the annual accounts. These include the valuation of the Trust's estate. These judgements have been reviewed and are considered appropriate and in accordance with the appropriate accounting standards and further analysis can be found in the accounting policies section of the Financial Statements. In the light of Covid-19, new guidance on material uncertainty with regard to valuations is noted following guidance issued by the Royal Institute of Chartered Surveyors.

Audit disclosure

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information

Statement on Report as Fair, Balanced and Understandable

The Board of Directors are responsible for preparing and agreeing the financial statements contained in the annual report and accounts. The Board confirms that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Enhanced Quality Governance Reporting

Arrangements for governing service quality are outlined in the Annual Governance Statement, which is presented as part of this Annual Report.

The Trust continues to measure performance on a monthly basis and is taking additional actions where required, to ensure that it meets all of its mandated performance targets. Performance review meetings are held with the regional NHS Improvement Team every two months and updates are promptly provided in response to all queries raised about the Trust's performance.

There were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHS Improvement ratings or Care Quality Commissions assessments. The Trust Annual Governance Statement details how the Trust has reviewed and assessed the effectiveness of the Trust's systems of internal control.

Compliance with NHS Improvement Licence

In June 2017, NHS Improvement notified the Trust that it was no longer in breach of its Licence Conditions and issued a 'Discontinuation of Undertakings' notice which removed the conditions set out in in the 2014 and 2013 undertakings.

Outlook for 2020/21

On 11 March 2020, the World Health Organisation declared a global pandemic as a result of COVID-19. Like the whole of the NHS, the Trust has taken significant steps to increase its capacity to manage an increased number of critically unwell patients, including those requiring intensive care. COVID-19 has had a significant impact on how the hospital is providing its services which is expected to continue during 2020/21. As already demonstrated, the Trust will continue to ensure the health and well-being of the its staff and the safety of its patients is maintained.

In its response to COVID-19, and as part of wider plans for the transformation of health services for the population of Milton Keynes, the Trust will continue to engage with its local partners, including those within the Bedfordshire, Luton and Milton Keynes ICS (Integrated Care System).

1.2.9 Environmental Sustainability

The Trust has continued to work during 2019/20 on its sustainable development plan, and it is expected that this will be rolled out during 2020/21. In the meantime, the organisation retains a commitment to sustainability and reducing its impact on the environment.

The environmental impact of any development on the site is assessed as part of the business case process. One of the Trust's objectives is to develop as a good corporate citizen, and this explicitly includes a commitment to reducing its environmental impact:

Objective 10 Develop as a Good Corporate Citizen	Key Deliverables
Reduce environmental impact through improved employee wellbeing	■ Evidence engagement of and communication with staff around green travel options and energy usage with the aim to reduce energy consumption, including encouraging uptake of the cycle to work scheme, and increased power points for electric car charging
Engage staff and patients to increase use of car share schemes, public transport and in reducing energy consumption	■ Continually review transport services across the site as a critical strand of the estates development programme
Increase opportunities for staff to engage in recycling, energy saving initiatives and community project involvement	■ Provision of recycling banks across the Trust, including clothes and textiles ■ Extension of existing furniture recycling programme
Engaging staff to reduce food wastage	■ Review of food provision to ensure quality, healthy eating options and waste minimisation

In addition, the Trust is committed to reducing carbon emissions as part of the national sustainability agenda.

The following table shows CO_2 performance per annum to date

Year	CO_2 emissions
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes
2014/15	9,786 Tonnes
2015/16	9,426 Tonnes
2016/17	9,660 Tonnes
2017/18	9,728 Tonnes
2018/19	9,075 Tonnes
2019/20	9,241 Tonnes

The slight increase in emissions in 2019/20 is mainly attributable to additional demand on the site as a whole, with the opening of the new Cancer Centre. There is an increased reliance on the Trust's medium voltage generators and its combined heat and power plants, both of which provide more efficient power and heating to the hospital and can export electricity back to the grid.

MKUH continued to be part of a joint waste management contract with the two other acute trusts within the ICS footprint, which has meant significant increases in the amount of recycling and diversion away from landfill.

1.2.10 Social and Community Issues

At the last census collection (2013), the stated population for Milton Keynes was estimated to be 255,700, and in 2015, the Office of National Statistics estimated the population to have reached 261,750. By way of context, in 1967 Milton Keynes was designated as a new town, with the area having a population of 60,000. In particular, the last two decades has seen double digit growth; the historical trend between 2001 and 2013 showed a population increase of 43,000 - a growth of 20.2% compared with a growth rate of 8.9% for England during the same period. Milton Keynes was the 20th fastest growing local authority in England between 2005 and 2015 with a growth of 17.1 per cent. With increased housing being built, more families are expected to move to the area, with Milton Keynes Council predicting a population of 500,000 by 2050.

The Population Bulletin 2013/14 outlined that the high population growth is expected to continue into the future and in addition there is anecdotal evidence which suggests that in all likelihood the population will increase at the same pace over the next decade. Current estimations suggest that the population of Milton Keynes will reach 308,500 by 2026. This is an increase of 46,750 people or 18 per cent between 2015 and 2026. It is further projected to reach 500,000 by 2050.

The two components of population growth are natural change and net migration; natural change refers to the difference between births and deaths and net migration refers to new residents arriving less any residents leaving the city. Natural change (difference between births and deaths) will add an average of 2,000 people to the population each year from 2015 to 2026. Net migration is the main driver of population growth peaking at 5,100 in 2019. This is driven by the planned house building to support migration from other parts of the UK, which is likely to be enhanced as part of the Cambridge-Milton Keynes-Oxford corridor development.

The age profile of the Milton Keynes population is younger than that for England as a whole. 22.6% of the Milton Keynes population are aged under 16 compared with 19.0% in England. The number of 25 to 64 year olds is projected to increase from 143,800 to 161,200, a rise of 12 per cent between 2015 and 2026. This age group represents the biggest proportion of all age groups throughout the years. 12.1% of the Milton Keynes population are aged 65+ compared with 17.3% in England. Looking forward however, the 65 to 79 year olds are projected to increase from 25,600 to 36,900, a rise of 44 per cent between 2015 and 2026. Although this age group does not represent the highest proportion of the population, the percentage increase is significant and the associated rise in demand for healthcare services will be substantial.

Between 2001 and 2011 the ethnic diversity (represented by those from an ethnic group other than "white" British) increased from 13.2% to 26.1%, compared to 20% in England. No data

Milton Keynes was the 20th fastest growing local authority in England between 2005 and 2015 **with a growth of 17.1 %**

is currently available to provide a context to the change in ethnicity over the next 10 years, but if historical trends are to be taken into account, healthcare services will need to be planned in such a way as to reflect this change in ethnicity, with a particular focus on the health and well-being agenda.

The change in the ethnic make-up and the emergence of different cultural communities has resulted in the people of Milton Keynes holding a wide range of religious beliefs; 62.1% of people in Milton Keynes have a religious identity. Incorporating religious insights into the planning and the delivery of care can ensure services take seriously the values and beliefs of the population. The Trust therefore recognises that pastoral and spiritual care is an integral part of any health need assessment, and that these are best considered on an individual basis.

Disproportionate levels of population growth in Milton Keynes when compared to England have also resulted in significant pockets of deprivation and poverty. Around 18% of the child population live in low-income families and furthermore there has been an 18% increase in children taken into care since 2012. The wards of Eaton Manor and Woughton are classed in the top 10% of most deprived wards in England when measured against the deprivation indicators of income, employment and education.

In addition to the population growth, the Trust has a catchment area which is wider than the boundaries of the Milton Keynes Unitary Authority, bringing in patients from parts of Northamptonshire and the market towns of Buckingham and Leighton Buzzard. Furthermore, there is demand for healthcare services from employees of the large number of major organisations who commute from outside the Trust's catchment area. The Trust is therefore actively working with its commissioners to address and meet the healthcare needs of all those currently using its services and those likely to do so in the future. A significant element of this work, in conjunction with other local health and care partners has involved a focus on developing plans to divert as many patients as possible away from the hospital setting. This will ultimately ensure that the Trust's services are focused only on those patients who require such intervention, and that appropriate services are developed within the primary and community settings to support those patients who do not immediately need to use secondary services.

1.2.11 Human Rights issues

The Trust takes account of the provisions of the Human Rights Act 1998, insofar as they relate to the provision of healthcare, as well as the NHS Constitution. The Trust pays particular attention to the NHS' seven key principles. With regard to principle 1 (the NHS provides a comprehensive service available to all), the Trust ensures that its service provision is based entirely on clinical need and priority. The Trust has in place a Patient Access Policy, last updated in March 2019, which sets the standards to be followed in relation to waiting list management and restates the commitment to and expectation of a maximum of 18 weeks' waiting time from referral to the start of treatment.

The Trust is also guided by principle 4 (the patient will be at the heart of everything the NHS does). In this regard, in 2019/20 the Trust devised a new Patient Experience Strategy to help ensure that patients' experience of accessing care at the Trust guides changes and improvements to service delivery. Feedback received via the various patient surveys and the Friends and Family Test also gives good indications of the level of patient satisfaction with the Trust's services.

The Trust is cognisant of the human rights of both current and prospective members of staff in carrying out its work. The requirement within the Human Rights Act that there be no discrimination in the application of human rights on any ground informs the Trust's approach to engaging with its staff. For example, in 2019/20, the Trust continued with its efforts to address the under-representation of staff from a BAME (black and minority ethnic) background in senior management roles, including through the commissioning of dedicated outreach work in the local community with members of under-represented groups, and the strengthening of a BAME staff network within the organisation. The new post of head of diversity, equality and inclusion was successfully recruited to in 2019/20 to ensure that the career goals and progression of under-represented groups remain high on the Trust's workforce agenda.

The Trust also ensures that its suite of human resources policies reflects both the content and spirit of the Human Rights Act.

1.2.12 Important Events Affecting the Trust since the end of the Financial Year

The following events have affected, or continue to affect the Trust since the end of the financial year:

- On 2 April 2020, the Secretary of State for Health and Social Care, announced that over £13bn of debt will be written off as part of a major financial reset for NHS providers. As a result, the Trust's Department of Health and Social Care interim revenue support and capital loans (totalling £130.9m as at 31 March 2020) will be written off as of 1 April 2020 and will be replaced with Public Dividend Capital for which there is no repayment obligation.
- Covid-19 has had a significant operational impact on the Trust, leading to changes in working arrangements and the way in which services are provided. The Trust expects Covid-19 to continue to have an impact during 2020/21 and is developing plans in order to continue to provide safe and effective services to patients.
- In response to the Covid-19 pandemic, NHS England and NHS Improvement implemented a new financing regime for the NHS with fixed amounts paid to each provider with top-ups to cover additional costs associated with the Covid-19 response. This funding regime is expected to continue for at least part of the 2020/21 year; however there remains uncertainty over the period for which it will operate and what, if anything, replaces the current financing regime.

1.2.13 Overseas Operations

The Trust has had no overseas operations in the reporting period.

Joe Harrison
Chief Executive

2. Accountability Report

2.1 Directors' Report

The directors are responsible for preparing the Annual Report and Accounts and consider the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess Milton Keynes University Hospital's performance, business model and strategy.

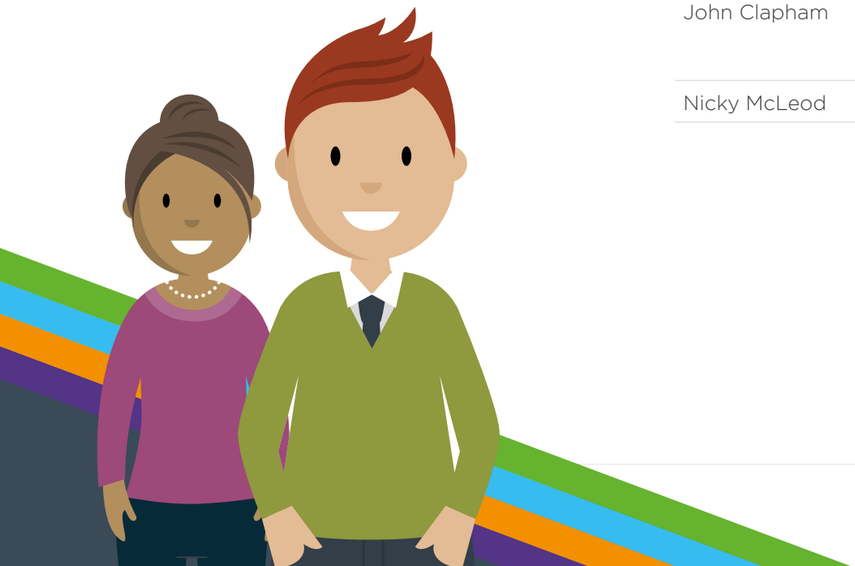
Milton Keynes University Hospital Foundation Trust (the Trust) has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles set out in the 2012 version of the UK Corporate Governance Code.

The Board of Directors (the Board) consider the Trust to be compliant with the Code of Governance.

2.1.1 Composition of the Board of Directors

The Board of Directors comprises full-time executive and part-time non-executive directors. Executive directors are employees of the NHS Foundation Trust, led by the chief executive, and are responsible for the day-to-day management of the Trust.

Non-executive directors are not employees, but officers; they bring to the Board an independent perspective and it is their role to challenge decisions and proposals made by the executive directors, and to hold executive directors to account.



The role of the Board, led by the Chairman, is to provide effective and proactive leadership of the Trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided and ensuring that the Trust is well-governed in every aspect of its activities.

The description below of each of the current directors' areas of expertise and experience demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that the directors bring to the Trust.

The composition of the Board of Directors at 31 March 2020 is detailed below:

Non-Executive Directors	
Simon Lloyd	**Chairman**
Tony Nolan	Non-executive director
Andrew Blakeman	Non-executive director
Parmjit Dhanda	Non-executive director *(stepped down February 2020)*
Helen Smart	Non-executive director
Heidi Travis	Non-executive director
John Clapham	Non-executive director *(representing the University of Buckingham)*
Nicky McLeod	Non-executive director

> *"The role of the Board, led by the Chairman, is to provide effective and proactive leadership of the Trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided and ensuring that the Trust is well-governed in every aspect of its activities."*

Executive Directors	
Joe Harrison	**Chief Executive**
Lisa Knight	Director of Patient Care and Chief Nurse *(left post April 2019)*
Nicky Burns-Muir	Director of Patient Care and Chief Nurse *(interim from April 2019, substantive from January 2020)*
Ian Reckless	Medical Director
John Blakesley	Deputy Chief Executive
Emma Livesley	Director of Operations *(from September 30, 2019)*
Danielle Petch	Director of Workforce
Michael Keech	Director of Finance
Kate Jarman	Director of Corporate Affairs *(non-voting)*
Caroline Hutton	Director of Clinical Services *(on secondment to NHSI from February 2020)*
Emma Goddard	Director of Service Development *(non-voting) (on secondment to the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership from January 2017)*

Other Board Members during 2019/20	
Ian Wilson	Associate Non-Executive Director *(on NHSI NeXt director scheme) -stepped down February 2020*

2.1.2 Biographies of Board Directors

Biographies for individuals who were serving as directors on the Board as at 31 March 2020 are detailed below. The Board of Directors is confident that it has within it the appropriate mix of skills and depth of experience to lead the Trust appropriately. The Board considers all the non-executive directors to be independent (with the exception of John Clapham) as they were appointed to their roles through open competition and are not employees of the Trust. The Register of Interests can be found on the Trust website: **www.mkuh.nhs.uk**

Simon Lloyd, Chairman

Simon joined the Trust in May 2015 for a three-year period and is due to complete his second term of office in April 2021. He originally qualified as a solicitor and spent some years in private practice as a corporate lawyer. He moved from private practice to work for Lloyds as an in-house lawyer before joining Bristol & West plc as Company Secretary. During his time at Bristol & West, Simon took on a number of functional responsibilities for the Bank of Ireland in the UK, including HR and Premises and Shared Services. Simon joined Alliance & Leicester in 2003 as Group Secretary and became Group Secretary and HR Director in 2007. Simon has held the roles of People & Talent Director, Chief People Officer & General Counsel and General Counsel & Chief Administrative Officer at Santander UK. He retired in December 2016.

Simon was appointed as Acting Chairman of the Trust in January 2017, following the sad passing of Baroness Margaret Wall. He was appointed to the role substantively following an open competition in November 2017. He lives in Milton Keynes.

Andrew Blakeman, non-executive director
(Senior Independent Director from 1 March 2018) (Chair, Audit Committee)

Andrew joined the Trust in February 2016 for a three-year period and is currently in his second term of office. He is a Chartered Accountant and has worked for BP for over 20 years in a variety of senior financial roles, most recently as Chief Financial Officer for BP's UK petrol station business. Andrew was a non-executive director on the board of NHS Blood & Transplant from 2008 to 2016 and was Chair of the Governance and Audit Committee, which covered audit, risk, quality and clinical governance. He also sits on the Quality and Clinical Governance Committee of Public Health England. He lives in Oxfordshire

Tony Nolan, non-executive director
(vice chairman with effect from February 2019) (Chair, Workforce and Development Assurance Committee)

Tony joined the Trust in March 2014 on a four-year appointment. He has been reappointed for a further two years. Tony has held senior positions in a number of multi-national companies in the technology sector and is currently the Transformation Director for Arqiva, the UK's leading TV, radio and mobile infrastructure provider. He lives in Buckinghamshire. He completed his second three-year term and stood down on March 31, 2020.

Parmjit Dhanda, non-executive director

Parmjit joined the Trust in February 2017 on a three-year appointment. During this time, he was Chair of the Charitable Funds Committee. He served as the Member of Parliament for Gloucester from 2001 to 2010, and was a Government Minister, covering the Young People and Families, Fire and Rescue Services and Community Cohesion portfolios. Parmjit has served as Non-Executive Director for an urban regeneration company and two Housing Associations. He is currently a Senior National Officer for the Prospect trade union. He lives in Buckinghamshire. He completed his three-year term of office in February 2020 and due to other commitments opted to stand down.

Helen Smart, non-executive director
(Chair, Quality and Clinical Risk Committee)

Helen joined the Trust in March 2018. A nurse and health visitor by background, she has worked across the NHS since 1986, and has held a variety of senior Executive roles, including as Executive Director of Nursing and Operational Director for Learning Disability Services at Northamptonshire Healthcare Trust, Deputy Director of Commissioning for Primary Care at NHS Bedfordshire and Director of Community Services and Lead Nurse for South Essex Partnership University NHS Foundation Trust, a role she retired from in July 2017. Since then, Helen has been operating in an interim consultancy capacity, working with the North Central London STP as Programme Director for the Care Closer to Home programme across five CCGs, and is currently at Hertfordshire Partnership Foundation Trust. She has also worked for the Department of Health, and in advisory roles for the CQC and at a Governmental level. She lives in South Northamptonshire.

Heidi Travis, non-executive director
(Chair, Finance and Investment Committee)

Heidi joined the Trust in March 2018. She joined Sue Ryder in March 2010 as Director of Retail, and took on the role of Chief Executive in September 2013. Previously, Heidi had worked as a business consultant developing small businesses. Before that, she spent 25 years at Marks & Spencer, most recently as an executive in group planning and strategy as well as managing a buying group. Heidi also worked as a lay member of the Aylesbury Vale CCG until 2013. She became a non-executive director for Bucks PCT (now Buckinghamshire Healthcare NHS Trust) in 2008 and chairs a Bucks speech and language therapy group. She lives in Milton Keynes.

John Clapham, non-executive director

John is a Pro Vice Chancellor of the University of Buckingham, and he represents the university on the MKUH Board. He has a background of working in the higher education industry and in biomedical research within the pharmaceutical industry. One of the founder team of the University of Buckingham Medical School, he has expertise in project management, pharmaceutical research, biomarkers, molecular biology, biotechnology, and people management. He is a strong research professional with a PhD focused on Biochemistry and Molecular Biology from Birkbeck College, University of London.

Nicola (Nicky) McLeod, non-executive director

Nicky joined the Trust in February 2019. She qualified as a general nurse in London, and later went on to work in sales and marketing roles within the pharmaceutical industry. 11 years later, she moved back into direct healthcare, taking up a role in Cygnet Health Care, an independent mental health care provider. After 11 years in that organisation, she became its Chief Operating Officer, with responsibility for 22 hospitals nationally. Nicky has a focus and a passion for organisational culture based on values and extensive experience in in-patient specialist mental health services. She lives in Northamptonshire.

Joe Harrison, Chief Executive

Joe joined the Trust as chief executive in February 2013. He was formerly chief executive at Bedford Hospital, and has 25 years' experience of working in the acute sector of the NHS, covering both big teaching hospitals and district general hospitals. His roles have included a range of senior operational and corporate positions at several London hospitals, and he has a track record of improving patient services and performance.

John Blakesley, Deputy Chief Executive

John has over 30 years' experience in the NHS. His career started in pathology, before moving into general management. He has undertaken a range of executive director roles as director of performance and delivery and deputy chief executive as well as director of market management (commissioning for a large PCT). In addition, John has experience of the commercial sector with a specialised surgical company. He has a particular interest in using information systems to improve patient care and decision-making.

Nicky Burns-Muir, Director of Patient Care and Chief Nurse

Nicky joined the Trust in 2016 as Deputy Chief Nurse. Prior to this Nicky worked as a senior nurse for 10 years in district general hospitals as well as tertiary trusts. She has undertaken many roles in her career including Head of Nursing for Cancer at Great Ormond Street Hospital. Nicky has an MBA from Exeter University and a Masters' in Leadership in Health from Kingston University. Nicky is also a trained coach and uses her coaching style to champion leadership and professional standards in Nursing, Midwifery and Therapies in order to drive high quality care and patient experience.

Dr Ian Reckless, Medical Director

Ian was appointed as Medical Director in April 2016. He trained at St George's Hospital Medical School, London and undertook postgraduate training in the Oxford area. Ian worked as Special Adviser to the Healthcare Commission in 2004, and was Special Assistant to the Chief Medical Officer in 2005/06. He was appointed Consultant Physician and Senior NIHR Research Fellow at the Oxford Radcliffe Hospitals NHS Trust, and he later held the roles of Associate Medical Director (Quality) and Clinical Director, Neurosciences at the successor Oxford University Hospitals NHS Foundation Trust. He continues to undertake clinical work both at Milton Keynes and in Oxford, where he remains Honorary Consultant Stroke Physician / Senior Clinical Lecturer at the John Radcliffe Hospital. He also contributes to the work of the Isle of Wight Clinical Commissioning Group as secondary care doctor on the Governing Body. Ian has a particular interest in postgraduate education, having previously served as Training Programme Director, and has authored books on general medicine, and the interface between medicine and the law.

Emma Livesley, Director of Operations

Emma joined MKUH from Nottingham University Hospital where she was interim Deputy Chief Operating Officer. She has a wealth of NHS experience which started in Public Health and migrated into operational and management experience in the acute provider sector. She was Director of Operations at University Hospitals Coventry and Warwickshire, and held senior management roles in Calderdale and Huddersfield FT and East and North Hertfordshire NHS Trust, the Royal Free, Guys and St Thomas' London. Prior to her appointment in Nottingham, Emma also spent 18 months with NHS Improvement in regulation. Emma's passion is building high quality operational teams who deliver the best services for patients through partnership working and embracing the transformation agenda.

Kate Jarman, Director of Corporate Affairs

Kate has substantial experience as a communications professional and company secretary, and has worked on and with boards in the acute health sector and police and criminal justice agencies. Before joining Milton Keynes University Hospital as Director of Corporate Affairs with responsibility for integrated governance and assurance, membership and corporate communications, Kate spent a number of years at Bedford Hospital, latterly as associate director of corporate affairs and communications and company secretary. Kate is passionate about staff and patient engagement, leadership, culture and about developing integrated governance systems to support the delivery of safe, effective, high quality care.

Mike Keech, Director of Finance

Mike qualified as a Chartered Accountant (ACA) and is a member of the Institute of Chartered Accountants in England and Wales (ICAEW). He has significant experience of NHS finances, having started his career as an external auditor of NHS foundation trusts before taking on a range of finance and strategy roles at the healthcare regulator NHS Improvement (previously Monitor). Prior to arriving at the Trust, he was heavily involved in supporting challenged health economies in developing plans to return to a sustainable position. His roles have included leading on the financial analysis for a Sustainability and Transformation Plan (STP) footprint and supporting NHS Improvement's work in a number of high-profile organisations.

Danielle Petch, Director of Workforce

Danielle joined the Trust as Director of Workforce in July 2018 from Rotherham NHS Foundation Trust. She has also previously worked at a PCT and a London teaching hospital. Danielle holds an MBA from Durham University and a BSc (Hons) in computer science from the University of St Andrews, and has completed the NHS Leadership Academy's Nye Bevan programme. Throughout her career, Danielle has led on a variety of initiatives to maximise workforce efficiency and staff experience. She is passionate about the efficient delivery of HR services, including making the best use of technology to drive service development. Danielle won an HPMA Award in 2018 for this work. Her strategic focus is to recruit and develop the workforce required today got the future.

Caroline Hutton, Director of Clinical Services
(on secondment to NHSI from February 2020)

Caroline joined the Trust in 2013 to lead on transformation, and was appointed substantively to the role of director of clinical services, responsible for operational management, in October 2014. She is a registered nurse with 29 years' NHS experience, and has held a number of senior positions both operationally and clinically, working across all healthcare sectors, including the leadership and delivery of complex cross-organisational projects and programmes. Caroline has significant experience of working in partnership with private sector organisations and commercial and legal teams from her leadership positions with the National Programme for IT, and is passionate about encouraging collaborative teamwork with a view to introducing new approaches to the delivery of patient care, as well as encouraging a data driven approach to operational planning and delivery.

Emma Goddard, Director of Service Development
(on secondment to the BLMK STP from November 2017)

Emma was appointed in December 2014 as director of service development. She has held various senior operational posts across a number of NHS hospitals, and has significant experience of clinical services within the acute sector, and partnership working with commissioners, primary care services and the private sector. Prior to joining Milton Keynes University Hospital, Emma spent some years working as chief operating officer at Bedford Hospital. She also spent some time working as interim director of operational performance, responsible for the day to day running of the sites and supporting the Foundation Trust applications at Hillingdon Hospitals.

2.1.3 Balance of Board Members and Independence

At the end of the financial year 2019/20, the Board of Directors comprised:

- Chairman of the Trust
- Seven further non-executive directors
- The chief executive
- Six further Executive directors
- Three non-voting directors (two who have been on secondment out of the Trust - one for the duration of the reporting period, and one since February 2020)

As at 31 March 2020, 50% of the Board of Directors were female (there were eight female and eight male Board members). The Board of Directors reviewed and confirmed the independence of all the non-executive directors (with the exception of John Clapham who represents the University of Buckingham) who served during the financial year 2019/20.

The Board of Directors also considers that the balance of skills and experience of its members is complete and appropriate to address the operational and economic challenges the Trust expects to face over the next few years.

2.1.4 Non-Executive Director Appointments

In February 2020 the first term of office of Parmjit Dhanda came to an end and due to other commitments Mr Dhanda decided not to stand for a second term. He left the Board on February 29, 2020. Tony Nolan's second term of office was due to come to an end in March 2020. All non-executive directors are eligible to serve two terms of office, provided that their maximum tenure does not exceed six years, and Mr Nolan therefore left the Board on March 31, 2020.

The appointment of non-executive directors of the Trust is the responsibility of the Council of Governors. A Non-Executive Appointments Committee of the Council has been established, and for the purposes of the exercise to fill these vacancies its membership comprised of:

- Alan Hastings (lead governor, publicly elected) (Chair)
- Clare Hill (publicly elected)
- Amanda Anderson (publicly elected)
- Andrew Buckley (appointed, MK Business Leaders representative)
- Simon Lloyd (Chairman of the Trust)

The recruitment process commenced in December 2019. An advertisement was placed on the NHS Improvement website inviting applications, and by the time it closed on January 13, 2020, 58 applications had been received. Following a shortlisting meeting, 6 candidates were invited to interviews scheduled for 3 February, 2020. All the members of the Non-Executive Appointments Committee were in attendance (with the exception of Andrew Buckley who was unwell) and they were supported as independent assessor, by Hattie Llewelyn Davies, Chair at Buckinghamshire NHS Healthcare Trust. On the day of the interviews, all the shortlisted candidates also took part in stakeholder panel discussions with a number of executive directors and other members of the Council of Governors who were not on the Appointments Committee.

Following this process, the Non-Executive Appointments Committee recommended to the Council of Governors that John Lisle and Haider Husain be appointed as non-executive directors of the Trust. This recommendation was accepted by directors of the Trust. This recommendation was accepted and the appointments will take effect from April 1, 2020.

During February 2019, the Chairman recommended to the Council of Governors that Andrew Blakeman be accepted as deputy chair, due to the standing down of Tony Nolan (the previous deputy chair), This is in addition to his current position as Senior Independent Director. This was unanimously agreed at the formal Council of Governors meeting on February 12, 2020.

A non-executive director may resign from their roles by giving the agreed period of notice in writing to the Chairman and the Council of Governors, and the Chairman may resign by giving notice to the Council of Governors. In addition, the Chairman or any non-executive director may be removed from office on the approval of three quarters of the members of the Council of Governors.

2.1.5 Board, Board-level Committee and Directors' Performance and Effectiveness Review

The Board of Directors meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high-level items relating to the Trust's strategy and how this is operationalised, its business plans and budgets, regulations and control, and the annual report and accounts. The Board delegates other matters to the executive directors and senior management as appropriate.

Meetings of the Board of Directors follow a formal agenda, which includes reports and updates on operational performance and against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by management, strategic issues, financial performance, and clinical governance. The performance measures include the amount of time that patients are required to wait to be treated at the emergency department, lengths of stay, the effectiveness of processes for infection control, patient experience measures, including the timeliness within which complaints are handled, and the results of the Friends and Family Test. The Board also benchmarks its performance against that of other Trusts of a similar size and configuration.

The executive and non-executive Directors recognise the importance of evaluating the performance and effectiveness of the Board of Directors as a whole, the sub-committees of the Board of Directors, and of individual directors. The performance of individual directors is assessed over the course of the year in terms of:

- Attendance at Board and Board committee meetings
- The independence of individual non-executive directors
- The effectiveness of the contributions of each executive and non-executive director to the business of the Board and its committees, both in and out of meetings
- The Board's effectiveness in providing a strategic direction to the Trust and its ability to provide the lead requisite leadership.

In respect of individual appraisals:

- The Chairman undertakes the appraisal of the chief executive and non-executive directors;
- The Chief Executive undertakes the appraisal of the executive directors;
- The Senior Independent Director undertakes the appraisal of the Chairman, having sought feedback from the rest of the Board of Directors, the Trust Secretary and from the Governors and key stakeholders
- The Chief Executive discusses and reviews the executive directors' appraisals with the Chairman and the Remuneration Committee.

The process for the appraisal of the chairman and the non-executive directors has been approved by the Council of Governors. Governors evaluate the performance of the Board of Directors as a whole in terms of meeting its targets and communicating with its staff, members and stakeholders.

The result of the evaluation process of the Board of Directors' performance in respect of the year ended 31 March 2019 was that the Board collectively and the directors individually were deemed to have performed well.

Evaluation of the committees indicates that they are working well, and the appointment of a new Chair to the Charitable Funds Committees is expected to lead to a considered refocusing of its approach to seeking and gaining assurance on the Board's behalf as to the quality of the services that the Trust provides.

Improvements made to the overall quality of information provided have led to richer and more in-depth discussions on the key issues, and a greater level of assurance to the committees and the Board.

The Board of Directors ensures that the principles set out in the Well-Led Framework not only inform their work, but are also embedded across the organisation. For example, the Board receives regular reports on all aspects Trust performance, and ensures that these address each of the eight Key Lines of Enquiry as set out in the Framework. Further detail about the Trust's approach to ensure that its services are Well-Led is set out in the Annual Governance Statement later on in this report.

2.1.6 Attendance at Board meetings

	Board of Directors (8)	Audit Ctte (4)	Charitable funds Ctte (4)	Finance & Investment Ctte (12)	Quality & Clinical Risk Ctte (4)	Remuneration Ctte (2)	Workforce Development Assurance Ctte (4)	Council of Governors (4)
Andrew Blakeman	7	4		1	4	1		2
John Blakesley	6	1		1				2
Nicky Burns-Muir	7	2			3		1	4
John Clapham	5	4						2
Parmjit Dhanda	7	1	4			1		3
Emma Goddard**								
Joe Harrison	7	1	0	9	2	2	1	2
Caroline Hutton *	7	1			3			
Ian Reckless	7	1	1	6	4		2	3
Kate Jarman	8		2		3			
Mike Keech	6	4	4	12				3
Lisa Knight***	1							
Emma Livesley****	2				1			1
Simon Lloyd	8	1	4	6	2	2	4	4
Nicky McLeod	7	2	2		2	2	3	1
Tony Nolan	6			6		2	4	3
Danielle Petch	7			1		1	4	
Helen Smart	7	3	1		3	1		4
Heidi Travis	8	1	2	12		2		4

**On secondment to NHS Improvement from February 2020. There is no expectation that Caroline Hutton will attend any MKUH board or committee meetings during the course of this secondment.*

***On secondment to BLMK STP from November 2017. There is no expectation that Emma Goddard will attend any MKUH board or committee meetings during the course of this secondment.*

****Lisa Knight left the Trust in April 2019.*

*****Emma Livesley joined the Trust in September 2019*

2.1.7 Detail of Company Directorships and Other Significant Interests Held by Directors or Governors

Members of the Board of Directors and the Council of Governors did not hold any other non-executive directorships or commitments that are disclosable under the NHSI Monitor Code of Governance.

2.1.8 Board Register of Interests

The Trust maintains three registers of interests. The first includes interests of all directors; the second interests of the Council of Governors, and the third relates to members of staff regarded as Decision Makers within the organisation but are not members of the Board of Directors. The register relating to Decision Making staff contains only their job titles and not their names. All three registers are held on the Trust website.

An annual report is made to the Trust Board regarding the interests of executive directors and non-executive directors. In addition, executive and non-executive directors are required to declare any potential conflict of interest that they may have in respect of any item on a Trust Board or Board Committee agenda. In the event that it is decided either by the Trust chairman or the chair of the committee that a conflict does in fact exist, the Board or committee member would be instructed to excuse themselves from the discussion of that particular item.

2.1.9 Audit Committee

The Audit Committee's key role is to ensure that the Trust has an adequate and effective system of internal controls. The Committee focuses on the establishment and maintenance of controls that are designed to give the Board reasonable assurance that the Trust's resources are safeguarded, waste and inefficiency limited, and that reliable information is produced to demonstrate that value for money is constantly sought.

The key responsibilities delegated by the Board to the Committee are to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems,
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement, and
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

The Audit Committee is chaired by Andrew Blakeman, a non-executive director of the Trust. As indicated above, Mr Blakeman has relevant financial experience, and therefore has the skills and knowledge to effectively perform this role. During the course of 2019/20, the other permanent members of the Committee was Helen Smart. (add anyone else)

The Committee met four times during 2019/20, with a fifth 'virtual' meeting held in March 2020 due to the Covid-19 outbreak. At each meeting it considered the work of the internal audit function, the work of the external auditors, including the framework within which they conduct the audit of the Trust's financial statements and its Quality Report indicators, and any issues that they wished to raise both in the course of the audits and following the conclusion of their work. The Committee also considered the work of the Trust's counter-fraud team, taking account of fraud trends that the Trust needs to be aware of, and steps being taken to raise fraud awareness across the Trust. It also considered a list of all debts that are to be written off; updates to the International Financial Reporting Standards and accounting policies, and the Trust's overall approach to risk management, including consideration of the board assurance framework and corporate risk register.

During 2018/19, the Trust engaged the services of RSM as its internal audit provider, and the Audit Committee agreed the ongoing internal audit work plan as put forward by the firm. It also received draft and final reports of their reviews, including reviewing management responses, and it ensured that recommendations arising out of reviews carried out by the previous internal audit providers were being carried forward. With regard to the external audit function, the Committee agreed with the external auditor the nature and scope of the of the audit as set out in their annual plan, discussed the auditors' evaluation of the audit risks and assessment of the Trust, and the impact of this on the audit fee set.

During the year, the Committee maintained its focus on quality of the data that the Trust generates and relies on in support of its operational activities. At several of its meetings in 2019/20, the Committee received and gave detailed consideration to updates received on the steps being taken to improve the accuracy of Referral to Treatment (RTT) counting, and the recording of pathway clock stops, and the correctness of the clock start and stop times for patients attending the Emergency Department. This was in line with the action plan emerging from findings from the external audit providers in their testing of performance indicators as mandated by NHS Improvement.

The Audit Committee received regular updates from the Trust's counter-fraud providers during 2019/20. The particular focus was on fraud prevention, the building up of awareness among staff as to what constituted, and steps to be taken to combat it. The Trust also continued to develop a more proactive approach to ensuring that payment is recovered from overseas patients who are not entitled to free care.

The Audit Committee received assurance through the Head of Internal Audit Opinion on the Trust's internal control environment and approach to identifying, assessment and mitigation planning to risks. This was supported by in year and year end reviews.

The Audit Committee reviews auditor independence both as part of its scrutiny of the annual report and accounts, and as part of its annual review of the auditors' work. The Committee has also engaged regularly with the external auditors throughout the year, including in private session. The Committee is satisfied that to the best of its knowledge, there are no issues that compromise the external auditors' independence. The Chair of the Committee regularly discusses the effectiveness of both internal and external auditors with the Director of Finance.

Deloitte has provided external audit services to the Trust since April 2012 when it was engaged on a five-year contract. In December 2016, the Council of Governors commenced the process, through an open procurement competition, of appointing new auditors. In May 2017, the Council of Governors agreed that Deloitte would be reappointed as the Trust's external auditors with effect from July 2017.

For the 2019/20 audit, the Trust incurred statutory audit fees of £84,000 (including irrecoverable VAT) and £41,514 other auditor remuneration (excluding recoverable VAT).

The following steps were taken during 2019/20 to ensure that auditor objectivity and independence is safeguarded:

- At each meeting of the Audit Committee attended by the external auditors they were asked to declare any interests that they may have in any of the items on the agenda. No such declarations were made.
- The external auditors have confirmed their compliance with the APB Ethical Standards for Auditors, and do not consider that their professional judgement or objectivity has been compromised.
- The Trust and the auditors ensured that fees for the provision of non-audit services by the external auditors did not exceed 70% of the audit fee, as mandated by the updated Auditor Guidance Note 1 issued in December 2016. The external auditors also did not perform any of the prohibited non-audit services set out in the guidance note. Details of the fees that were charged for non-audit work have been disclosed in the external auditors' report, and no further fees were charged.
- The external auditors have continued throughout the year to review their independence and ensure that appropriate safeguards are in place. These include the rotation of senior partners and professional staff, and the involvement of additional partners and professional staff to carry out reviews of the work performed and to advise as necessary.

2.1.10 Remuneration Committee

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chairman and comprises all the non-executive directors. The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the chief executive and the executive directors. The Chief Executive and the Director of Workforce attend the meeting but leave when discussions about their own positions are to be held.

The Remuneration Committee met on two occasions in 2019/20.

2.2 Council of Governors

The Council of Governors is responsible for representing the interests of NHS Foundation Trust members, the public, and members of staff, and together with partner organisations of the Trust, it shares information about key decisions with the membership.

The Board of Directors reports to the Council of Governors on the performance of the Trust and its progress against agreed strategic and corporate objectives, and consults on its future direction. In particular, the Council of Governors holds the non-executive directors to account for the performance of the Board.

Governors report matters of concern or interest raised at local health events or constituency meetings to their counterparts and to the directors. Members of the public have the opportunity to raise questions addressed to the Governors, directors or any other staff members in attendance at the local health events or Council of Governor meetings.

All non-executive and a number of executive directors are asked to attend the Council of Governors' meetings to gain an understanding of Governors' and Members' views, answer questions raised and also to update Governors about the activities of the Board and its Committees. Other staff often also attend to provide assurance or to report on progress on matters of interest.

Developing and maintaining effective relationships with the non-executive directors has remained a key priority in 2019/20.

The Council of Governors is responsible for non-executive director appointments, and during 2019/20, they appointed two new Non-Executive Directors, John Lisle and Haider Husain. They also approved the appointment of Andrew Blakeman as deputy chairman.

To enable the Council of Governors to effectively exercise their statutory duties, the Board of Directors ensures that the Council receives the Annual Report and Accounts, is consulted on the content of the Quality Account and receives management reports detailing Trust performance in all areas. Presentation of the 2019/20 Annual Report and Accounts took place at the Council of Governors' meeting in July 2020.

During the course of 2019/20, the Council of Governors took advantage of a number of formal and informal opportunities to engage with the Trust membership, with a view to seeking their views on the Trust's performance, plans and priorities.

Feedback received by governors from these and other interactions with Trust members and the public was reflected in their comments on the Trust's Annual Plan and the Patient Experience Strategy.

2.2.1 Membership of the Council of Governors

The Council of Governors is chaired by the Trust chairman. It consists of 12 governors elected by public members of the Trust (four vacancies as at 31 March 2020), representing a geographic constituency, two governors elected by staff of the Trust (five vacancies as at 31 March 2020), and four appointed governors (no vacancies as at 31 March 2020).

The table at Appendix 2 lists the governors and their attendance record at the four Public Council of Governors meetings that took place in the year.

In light of its status as a University Trust, the Constitution has been updated to allow for a representative from the University of Buckingham to join the Council of Governors as an appointed governor. Discussions about this are being held with the university.

2.2.2 Register of Governors' Interests

A register of governors' interests is maintained by Milton Keynes University Hospital NHS Foundation Trust, and is published on the Trust website.

2.2.3 Lead Governor

The Council of Governors are required nominate one from among their number to take on the role of Lead Governor. The Lead Governor's formal role is to act as a point of contact with NHS Improvement in the extreme and unlikely event that serious concerns emerge about the board leadership of the Trust, or the processes used for appointing the chairperson or non-executive directors, such that NHS Improvement is contemplating using its formal powers to remove the chair person or non-executive directors.

At MKUH, the lead governor also acts as vice-chair of the Council of Governors, and may chair meetings of the Council in the Chair's absence. The lead governor normally also chairs the Non-Executive Appointments Committee. Alan Hastings, a publicly elected governor representing the Bletchley constituency was formally nominated for his second term lead governor in at the Council of Governors meeting in February 2020 on an 18-month tenure.

2.2.4 Elections

In 2019/20 elections were held for the following seats on the Council of Governors.

The Trust commissioned the services of UK Engage to undertake the election process.

Date	Constituency (see Appendix 1 for key)	Result
March 2020	**PUBLIC:** Walton Park, Danesborough, Middleton, Woughton	Niran Seriki (elected) Clare Hill (re-elected)
March 2020	**PUBLIC:** Stantonbury, Stony Stratford, Wolverson	Ann Thomas (elected)
March 2020	**PUBLIC:** Hanslope Park, Olney, Sherington, Newport Pagnell	Alan Hancock (re-elected)
March 2020	**STAFF:** Doctors and Dentists:	Raju Thomas Kuzhively (elected)
March 2020	**STAFF:** Non Clinical (Admin & Clerical, Estates, Finance. HR, Management).	David Barber (elected)

2.2.5 Governor Development

Milton Keynes University Hospital NHS Foundation Trust is committed to supporting the members of the Council of Governors in carrying out their roles effectively. Governors were provided with development and knowledge-building opportunities during the year. These included attending Board and sub-committee meetings as observers. They also are members of the Patient Experience Group attending food focus meetings, reviewing patient literature.

In addition, the Trust has supported engagement by the current lead governor with his counterparts across the East of England region, with a view to gaining and sharing best practice and new ideas, particularly in relation to member engagement and development.

The Lead Governor and various Governors attend a range of events and workshops on a variety of subjects, both within the Hospital and externally. Subjects include such as End of Life care, Population Health Management, Community Action Group for local charities, Working Together across the Thames Valley area, Legal Rights, Lead Governor Network, where the way other Trusts work, both Acute and Mental Health, across the East of England, is discussed.

The format for the Council of Governors meetings has continued to develop and in 2019/20 has included presentations on topical issues within the Trust. Governors receive summary reports of the deliberations at Board Committee meetings and are updated on key messages from Management Board meetings. Verbal updates from the Chairman and Chief Executive also highlight key messages from Board meetings and keep governors abreast of important developments within the wider NHS.

In the course of the year, governors have maintained their interest in understanding the experience of patients who use the hospital's services, with many taking part in '15 steps challenge' visits in which the quality of care provided is assessed from a patient and carer's perspective to clinical areas. Several governors have also become involved with and contribute to groups across the hospital who are seeking to improve the experience of patients with specific needs, including those with a learning disability and others with impaired mobility. A number of governors have also taken part in Patient-Led Assessments of the Care Environment (PLACE) assessments, which are in-depth reviews of various wards, which include meal times and involvement in new food tastings.

Governors are encouraged to attend external events and in 2019/20, a number of governors attended events hosted by Healthwatch Milton Keynes. In the intervals between formal Council meetings, governors meet informally as an engagement group, specifically to develop their approach to engaging effectively with Foundation Trust members within their constituencies, and help grow the overall size of the Trust membership. There is an Engagement Strategy in place, for which the group is responsible, and members of Trust staff may be called upon to help support its implementation. Due to the Covid-19 pandemic towards the end of the year, such opportunities for engagement were curtailed but the intention is to increase these opportunities as and when it is deemed safe to do so.

2.2.6 Attendance at Council of Governor Meetings

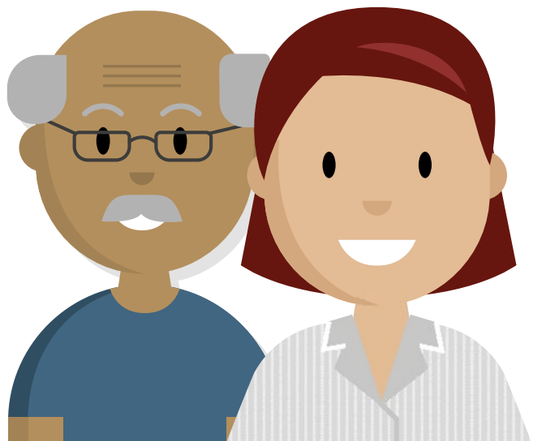
The Council of Governors has met formally four times during the year, (five including the Annual Members' Meeting held in September 2019), and this is in line with the Trust's Constitution. Following each meeting, the approved minutes are formally presented to the Board. Details of governors' attendance at the four Council of Governors meetings held in 2019/20 are included in Appendix 2.

> *"The Trust has supported engagement by the current lead governor with his counterparts across the East of England region, with a view to gaining and sharing best practice and new ideas, particularly in relation to member engagement and development."*

2.3 Membership

Milton Keynes University Hospital NHS Foundation Trust is committed to establishing and growing an effective membership, and during 2019/20, a number of additional steps have been taken to improve engagement and increase membership.

In 2019/20 work has continued to secure the Trust's membership community by addressing natural attrition and increasing its demographic diversity. Efforts continue to ensure that the database properly reflects the true number of eligible staff and public members. This has enabled efficient, effective communication to be made in the most convenient way to members and broadened the involvement of the public membership. A summary newsletter highlighting key developments of the key points of the Annual Report was also produced.



The Trust currently has **5382 public members** and **2997 staff members** on its membership register. The total membership is therefore **8379**.

2.3.1 Number and Analysis of Members

	2019/20	2018/19
Public constituency		
At year start 1 April	5464	5550
New members	0	15
Members leaving	78	101
At year end 31 March	5382	5464
Staff constituency		
At year start (1 April)	2722	2927
At year end (31 March)	2997	2722
Public constituency: Age (years)		
0-16	1	6
17-21	17	29
22+	2072	2102
Not declared	3292	3327
Public constituency: Ethnicity		
White	4221	4284
Mixed	81	81
Asian or Asian British	373	387
Black or Black British	246	249
Other	37	39
Not declared	424	424
Public constituency: Gender		
Male	2104	2144
Female	3278	3320

"The Trust has been actively working to attract as many local residents as possible to become members and have an involvement with the hospital."

2.3.2 Membership Constituencies

The Trust has staff and public constituencies, and has also appointed a number of governors to represent local stakeholders with whom it works in partnership. The Trust Constitution enables all members of staff who have been appointed to a post for a minimum of twelve months to automatically become members unless they decide to opt out of membership. Members of the public living within the Trust's catchment area who are over the age of 14 and not employed by the Trust are entitled to become public members, and the Trust has been actively working to attract as many local residents as possible to become members and have an involvement with the hospital.
To stand for election to become a Governor, applicants must be aged 16 years or over.

Public Constituency	Members
Bletchley and Fenny Stratford, Denbigh, Eaton Manor and Whaddon	1053
Emerson Valley, Furzton, Loughton Park	784
Linford South, Bradwell, Campbell Park	804
Hanslope Park, Olney, Sherington, Newport Pagnell North, Newport Pagnell South, Linford North	653
Walton Park, Danesborough, Middleton, Woughton	820
Stantonbury, Stony Stratford and Wolverton	744
Outer catchment area: - (Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn)	400
Extended catchment area, that includes the remainder of the county area of Northamptonshire, Buckinghamshire and Bedfordshire (not already covered in the outer catchment area) the unitary council area of Luton and the district council areas of Cherwell, Oxford City and South Oxfordshire.	
Total	**5382**

The Trust currently has 5382 public members and 2997 staff members on its membership register. The total membership is therefore 8379.

2.3.3 Membership Recruitment and Engagement

The Trust has continued to make efforts to grow and engage with its membership, with members of the Council of Governors, through their engagement, taking an active role in recruiting new members.

2.3.4 Contacting the Council of Governors

Anyone wishing to contact the Council of Governors or enquire about becoming a member can do so in writing or by using a dedicated membership email address: **Foundation.Members@mkuh.nhs.uk**. Contact can also be made directly by telephoning the Trust Secretariat Office on **01908 996234**.

2.4 Patient Care

The Trust has continued to improve care quality and patient services, with examples in the performance and quality reports. The Trust monitors quality and key targets closely, with detailed narrative and data available in the performance report and dashboard.

2.4.1 Care Quality Commission Inspections and Action Plans

The Trust had an unannounced focused CQC inspection in April and May 2019 to check how improvements had been made in urgent and emergency care, surgery, medical care including older people's care service and maternity services. In terms of 'safe', medical care was given a rating of 'good' (from 'requires improvement' in 2016); in Surgery, 'safe' was regraded from 'good' to 'requires improvement'. In urgent and emergency care, the rating for 'well-led' was amended from 'good' to 'requires improvement.' All other inspected areas maintained their previous ratings.

There were a number of areas that were not inspected – these were critical care, outpatients, diagnostic imaging, children and young people's services and end of life care. These areas retain their previous ratings awarded in 2014/16were not inspected and so their ratings remain from the previous inspection in October 2016. All of these services were rated as "Good" at that time.

Overall Ratings for Milton Keynes University Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Key findings from the report:

Are services safe?

- Medical care including older people's care and maternity services were rated as good.
- Urgent and emergency care and surgery were rated as requirement improvements. Not all staff had completed mandatory training, prevent and control infection processes were not always followed, emergency equipment was not always checked daily as per Trust policy, medicines were not always stored correctly and not all safety results and performance met the expected standard.

Are services effective?

- Urgent and emergency care, surgery, medical care including older people's care service and maternity services were rated as good. The hospital provided care and treatment based on national guidance and evidence of its effectiveness; staff assessed and monitored patients regularly to see if they were in pain, staff were competent for their roles and understood their roles and responsibilities in relation to consent and under the Mental Health Act (MHA) 2003, the Mental Capacity act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Are services caring?

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

- The services inspected were rated as good, the Trust mostly planned and provided services in a way that met the needs of local people, patients' individual needs were taken into account; the Trust treated concerns and complaints seriously, investigated and learned lessons from them, although some complaints were not always responded to within the time lines of the Trust's complaints policy.

Are services well-led?

- Surgery, medical care including older people's care service and maternity services were rated as good. The Trust had managers at all levels with the right skills. The Trust collected, analysed, managed and used information well to support all its activities. They had effective systems for identifying risks, planning to eliminate or reduce them. The Trust engaged well with patients, staff and stakeholders.
- Urgent and emergency care was rated as requires improvement because not all managers had undergone formal leadership training and some did not have the capacity to carry out all aspects of the leadership role, including ensuring patient risk assessments were always completed.

Outstanding practice

The CQC chose to highlight the following as areas of outstanding practice at the Trust:

In maternity:

Two new smartphone apps for pregnant women had been introduced, which enabled women to take more ownership and management of their care on a day to day basis.

In December 2018 the Warm Baby Bundle red hat initiative was rolled out across the maternity service for babies at risk of hypothermia and in extra need of skin-to-skin contacts.

An online patient portal was introduced to empower patients to manage their own health care appointments.

In January 2019, pregnant women who had uncomplicated pregnancy were offered the option of an outpatient induction of labour.

In medical care:

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met those needs, was accessible and promoted equality.

The wards ensured that patients were given activities and welcome packs. Staff really promoted independence, enabling patients to eat dinner at tables, take part in group activities and ensure they were ready for discharge.

The service was supported with social workers and dedicated ward discharge teams, where there was effective communication and the discharge process was discussed at parts of the patient's journey.

Areas of compliance or enforcements actions:

The Trust received no notifications of compliance or enforcement actions as a result of this report.

Areas were identified for improvement, and the Trust took immediate action to ensure those recommendations were acted upon:

In urgent and emergency care:

- The service must ensure that immediate life support and paediatric immediate life support training compliance is in line with Trust targets.
  This has now been done.
- The service must ensure that staff are complaint with hand hygiene and personal protective equipment guidelines.
  Staff received additional training to ensure compliance.
- The trust must ensure that all emergency equipment checks are done in line with Trust policy and that there is a system in place for ensuring this is completed.
  A system has been developed and implemented.
- The service must ensure that all patients receive relevant risk assessments.
  This was implemented with immediate effect, with additional training given to staff performing falls, pressure ulcer and nutritional risk assessments.
- The service must ensure there are robust action plans to address areas of non-compliance to local and national audits.
  This has been implemented to ensure compliance.

In relation to surgery core service:

- The Trust must ensure that basic life support training for all staff and safeguarding training compliance for medical staff is in line with targets.
  A robust plan of action was implemented to ensure compliance.
- Ensure that controlled drugs are checked, and accurate records maintained.
  This has been scrupulously enforced and maintained.
- Ensure that staff are compliant with personal protective equipment, safe handling of dirty instrumentation and bare below the elbows guidelines.
  This is robustly enforced and checked at several times each day.

2.4.2 Improvements in Patient/ Carer Information

The Trust uses the Patient Accessible Information Standard and continually seeks opportunities to improve patient and carer information to improve access to care and services and support decision-making.

2.4.3 Information on Complaints Handling

The Trust has a complaints and patient advice and liaison service to co-ordinate the investigation, response and resolution of complaints within statutory timeframes. The Trust is continually seeking to improve the way in which complaints and issues are managed, particularly in involving and empowering patients and families more effectively through the complaints process.

2.4.4 Stakeholder Relations

The Trust's policy is to engage, involve and consult with the public, patients, carers and other stakeholders on improving the care we provide. We do this by finding out what our patients and other stakeholders think about the care they have received and, through our Council of Governors, asking for views on our longer-term plans. Members are not just informed of issues regarding the Trust, but are actively involved in shaping services.

While the main forum for representing the interests of patients, carers, employees and the local community is through the Council of Governors, we have started a number of initiatives to open up channels for the wider community. There are a number of thriving patient support groups at the Trust, including the Glaucoma Support Group, which celebrated its fifth birthday last year.

Milton Keynes Clinical Commissioning Group

The Trust has established a working relationship with the CCG for contract negotiations and longer term health care planning.

Health and Adult Social Care Select Committee

The chief executive, the chairman and governors have continued to keep the elected representatives of Milton Keynes Council and in particular, the Health and Adult Social Care Committee appraised of service issues at the Trust. The Council have continued to support the strategic direction of the Trust. In addition, the Council has a new representative on the Council of Governors, Councillor Andy Reilly.

Health and Wellbeing Board

The Chief Executive represents the Trust on the Health and Wellbeing Board and reports any issues back to the Trust Board and governors, as appropriate.

Milton Keynes Adult Safeguarding Board

The Trust is an active member of the Milton Keynes Safeguarding Adults Board, the local group responsible for overseeing Safeguarding. It is a multi-agency group with representatives from the council, health services, police, voluntary sector and independent inspection and regulation services.

Healthwatch Milton Keynes

Throughout 2019/20 collaboration continued as appropriate between the Council of Governors and Healthwatch Milton Keynes. The remit of both the Council of Governors and Healthwatch is complementary; both bodies representing the health interests and concerns of and people of Milton Keynes and surrounding areas. The Chief Executive of Healthwatch Milton Keynes is an appointed member of the Trust's Council of Governors and another governor is a co-opted member of the Healthwatch Milton Keynes Management Board.

Healthwatch Milton Keynes CEO sits as an appointed governor on Milton Keynes Hospital's Council of Governors. Healthwatch Milton Keynes regularly supports the hospital with volunteers to undertake 15 steps and PLACE assessments. In 2019-20 Healthwatch Milton Keynes undertook an Enter and View visit to the Maternity/ Labour Wards to hear from patients about their experiences of care at the hospital in collaboration with the Hospital and the Maternity:MK.

Healthwatch Milton Keynes also liaise closely with the hospital and PALS team regarding concerns and compliments about care at the hospital raised directly with Healthwatch Milton Keynes.

2.4.5 Other Patient and Public Involvement Activity

The Trust has a diverse range of patient and public involvement activity and has significantly developed opportunities for involvement throughout the year. Examples include the '15 Steps Challenge initiative; engagement workshops and public meetings on the STP/ICS; PLACE assessments; and patient and carer stories at the Board and Council of Governors.

Political and Charitable Donations

There have been no political donations made by the Trust or charitable donation of the nature specified in the regulations made during the financial year. The Trust continues to benefit from charitable donations from its charity, Milton Keynes Hospital Charity, and is very grateful for the efforts of fundraisers and members of the public for their continued support.

Better Payments Practice Code and Public Contracts Regulation

The Trust's policy is to pay its suppliers in accordance with its contractual terms and has, in most case, complied with the Better Payments Practice Code. The Trust's achievement of the BPPC target has increased in the year and whilst below the target for payment within 30 days, invoices paid within 33 days were 91% (61,353 in volume) and 92% (£133,972,619 in value). The split between NHS and Non-NHS invoiced is detailed below

For the Year Ended 31st March 2020			
	Number of Invoices Paid within 30 days	**Total Number of Invoices Paid**	**% Number paid within 30 days**
NHS	1,545	2,343	66%
Non NHS	53,532	65,304	82%
Total	**55,077**	**67,647**	**81%**
	Value of Invoices Paid within 30 days	**Total Value of Invoices Paid**	**% Value paid within 30 days**
NHS	4,901,898	8,720,071	56%
Non NHS	123,232,620	137,395,379	90%
Total	**128,134,517.62**	**146,115,450**	**88%**

For the Year Ended 31st March 2019			
	Number of Invoices Paid within 30 days	**Total Number of Invoices Paid**	**% Number paid within 30 days**
NHS	1,234	2,205	56%
Non NHS	50,820	67,381	75%
Total	**52,054**	**69,586**	**75%**
	Value of Invoices Paid within 30 days	**Total Value of Invoices Paid**	**% Value paid within 30 days**
NHS	4,079,965	7,275,273	56%
Non NHS	104,673,879	120,165,368	87%
Total	**108,753,844**	**127,440,641**	**85%**

Income Disclosures Required by Section 43 (2A) of the NHS Act 2006

Income disclosures are included in the notes to the accounts.

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

2.5. Statement as to Disclosure to the Auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information.

2.6 Remuneration Report

The Remuneration Report describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008, and the NHS Foundation Trust Code of Governance.

The Remuneration Report comprises three parts:

1. Annual statement on remuneration
2. Senior managers' remuneration policy
3. Annual report on remuneration

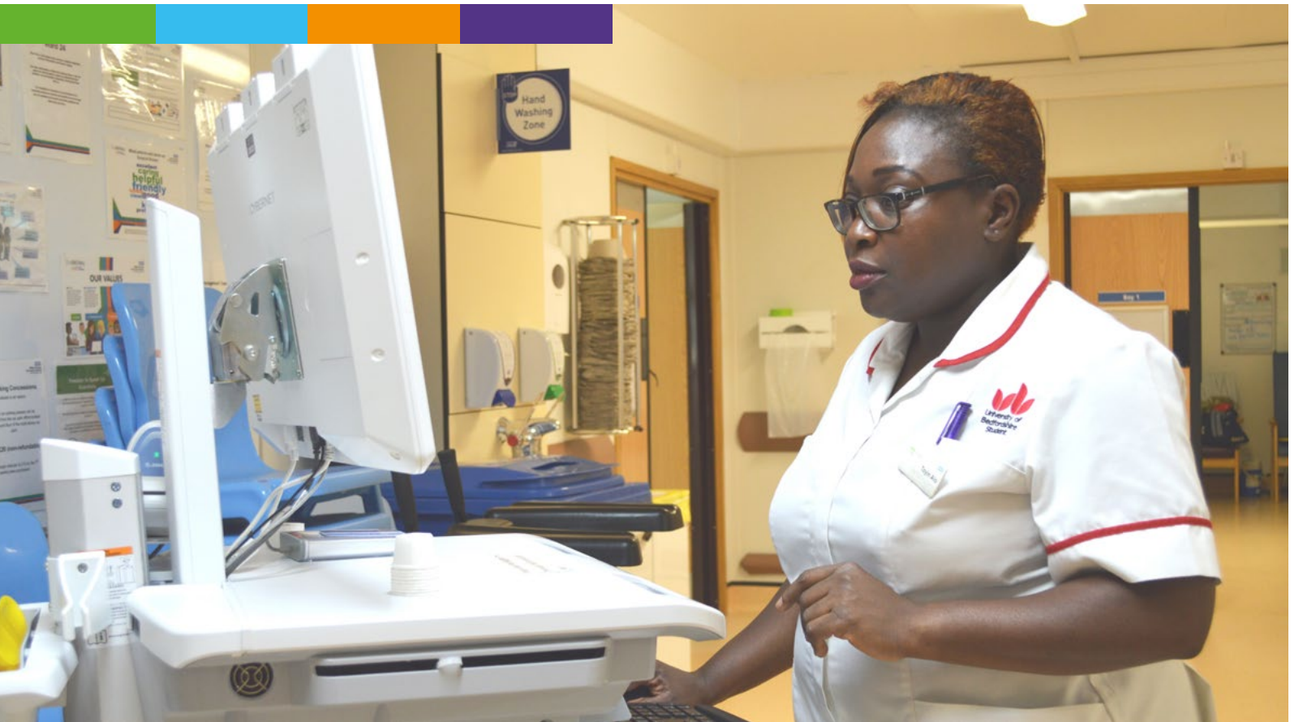
2.6.1 Annual Statement on Remuneration

For the period until 31 March 2020 there were no Trust Board members employed via non-payroll means.

A number of Board level changes took place in 2019/20. Lisa Knight left her role as Director of Patient Care and Chief Nurse in April 2019 and was replaced by Nicola Burns-Muir who came into post on an interim basis in April 2019 and then permanently in January 2020. Caroline Hutton moved into a new role of Director of Service Improvement in August 2019. Emma Livesley joined the Board in September 2019 as Director of Operations. Caroline Hutton began a secondment to NHSI/E in February 2020. Finally, Emma Goddard continued her secondment to the BLMK ICS (Bedford, Luton and Milton Keynes Integrated Care System), now in the role of Acting Managing Director.

There were eight non-executive and ten executive directors on the Board of Directors in 2019/20 (two on secondment as detailed in the above paragraph). Tony Nolan left the Board in March 2020 having completed two full terms totaling six years, Parmjit Dhanda left the Board in February 2020 having completed one term.

In 2019/20 executive salaries were agreed by the Remuneration Committee taking into account national guidance.



2.6.2 Senior Managers' Remuneration Policy

Future Policy Table					
Item	**Salary/Fees**	**Taxable Benefits**	**Annual Performance Related Bonus**	**Long Term Related Bonus**	**Pension Related Benefits**
Support for the short and long term objectives of the Foundation Trust	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	None paid	None paid	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid in even twelfths	None disclosed	None paid	None paid	Employee and employer contributions
Maximum payment	As set out in the Accounts	None disclosed	None paid	None paid	Not applicable
Framework used to assess performance	Trust appraisal system	None disclosed	None paid	None paid	Not applicable
Performance measures	Tailored to individual posts	None disclosed	None paid	None paid	Not applicable
Amount paid for minimum level of performance and any further level of performance	Salaries are agreed on appointment and set out in the contract of employment	None disclosed	None paid	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any overpayments may be recovered	None disclosed	None paid	None paid	Not applicable

Non-executive Directors are appointed on fixed terms contracts, normally three or four years in length, and they do not gain access to the Pension Scheme as a result of this engagement.

The fee payable to Non-executive Directors is set out in the table on page 61. They do not receive any other payments from the Trust.

2.6.2.1 Service Contract Obligations and Policy on Payment for Loss Office

All executive directors are employed on permanent or fixed term contracts and are required to give six months' notice to terminate their contract. In line with NHS Employers' guidance, the notice period for the trust's very senior managers (VSMs) is six months. Terms of each of the non-executive directors are given in the details of the Board members from page 31.Payment for loss of office is covered within contractual notice periods and standard employment policies and legislation.

2.6.2.2 Trust's Consideration of Employment Conditions

Other members of staff who are not Board members are employed on agenda for change terms and conditions and any percentage pay increases are applied in accordance with national agreements. The Remuneration Committee agrees senior managers pay and conditions following consideration of benchmarking information on comparable roles. Employees of the Trust are not consulted on senior manager remuneration.

2.6.3 Annual Report on Remuneration

In line with the Secretary of State for Health's request in his letter of 2 June 2015, the Chief Executive personally scrutinised and approved the remuneration of very senior managers (executive directors) to ensure that they are necessary and justifiable.

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chairman and comprises all the non-executive directors (see their details on table on page 59).

The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the chief executive and the executive directors. The Chief Executive and Director of Workforce attend the meeting but leave when discussions about their own positions are to be discussed. The Remuneration Committee met on two occasions in 2019/20. Information on attendance is contained within the Directors' Report.

The Trust reviewed its remuneration practice relating to executive directors during 2019/20 and has an agreed remuneration policy and strategy. The policy reflects recent practice of not linking director pay progression to individual performance and of not having performance related bonuses. When considering proposals on remuneration the Remuneration Committee adopts the same principles on diversity and inclusion as set out in paragraph 2.8.11 of the Staff Report. Both local and national benchmarking information regarding remuneration will continue to be provided to the Remuneration Committee. Further, in line with the Secretary of State for Health's letter of 2 June 2015 to chairs of NHS Trusts, the Trust reviews the amounts paid to directors to ensure that they are necessary and justifiable. The Chairman personally scrutinises and approves any new very senior manager appointment in the Trust.

The Committee reviewed the NHS pension arrangements for senior clinical staff. As the existing NHS pension arrangements were not considered to be suitable for all staff, the Committee approved the introduction of a split employment option with pension contribution reward alternative for certain categories of eligible staff whereby an individual would be allowed to enter into two separate contracts allowing the individual to remain opted-in to the pension for one contract and to opt-out for the other which would allow flexibility to control pension growth and associated benefits. This was introduced on a non-contractual basis and can be removed at any time.

The remuneration and expenses for the Chair and non-executive directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as NHSI and NHS Providers. In 2019/20, the Council reviewed the remuneration of non-executive directors as it had remained at the same level for five years. The Council agreed that the remuneration of non-executive directors should increase from £12,000 a year to £13,000 a year from 1 March 2020. The Council agreed that the remuneration of the Chair should increase from £45,000 to £47,100 upon the appointment of the next Chair. The council also agreed that an additional responsibility allowance of £2,000 should be introduced for the chair of the audit committee and for the senior independent director, provided that if those posts are held by the same individual only one additional responsibility allowance of £2,000 should be paid.

2.6.4 Tenure and notice periods of Board of Directors

Non-Executive Directors

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Simon Lloyd	Chairman	May 2015	April 2021	1 month
Andrew Blakeman	Non-executive director	Feb 2016	Mar 2022	1 month
Helen Smart	Non-executive director	March 2018	Feb 2022	1 month
Heidi Travis	Non-executive director	March 2018	Feb 2021	1 month
John Clapham	Non-executive director	March 2018	Feb 2020	1 month
Nicky McLeod	Non-executive director	February 2019	Jan 2022	1 month

Executive Directors

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Joe Harrison	Chief Executive	Feb 2013	N/A	6 months
Nicola Burns-Muir	Director of Patient Care and Chief Nurse	April 2019	N/A	6 months
Emma Livesley	Director of Operations	September 2019	N/A	6 months
Ian Reckless	Medical Director	April 2016	N/A	6 months
John Blakesley	Deputy Chief Executive	Apr 2014	N/A	6 months
Danielle Petch	Director of Workforce	July 2018	N/A	6 months
Mike Keech	Director of Finance	Dec 2016	N/A	6 months
Kate Jarman	Director of Corporate Affairs	May 2014	N/A	6 months
Caroline Hutton	Director of Service Improvement	Oct 2014	N/A	6 months
Emma Goddard	Director of Service Development	Dec 2014	N/A	6 months

Other Board members during 2019/20

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Tony Nolan	Non-executive director	March 2014	Term ended in March 2020	1 month
Parmjit Dhanda	Non-executive director	March 2017	Term ended February 29, 2020	1 month
Lisa Knight	Director of Patient Care and Chief Nurse	Oct 2012	April 2019	6 months

Details of remuneration, including salaries and pension entitlements of the Board of Directors are published in section 6.5 of the annual accounts. Details on the median/mid-point and highest paid director are included in section 6.6 of the annual accounts.

In 2019/20 and 2018/19 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £12,000 to £207,500 (2018/19 from £6,000 to £194,800).

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The Trust's highest paid Director was the Chief Executive and the previous year's highest paid Director was the Chief Executive.

The details of other remuneration, travel and assistance for directors and non-executive directors are attached in table 1.

The only non-cash element of the senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme, which apply to all staff.

With the exception of benefits payable under the NHS pension scheme in respect of early retirement (whether this might be actuarially reduced or ill-health related), no further benefit is payable to a senior manager in the event of their early retirement. Furthermore, no service contract obligations apply which could give rise to, or impact on, remuneration payments or payments for loss of office.

The Trust notes that NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related Cash Equivalent Transfer Values (CETVs) set out on page 64 of this report do not allow for any potential future adjustments that may arise from this judgement.

In preparing its senior managers' remuneration policy, the Trust has benchmarked itself against other medium sized acute trusts and has taken account of national guidance on senior managers' pay.

The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff. The Trust has a policy in place that reviews the employment status of contractors to assess if the contractor is an employee or self-employed as per HMRC's assessment criteria. The Trust's policy is not to employ anyone through their own company is they do not meet the self-employment status

2.6.5 Directors' Remuneration Report Statement 2019/20 (subject to audit)

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Name and Title	Year Ended 31 March 2020					
	Salary (bands of £5,000) £000	Taxable Benefits (To the nearest £100) £000	Annual Performance Related bonuses (Bands of £5,000) £000	Long term Performance Related bonuses (Bands of £5,000) £000	Pension Benefits (Bands of £2,500) £000	Total (Bands of £5,000) £000
Joseph Harrison Chief Executive Officer	205-210	0	0	0	2.5-5	210-215
Mike Keech Director of Finance	135-140	0	0	0	40-42.5	175-180
Lisa Knight (to end April 2019)* Director of Patient Care / Chief Nurse	5-10	0	0	0	147.5-150	155-160
John Blakesley Deputy Chief Executive	120-125	0	0	0	0	120-125
Nicky Burns-Muir (from end April 2019) Director of Patient Care/Chief Nurse	105-110	0	0	0	245-247.5	350-355
Danielle Petch Director of Workforce	115-120	0	0	0	0	115-120
Ian Reckless Medical Director	190-195	0	0	0	0	190-195
Emma Goddard (on secondment all year) Director of Service Development	115-120	0	0	0	0	115-120
Kate Jarman Director of Corporate Affairs	110-115	0	0	0	57.5-60	170-175
Caroline Hutton (on secondment from Feb 2020) Director of Clinical Services	130-135	0	0	0	17.5-20	150-155
Emma Livesley (from Sept 30, 2019) Director of Operations	55-60	0	0	0	7.5-10	60-65
Simon Lloyd Chairman	45-50	0	0	0	N/A	45-50
Tony Nolan (to March 31, 2020) Non-Executive Director	10-15	0	0	0	N/A	10-15
Andrew Blakeman Non-Executive Director	10-15	0	0	0	N/A	10-15
Parmjit Dhanda (to Feb 29, 2020) Non-Executive Director	10-15	0	0	0	N/A	10-15
Helen Smart Non-Executive Director	10-15	0	0	0	N/A	10-15
Heidi Travis Non-Executive Director	10-15	0	0	0	N/A	10-15
John Clapham Non-Executive Director	10-15	0	0	0	N/A	10-15
Nicola McLeod Non-Executive Director	10-15	0	0	0	N/A	10-15

** The value of the pension benefit is calculated as at 31 March 2020. As a result, the pension benefit for Lisa Knight reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following her departure from the Trust on 24th April 2019*

Name and Title	Year Ended 31 March 2019					
	Salary (bands of £5,000) £000	Taxable Benefits (To the nearest £100) £000	Annual Performance Related bonuses (Bands of £5,000) £000	Long term Performance Related bonuses (Bands of £5,000) £000	Pension Benefits (Bands of £2,500) £000	Total (Bands of £5,000) £000
Joseph Harrison Chief Executive Officer	175-180	0	0	0	50-52.5	225-230
Mike Keech Director of Finance	115-120	0	0	0	25-27.5	145-150
Lisa Knight Director of Patient Care / Chief Nurse	110-115	0	0	0	32.5-35	140-145
John Blakesley Deputy Chief Executive	150-155	0	0	0	N/A	150-155
Ogechi Emeadi (left in July 2018) Director of Workforce	100-105	0	0	0	30-32.5	130-135
Danielle Petch (from July 2018) Director of Workforce	80-85	0	0	0	0	80-85
Ian Reckless Medical Director	165-170	0	0	0	5-7.5	175-180
Emma Goddard Director of Service Development	110-115	0	0	0	27.5-30	140-145
Kate Jarman Director of Corporate Affairs	85-90	0	0	0	52.5-55	140-145
Caroline Hutton Director of Operations	130-135	0	0	0	150-152.5	280-285
Simon Lloyd Chairman	45-50	0	0	0	N/A	45-50
Tony Nolan Non-Executive Director	10-15	0	0	0	N/A	10-15
Robert Green (to 31/12/2018) Non Executive Director	10-15	0	0	0	N/A	10-15
Andrew Blakeman Non-Executive Director	10-15	0	0	0	N/A	10-15
Parmjit Dhanda Non-Executive Director	10-15	0	0	0	N/A	10-15
Helen Smart Non Executive Director	0-5	0	0	0	N/A	0-5
Heidi Travis Non Executive Director	0-5	0	0	0	N/A	0-5
John Clapham Non Executive Director	0-5	0	0	0	N/A	0-5

Name and Title	Year Ended 31 March 2020	
	Other Remuneration (To the nearest £100) £	Travel & Subsistence (To the nearest £100) £
Joseph Harrison Chief Executive Officer	400	2,500
Mike Keech Director of Finance	0	800
Nicky Burns-Muir Director of Patient Care / Chief Nurse	0	0
John Blakesley Deputy Chief Executive	200	100
Lisa Knight (to April 2019) Director of Patient Care/ Chief Nurse	0	0
Danielle Petch Director of Workforce	0	500
Ian Reckless Medical Director	600	800
Emma Goddard (on secondment all year) Director of Service Development	0	800
Kate Jarman Director of Corporate Affairs	0	0
Caroline Hutton (on secondment from February 2020) Director of Clinical Services	0	0
Emma Livesley (from Sept 2019) Director of Operations	0	100
Simon Lloyd Chairman	0	100
Tony Nolan Non-Executive Director	0	1,100
Andrew Blakeman Non-Executive Director	0	0
Parmjit Dhanda (to February 2020) Non-Executive Director	0	700
Helen Smart Non-Executive Director	0	100
Heidi Travis Non-Executive Director	0	0
John Clapham Non-Executive Director	0	0
Nicola McLeod (from Feb 2019) Non-Executive Director	0	400

Name and Title	Year Ended 31 March 2019	
	Other Remuneration (To the nearest £100) £	Travel & Subsistence (To the nearest £100) £
Joseph Harrison Chief Executive Officer	700	2,000
Mike Keech Director of Finance	0	0
Lisa Knight Director of Patient Care / Chief Nurse	0	100
John Blakesley Deputy Chief Executive	0	0
Ogechi Emeadi (to July 2018) Director of Workforce	0	0
Danielle Petch (from July 2018) Director of Workforce	0	0
Ian Reckless Medical Director	700	1,100
Emma Goddard (on secondment to BLMK ICS during the reporting period) Director of Service Development	0	1,400
Kate Jarman Director of Corporate Affairs	100	100
Caroline Hutton (on secondment to NHS England from February 2020) Director of Clinical Services	0	0
Simon Lloyd Chairman	0	0
Tony Nolan Non-Executive Director	0	500
Robert Green Non-Executive Director	0	0
Andrew Blakeman Non-Executive Director	0	0
Parmjit Dhanda Non-Executive Director	0	800
Helen Smart (from 1st March 2018) Non-Executive Director	0	0
Heidi Travis (from 1st March 2018) Non-Executive Director	0	0
John Clapham (from 1st March 2018) Non-Executive Director	0	0

Salaries and Allowances 2019/20 – subject to audit

Name and Title	Real increase in pension at pension age (Bands of £2.5k) £000	Real increase in pension lump sum at pension age (Bands of £2.5k) £000	Total accrued pension at pension age at 31st March 2020 (Bands of £5k) £000	Lump sump at pension age related to accrued pension at 31st March 2020 (Bands of £5k) £000	Cash Equivalent Transfer Value at 31st March 2019 (Bands of £1k) £000	Real Increase in Cash Equivalent Transfer Value (Bands of £1k) £000	Cash Equivalent Transfer Value at 31st March 2020 (Bands of £1k) £000	Employer's contribution to stakeholder pension (Bands of £1k) £000
Joe Harrison* Chief Executive Officer	0-2.5	0	30-35	70-75	1094	0	920	20
Mike Keech Director of Finance	2.5-5	0	5-10	N/A	52	3	74	19
Lisa Knight** Director of Patient Care / Chief Nurse	0-2.5	0-2.5	55-60	135-140	969	8	1,115	0
Nicky Burns-Muir Director of Patient Care/Chief Nurse	10-12.5	40-42.5	35-40	110-115	557	221	797	15
Caroline Hutton Director of Clinical Services	0-2.5	0	45-50	100-105	859	22	900	19
Kate Jarman Director of Corporate Affairs	2.5-5	2.5-5	20-25	30-35	211	29	255	16
Emma Goddard Director of Service Improvement	0	0	15-20	N/A	174	1	184	4
Ian Reckless Medical Director	0	0	40-45	100-105	773	0	698	13
Emma Livesley Director of Operations	0-2.5	0	25.30	55-60	448	3	462	8

NOTES

**The cash equivalent transfer value as at 31 March 2020 is calculated in accordance with the 1995 section of the NHS pension scheme rules under which pension entitlement is based on the highest pensionable salary in the last three years*

***The value of the pension benefit is calculated as at 31 March 2020. As a result, the pension benefit for Lisa Knight reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following her departure from the Trust on 24th April 2019*

**** Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.*

Salaries and Allowances 2018/19

Name and Title	Real increase in pension at pension age (Bands of £2.5k) £000	Real increase in pension lump sum at pension age (Bands of £2.5k) £000	Total accrued pension at pension age at 31st March 2019 (Bands of £5k) £000	Lump sump at pension age related to accrued pension at 31st March 2019 (Bands of £5k) £000	Cash Equivalent Transfer Value at 31st March 2018 (Bands of £1k) £000	Real Increase in Cash Equivalent Transfer Value (Bands of £1k) £000	Cash Equivalent Transfer Value at 31st March 2019 (Bands of £1k) £000	Employer's contribution to stakeholder pension (Bands of £1k) £000
Joe Harrison Chief Executive Officer	-	-	30-35	65-70	948	121	1,069	20
Mike Keech Director of Finance	0-2.5	0	5-10	N/A	25	22	47	17
Lisa Knight Director of Patient Care / Chief Nurse	2.5-5	7.5-10	45-50	120-125	771	175	946	16
Ogechi Emeadi Director of Workforce	0-2.5	0-2.5	35-40	90-95	584	45	719	15
Caroline Hutton Director of Clinical Services	0-2.5	0	40-45	100-105	730	108	839	19
Kate Jarman Director of Corporate Affairs	0-2.5	0-2.5	15-20	25-30	153	52	204	13
Emma Goddard Director of Service Improvement	0-2.5	0	15-20	N/A	130	35	177	16
Ian Reckless Medical Director	2.5-5	10-12.5	45-50	115-120	524	116	754	12

2.6.6 Governor Expenses

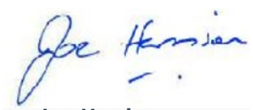
Governors are permitted to claim an allowance of £10 for any meeting of the Council of Governors they attend or an external meeting that they attend on behalf of the Trust e.g. Healthwatch Milton Keynes Executive. Details of the claims made in 2019/20 are attached at table 2. Details of Governors who held office in 2018/19 are given at Appendix 1.

Governor Expenses 2019/20

Governor	Amount £
Alan Hastings (lead governor)	129.98
Total	**129.98**

Governor Expenses 2018/19

Governor	Amount £
Siddhartha Nandi-Purkayastha (Governors' meeting)	20.00
Alan Hastings	37.25
Douglas Campbell	90.00
Carolyn Peirson	60.00
Total	**207.25**



Joe Harrison

Chief Executive

Date: 11th June 2020

2.7 Staff Report

This section of the report provides information on staff, including staff numbers, costs and key workforce performance information.

2.7.1 Analysis of Staff Costs (subject to audit)

Staff Costs	Permanently Employed £0	Other £0	Total £0
Employee expenses – staff	172,387	11,096	183,483
Employee expenses – executive directors	1,484	0	1,484
Total	**173,871**	**11,096**	**184,967**

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the FTC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs			2019/20	2018/19
	Permanent	Other	**Total**	Total
	£000	£000	**£000**	£000
Salaries and wages	136,397	2,139	**138,536**	127,341
Social security costs	14,803	0	**14,803**	13,887
Apprenticeship levy	694	0	**694**	654
Employer's contributions to NHS pensions	15,321	0	**15,321**	14,562
Pension cost - other	6,656	0	**6,656**	0
Temporary staff	0	8,957	**8,957**	9,676
Total gross staff costs	**173,871**	**11,096**	**184,967**	**166,120**

2.7.2 Analysis of Average Staff Numbers

The table below shows a breakdown of our average workforce by staff group as at 31 March 2020.

Average headcount – 2019/20 (subject to audit)

	Assignment Category				
Staff Group	**Fixed Term Temp**	**Non-Exec Director / Chair**	**Permanent**	**Zero Hour Locum / Bank**	**Total Headcount**
Add Prof Scientific and Technic	2	-	100	36	138
Additional Clinical Services	9	-	607	515	1,132
Administrative and Clerical	50	7	715	107	879
Allied Health Professionals	4	-	172	25	201
Estates and Ancillary	3	-	358	34	395
Healthcare Scientists	-	-	82	27	109
Medical and Dental	160	-	264	359	783
Nursing and Midwifery Registered	25	-	1,029	264	1,318
Grand Total	**254**	**7**	**3,326**	**1,366**	**4,953**

Average number of employees (WTE basis) (subject to audit)

			2019/20	2018/19
	Permanent	**Other**	**Total**	**Total**
	Number	Number	Number	Number
Medical and Dental	444	29	**473**	445
Administration and Estates	618	87	**704**	437
Healthcare assistants and other support staff	793	193	**986**	1,197
Nursing, midwifery and health visiting staff	869	197	**1,066**	1,046
Scientific, therapeutic and technical staff	250	17	**267**	305
Healthcare science staff	73	6	**79**	32
Other	0	0	**0**	14
Total average numbers	**3,047**	**528**	**3,575**	**3,476**

The following is a breakdown of staff by gender:

Staff	Female	Male	Total
Senior Managers	9	8	17
Other Senior Managers	0	0	0
Employees	2992	775	3767
Total	**3001**	**783**	**3784**

As at 31 March 2020, the Trust Board comprised eight non-executive directors (5 male and three female) and 10 executive directors (four male and six female – two on secondment as of March 31, 2020).

2.7.3 Absence rate for year to 31/03/2020:

Sickness Absence 2019/20

Trust Absence 12 months to 31 March 2020	Cumulative Abs (WTE)	Cumulative Avail (WTE)	Cumulative % Abs Rate (WTE)	Short Term % Abs Rate (WTE)	Long Term % Abs Rate (WTE)	No of Episodes
All Staff Groups	46,898	1,134,656	4.13%	1.91%	2.23%	7,077

Sickness Absence 2018/19

Trust Absence 12 months to 31 March 2019	Cumulative Abs (WTE)	Cumulative Avail (WTE)	Cumulative % Abs Rate (WTE)	Short Term % Abs Rate (WTE)	Long Term % Abs Rate (WTE)	No of Episodes
All Staff Groups	43,899	1,109,712	3.96%	1.72%	2.24%	6,697

The top ten reasons for Trust sickness absence are now reported routinely to the Trust's Management Board across a number of levels for visibility and action planning. Work has commenced, to improve the level of 'unknown' absence through an improved return to work process and stronger procedural guidance in our revised Sickness Absence and Attendance policy which launched in December 2018 following extensive consultation.

The health and wellbeing of our staff continues to be a top priority for the Trust, in terms of improving workforce effectiveness and its effect on patient care. By focusing on 'hotspot' areas of sickness absence, we have been able to bring about conclusions to long term individual cases, reduce intermittent absence levels and identify areas of best practice to champion and from which to learn. As at the end March 2020, the Trust's sickness absence level was slightly above its target of 4% in 2019/20, however, this figure has consistently been below that of the previous two financial years.

2.7.4 Expenditure on consultancy

The Trust incurred £58k relating to consultancy services. This included amounts relating to an external well-led review (as required by the Trust's licence with Monitor) and specialist expertise in support of estates projects.

2.7.5 Staff Policies and actions applied during the Financial Year

Workforce strategy (2018 to 2021)

To deliver the Trust's challenging agenda in line with the Long Term Plan, an integrated approach to patient care, workforce management, organisational development and workforce planning is essential. Approved in October 2018, the Trust's Workforce Strategy and Plan set out the strategic framework for various aspects of the MKUH workforce and plan for delivery, ownership and governance, respectively. On an annual basis, objectives for the year ahead are agreed with Trust Board, in line with the Workforce Strategy, with time bound activities to support their delivery.

The 2018-2021 Workforce Strategy focusses on recruiting and retaining the Workforce, providing a healthy engaged workforce and ensuring workforce efficiency is maximised. The Workforce Strategy is split into three key workstreams:

- Attract, recruit, retain and develop talented staff who embody our values
- A healthy workplace with effective employee engagement and wellbeing
- Maximise productivity through innovative & efficient workforce and infrastructure

The delivery of these is monitored by the Workforce Development and Assurance Committee, a sub-committee of the Trust Board, and by the HR Teams as part of the Workforce Strategy Delivery Programme.

The Workforce Strategy aims to ensure an engaged and well-trained workforce is available in the short, medium and long term. Alongside the Workforce Strategy delivery actions business as usual processes take place to ensure the right staff are available in the right place, at the right time.

The strategy and business as usual actions include:

1. Enhanced and focused recruitment campaigns to recruit to hard to fill roles, as well as high turnover roles such as Health Care Assistants, Band 5 Nurses and administrative and clerical
2. Development and integration of new and emerging roles, such as Nursing Associates and Advanced Nurse Practitioners
3. Regular review and monitoring of safe staffing levels, including the use of the Safer Nursing Care Tool and BirthRate Plus for bi-annual establishment reviews
4. Robust rostering practices, including the use of Check & Challenge meetings to scrutinise rosters
5. Recording and monitoring of Care Hours Per Patient Day (CHPPD), reported to Board as part of the Board Nursing Staffing Report
6. Short, medium and long term workforce planning practices to develop and staff service models, now and in the future
7. Design and implementation of retention initiatives, including enhanced benefits offering
8. Enhanced wellbeing package, promoting and improving the health of our workforce
9. Comprehensive training packages and use of central funding and apprenticeships to ensure training is widely available

"To deliver the Trust's challenging agenda in line with the Long Term Plan, an integrated approach to patient care, workforce management, organisational development and workforce planning is essential."

The above listed activities support the NHSI Developing Workforce Safeguard recommendations, ensuring the wards as staffed safely and that staffing levels are monitored and adjusted as required and that the Trust is managing not only the workforce of today but also planning for the workforce of tomorrow.

Our Recruitment and Selection policy ensures that we are able to give full and fair consideration to applications for employment made by disabled persons. All our jobs are advertised on the national NHS jobs website and via our electronic recruitment system, TRAC, which not only promotes equal opportunities at recruitment stages, but also allows disabled candidates to declare known or suspected conditions and how we might overcome these by adjusting our selection activities. Such conditions are made known to recruiting managers by the recruitment team after the shortlisting process has taken place to ensure that the risk of discrimination is minimised.

The Trust has various means of supporting employees to continue their employment and receive training and retraining in the event that they should become disabled persons during their Trust employment. A comprehensive Sickness Absence and Attendance policy and 'Working with Disabilities' guidance provide policy and procedural guidance in this regard and managers, colleagues and interventions, such as adjustments to working roles and redeployments, are supported and facilitated by specialist Occupational Health, HR Advisor and HR Business Partner input. External agencies, such as Access to Work and Remploy are also engaged on a case-by-case basis, where it is believed that the Trust, its managers or its colleagues could benefit from expert technical or financial support. The Trust is an accredited 'Disability Confident' Employer and was an active participant in the formative stages of the Workforce Disability Equality Standard prior to its introduction in April 2019. The Trust's Disability Network was launched in 2018/19 to support staff engagement and ensure that underrepresented colleagues can have peer support and a collective voice within the organisation. In 2019/20, MKUH Pride network was established to support LGBTQ+ colleagues and a Women's Network was also established to support the female workforce.

The Trust's Appraisal and Statutory and Mandatory training framework provide that training, career development and promotion of disabled employees are facilitated through individualised actions and personal development plans that are aligned to the Trust's core values. Such an approach promotes equal opportunities through promotion of learning and development and it also seeks to reduce the impact of potential inequalities caused by the condition or disability of an individual in a supportive way. All Trust policies have an Equality Impact Assessments undertaken during the policy consultation process, ensuring that the Trust has due regard of particular issues and has considered implementation of mitigating actions in respect of all protected characteristics.

In terms of engagement, the Trust uses various means of communicating matters of concern to our workforce. Such an approach ensures no group is left without receiving key messages. The discussions and outcomes of Trust meetings, such as Management Board, are cascaded through to colleagues in person and via email, monthly newsletters are produced and the intranet and Workforce website are increasingly being used for this purpose, in addition to the staff forum/ bulletin board.

In 2019/20, the Trust's co-developed Bank Staff Booking app, Ryalto, was developed further to provide another accessible platform for information sharing, networking and engagement with push notification functionality.

In 2019/20 the Trust has continued to use payslip attachments as a means of reaching its staff; bi-annual free coffee 'thank you' vouchers from the Chief Executive have proved most popular, as did free water and soft drinks distributed to all areas of the Trust during very hot weather in the summer of 2019.

'All acute users' emails are routinely used in addition to a variety of on-site and web-based seminars, such as the Chief Executive's Roadshows and the Chief Executive's Leadership Forums. More recently, the Trust has made more use of local surveys via its web-based applications, e.g. health and wellbeing and staff benefits surveys, Staff Friends and Family test. With the addition of the third annual Event in the Tent in May 2019, such engagement activities have become increasingly important in 2019/20 as the Trust has sought to celebrate its successes, meaningfully engage its staff and ensure that mission critical information is disseminated at scale and pace. To that end, the Trust hosted its first regional Greatix one-day event, celebrating the good things that staff in the Thames Valley area are achieving within their individual healthcare settings.

The Trust has a long-standing Recognition Agreement with Staff Side partners. The Recognition Agreement provides the governance framework for the monthly Joint Consultative and Negotiation Committee (JCNC) meetings which

are chaired on an alternate basis by the Staff Side Chair and the Director of Workforce. The Medical and Dental Joint Local Negotiating Committee (JLNC) also falls under the governance framework of the JCNC.

A full and comprehensive review of all workforce policies and procedures commenced in 2016/17 under the guidance of the JCNC to ensure that we seek to align to regional policy/direction or differentiate in order to set us apart, depending on specific need/aim or purpose (e.g. becoming an employer of choice in the region). In 2019/20 the Trust reviewed and/or approved 9 of its 40 Workforce, Education, Learning and Medical and Dental policies. 9 further new workforce policies are currently under development as we seek to support and develop our workforce further in-line with the Workforce Strategy and Trust Objectives.

Furthermore, the Trust's Management of Organisational Change Policy provides framework agreed in partnership with Staff Side colleagues for consultations where organisational change is required. In this way, early Staff Side involvement in organisational change programmes is sought, in order to capitalise on consultation opportunities in a meaningful way with our colleagues and their representatives. Staff Side colleagues are also involved and engaged in key Trust activities such as the Equality, Diversity and Inclusion network, the On-Call working group, job matching panels and our Staff Engagement networks, and We Care steering group.

Together these ensure that we seek the views of our workforce in a holistic and inclusive way, demonstrating our ongoing commitment to partnership working.

The Trust has numerous policies and procedures with regard to countering fraud and we work routinely with Counter Fraud specialists to support our efforts in this regard. The Trust has a comprehensive set of Standing Financial Instructions (SFIs) and a standalone counter fraud and reporting policy, including the involvement and roles of internal and external auditors. Separate to these, the Trust has its own Gifts, Donations and Hospitality Declarations policy in addition to specific clauses in the standard Trust contract of employment covering this area.

In line with critical national requirements, in 2019/20 the Trust also continued to support key employee relations activity by promoting its Freedom to Speak Up Guardians (Raising Concerns), Guardian of Safer Working (Medical and Dental colleagues) and ongoing participation in its Junior Doctors forum.

2.7.6 Staff side time spent on union facilities

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force in April 2017. The regulations require that NHS employers publish certain information about trade union officials and facilities time. The following tables show facilities activity and cost among the unions that are recognised by the Trust over the course of 2018/19. These figures are collated and reported to the Trust's Joint Consultative and Negotiation Committee (JCNC).

Table 1 – Relevant union officials

Table 1 outlines the total number of MKUH employees who were relevant union officials during 2019/20

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
22	19.93

Table 2 – Percentage of time spent on facility time

Table 2 outlines the number of MKUH employees who were relevant union officials employed during the 2019/20 who spent (a) 0%, (b) 1%-50%, (c) 51%-99% or (d) 100% of their working hours on facility time.

Percentage of time	Number of employees
0%	2
1-50%	20
51%-99%	
100%	

Table 3 – Percentage of pay bill spent on facility time

Table 3 provides the percentage of the MKUH total pay bill spent on paying employees who were relevant union officials for facility time during 2019/20

Description	Figures
Total cost of facility time	£33,248.86
Total pay bill	£1,501,551.87
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	2.21%

Table 4 – Paid trade union activities

Table 4 provides the number hours spent by employees who were relevant union officials during 2019/20 on paid trade union activities, expressed as a percentage of total paid facility time hours,

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:

(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

3.13%

2.7.7 Health and Safety Performance and Staff Health and Wellbeing

In line with our strategic workforce direction for 2019/20, a greater focus was placed on supporting our colleagues through core Occupational Health services and Staff Health and Wellbeing' activities.

The SH&WB department undertakes both pre-employment and employment fitness for work assessments. It also provides an immunisation/ screening programme to ensure staff are protected against infectious and communicable diseases in line with Department of Health guidance.

The service continues to support the Trust with the management of sickness absence and providing advice in relation to health conditions which may have an impact upon an individual's health at work or vice versa. Through an Employee Assistance Programme, the Trust offers a number of support to staff on a free and confidential basis, including; emotional and psychological support such as counselling and financial and legal advice. Following the approval of the Trust's first health and wellbeing strategy in 2016/17, several key features have been delivered including a staff physiotherapy early intervention service for colleagues suffering with musculoskeletal complaints, the service has been overwhelmingly well received by colleagues and helped many to return to work sooner than they would have done without such intervention, enabling the Trust to reduce its temporary staffing usage. The Trust has also, for the fourth consecutive year, successfully achieved its Flu immunisation target ensuring that 80.1% of its frontline health care colleagues were vaccinated against the flu virus. Weekly uptake of flu vaccinations was reported on a weekly basis to the executive team and socialised with the Trust via the CEO weekly newsletter (jab-o-meter) and Social Media channels.

The Trust now has over 70 trained Mental Health First Aiders (MHFAs) who can be called upon in the first instance to help signpost colleagues to appropriate support if required.

To support the spiritual needs of our staff of all faiths and none, the Chapel offers a quiet space for reflection at all times. In 2019/20, considerable work was undertaken to remodel the space to create separate prayer rooms for our Muslim colleagues, with separate washing facilities for men and women.

The health and wellbeing steering group continues to meet on a monthly basis, led by our Head of Staff Health and Wellbeing with quarterly reporting to the overarching senior Workforce Board and also to the sub-Trust Board, NED chaired, Workforce and Development Assurance Committee. In 2019/20 the group has enlisted more Health and Wellbeing Champions and sought to oversee delivery of the Trust's Health and Wellbeing Strategy with staff side support. The strategy sets out our intent to engage with partners to ensure that the wellbeing of our workforce underpins excellent performance through education, prevention and effective management of health conditions.

The Trust has used various means of communicating developments (payslip attachments, email, health and wellbeing events, Event in the Tent, quarterly newsletter, workforce website) and the service has delivered a series of monthly activities in support of health and wellbeing education and prevention.

The Trust's 2019 National Staff Survey results confirm that it continues to improve the health and wellbeing of our organisation. This is underpinned by an improved staff benefits package which was rolled out during 2019/20, which included free car parking, free tea and coffee, improved terms of special leave and discounted gym memberships.

2.7.8 Staff Survey Results

Statement of approach for staff engagement

Staff engagement is very important to us, our workforce is our greatest asset. The 2019 national staff survey was undertaken between October and December 2019.

The Trust changed provider from Picker to Quality Health to administer its survey and undertake analysis on its behalf,

2019's survey was MKUH's 6th successive full census; 1914 *(1914 respondents from an eligible sample of 3447 staff)* colleagues returned their completed survey within the deadline requirement; a response rate of 55.5% a noticeable increase from the 43.7% 2018 response rate and is well above the average for acute Trusts in England at 46.3%.

We had a response rate of 55.5%
a noticeable increase from the 43.7% 2018 response rate and well above the average for acute Trusts in England at 46.3%

Staff were encouraged to complete the survey with regular communications reminders, posters in staff rooms with answers to frequently asked questions, publicity at meetings, monitoring and chasing of non-return areas and all staff who completed the survey took part in a prize draw.

Summary of Performance – results from the 2019 staff survey

The 2019 Staff Survey has 11 key themes (2018 had 10) an updated benchmark report and a 3-year trend analysis.

Themes are scored on a 0-10 scale, with a higher score being a better result. All questions are now presented in the updated benchmark reports, so that questions can be viewed separately rather than summary indicator results.

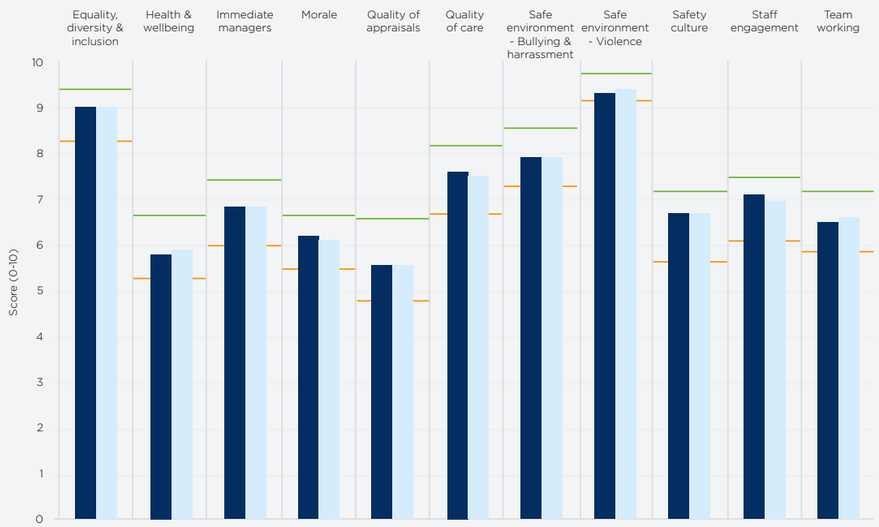
The staff engagement score has been calculated using the same questions as in previous years but adjusted to a 0-10pt scale. Historical data has been re-calculated to use the new scale so that we are able to make comparisons with prior years more easily.

The staff survey in 2019 is reported using 11 themes: Equality, diversity & inclusion; Health & wellbeing; Immediate managers; Morale; Quality of appraisals; Quality of Care; Safe environment – Bullying & harassment; Safe environment – Violence; Safety culture; and Staff engagement. The new theme is 'Team working'.

There are 85 organisations in our sector. The Trust scored above the benchmarking for the sector, in the following themes: Morale, Quality of Care; and Staff engagement. The Trust's staff engagement score has risen slightly from 7.0 to 7.11. The Trust scored in line with the average for the sector in Equality, Diversity and Inclusion, Immediate managers, quality of appraisals, safe environment – bullying and harassment, and safety culture.

	2019/20		2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	9	9	8.9	9.1	9	9.1
Health & wellbeing	5.8	5.9	5.9	5.9	6	6
Immediate managers	6.8	6.8	6.8	6.7	6.8	6.7
Morale	6.2	6.1	6	6.1	Not asked	
Quality of appraisals	5.6	5.6	5.3	5.4	5.3	5.3
Quality of care	7.6	7.5	7.5	7.4	7.6	7.5
Safe environment – bullying & harassment	7.9	7.9	7.9	7.9	7.9	8
Safe environment – violence	9.3	9.4	9.4	9.4	9.3	9.4
Safety culture	6.7	6.7	6.7	6.6	6.6	6.6
Staff engagement	7.1	7	7	7	7	7
Team Working	6.5	6.6	Not previously asked			

The table below shows the 11 theme scores for 2019



Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your Org	9.0	5.8	6.8	6.2	5.6	7.6	7.9	9.3	6.7	7.1	6.5
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	1,871	1,885	1,899	1,867	1,638	1,694	1,864	1,862	1,878	1,902	1,889

The questions where the Trust has shown statistically significant improvements or declines (more than a 3% swing) are listed below: -

There were 89 questions in the staff survey which could be given a positive or negative score. Of these:

57 questions showed some improvement in score from 2018,

18 questions stayed the same score as last year,

14 questions showed a drop in score from 2018.

- **Q5f. The extent to which my organisation values my work.**
  The positive score for this has moved from 43% last year to 48% in 2019. 5% swing is a significant improvement.
- **Q9c. Senior managers here try to involve staff in important decisions.**
  The positive score for this has moved from 32% last year to 36% in 2019. Another significant improvement.
- **Q9d. Senior managers act on staff feedback.**
  The positive score for this has moved from 33% last year to 37% this year. These scores indicate a move toward senior managers engaging more with staff.
- **Q10b. On average, how many additional PAID hours do you work per week for this organisation, over above your contracted hours?**
  There has been a large decrease in people working additional paid hours. 50% of staff now say they work no additional hours, improved from 57% in 2018. However, those staff who are still working additional hours have increased: see Q10c
  - » 22% now work up to 5 additional hours, compared to 19% last year
  - » 16% now work 6-10 additional hours, compared to 13% last year
  - » 12% work 11+ additional hours, compared to 11% last year
- **Q10c. On average, how many UNPAID hours do you work per week for this organisation, over and above your contracted hours?**
  - » 45% now say they work no additional unpaid hours, compared to 41% last year. The number of people who do work unpaid hours has fallen, it can be surmised that more of those are being paid for the work they do.
  - » 43% now work up to 5 additional hours, compared to 46% last year
  - » 8% now work 6-10 additional hours, compared to 9% last year
  - » Those working 11+ additional hours has stayed the same at 4%
- **Q11b. In the last 12 months have you experienced MSK problems as a result of work activities?**
  32% now say they have had MSK problems, compared to 27% last year so this response is 5% worse than 2018 staff survey response rate.
- **Q11e. Have you felt pressure from your manager to come to work?**
  Fewer people now feel under pressure from their manager, with 77% saying no, compared to 73% last year. There is also some slight decrease in those who say they have felt pressure from colleagues (2% improvement), and also a decrease in those who put themselves under pressure, down to 89% from 92% last year.
- **Q12d. The last time you experienced physical violence at work, did you or a colleague report it?**
  There is no change to this score, it stays the same at 72% - but there is a significant difference between this Trust and the national average, which is only 66%
- **Q13d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?**
  The numbers now reporting these incidents has increased from 51% to 55%.

  Related to this - Q13b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from your manager has a positive increase, with 90% now saying they have not been bullied by a manager, rather than the 88% last year – however it still means that 10% of staff are experiencing bullying, so still cause for concern. Q13c in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from your colleagues also has a positive increase, although slight (1%) the only measure where harassment, bullying or abuse at work has got worse has been from patients, service users, their relatives or members of the public.

- **Q19a. In the last 12 months, have you had an appraisal?**
  This has positively increased from 87% to 90%. Additionally, those saying at Q19e that they discussed organisational values has also increased from 73% to 79%. Training needs identified also rose from 62% to 65% at Q19f, although those having management support to receive training dropped from 88% to 87%.
- **Q21a. Care of patients/service users is my organisation's top priority.**
  The positive score increased from 78% to 82%. There was also an increase in acting on concerns raised by patients/service users – up to 76% from 74%.
- **Q21c. I would recommend my organisation as a place to work.**
  This has increased from 63% to 66% and is also reflected in Q21d where more people would recommend the hospital if friend/relative needed care (up from 68% to 70%).
- **Q23a. I often think about leaving this organisation.**
  The numbers of people considering leaving has decreased significantly from 31% to 26%. At Q23b, those who will probably look for another job in the next year has also decreased from 22% to 20%. At Q23c those who will leave when they can find another job has also dropped from 18% to 15%.
- **Q28b. Has your employer made adequate adjustment to enable you to carry out your work?**
  For those with any physical/mental health conditions, disabilities or illnesses for 12+ months there has been an increase in those saying that adjustments have been made – up to 74% from 70%. The actual number of positive respondents for this is 160, which is a significant number of people being enabled to continue to work.

Overall Staff Engagement

Our NHS Survey contractor, Quality Health provided the following information in the summary report for 2019. The national staff survey is measured across three themes: Motivation, improvement and advocacy. 9 questions contribute to the overall staff engagement score, 6 have shown significant improvement, 2 have remained constant and 1 has decreased. Overall the staff engagement score has moved from 7.0 to 7.11. Compared to the 43 organisations in the sector within Quality Health the Trust was 13th out of 43 organisations.

		2018	2019	
Staff Motivation				
Q2a	I look forward to going to work	60%	63%	3%
Q2b	I am enthusiastic about my job	75%	76%	1%
Q2c	Time passes quickly when I'm working	76%	76%	=
Staff's ability to contribute to improvements				
Q4a	There are frequent opportunities for me to show initiative in my role.	73%	71%	2%
Q4b	I am able to make suggestions to improve the work of my team or department	73%	72%	1%
Q4d	I am able to make improvements happen in my area of work	54%	56%	2%
Whether staff would recommend MKUH as a place to work or receive care				
Q21a	Care of pts and service users is my organisations top priority	78%	82%	4%
Q21c	I would recommend my organisation as a place to work	63%	66%	3%
Q21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	68%	70%	2%

In 2018 the Trust launched "Staff Survey Goes Large" in 7 areas where the survey results highlighted the greatest opportunity for improvement. A number of changes and improvements have taken place in these areas over 2018 and 2019.

The areas which were part of Staff Survey Goes Large in the 2018 plan, with the exception of one area which remained constant (at 82% return rate) all significantly increased their response rates. This leads us to surmise that staff believe that the listening events are worthwhile, that we are listening and acting upon their concerns and that the Staff survey is confidential, acted upon and worth completing.

> *"We surmise that staff believe that the listening events are worthwhile, that we are listening and acting upon their concerns and that the Staff survey is confidential, acted upon and worth completing."*

	2018 response rate	2019 response rate	Improvement %
Catering - patients	56%	64%	8%
Catering – Restaurant	46%	73%	27%
Chemical Pathology	52%	59%	7%
General Pathology	82%	82%	0%
Domestics	30%	60%	30%
Haematology	68%	88%	20%
Histopathology	33%	96%	63%
Maternity	27%	32%	5%
Microbiology	75%	81%	6%
Pharmacy	64%	69%	5%
Specialist Midwives	68%	75%	7%

In 2019, all line managers, in areas and departments of the Trust took part in staff listening exercises to ensure that staff's suggestions, ideas for improvements and any concerns were aired. The line managers then took these actions forwards together with their teams and regularly updated the teams on progress.

Statement of key priority areas and how they will be measured.

Action plans to address areas of concern

The NSS 2020 action plan incorporates and builds upon the elements which have worked well in last year's action plan and includes the priorities which we think are most important to improve upon, which are questions which were decreasing in scores or in the 20% lowest percentiles.

- Staff survey results published and shared across the organisation
- Schedule further listening events in every department, using the staff survey toolkit hold listening events -
  - Q4a - Give opportunities for staff to show initiative in their roles
  - Q4B - Give opportunities to make suggestions to improve the work of the team/ department – the organisation is below national average, and this is a decreasing (worsening score)
  - Q4c - involved in deciding on changes affecting my team / work area
- Understand from staff, causes of MSK problems and implement supportive solutions. Pre-empt MSK issues wherever possible -
  - Q11b in the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities
- A focus on reducing any bullying and harassment. The new Head of Equality Diversity and Inclusion is now in post to support this work. Although these are improving scores, we want to understand this more as it is does not triangulate with other data (HR cases, Datix's stress related absences)
  - Q13a – from members of the public – slightly worsening, level for sector
  - Q13b – from managers, improving picture better than average for sector
  - Q13c – other colleagues
- Upskill line managers in how to support their teams to access learning and development opportunities
  - Q19f Were learning and development needs identified? Improving score but below sector average
  - Q19g Managers to support staff with training
- Improved team working – the organisation scored slightly below sector average in this theme.
  - Q4i -Increasing effectiveness of teams - We are below national average, and this is a decreasing (worsening score)
- Continue to increase and publicise our staff benefits package
- Plan staff appreciation events and staff appreciation month for Sept 2020

The 2019 staff survey has much improved, both in response rate, (465 more responses than previously, 13.5% more) and response scores. The majority of the questions and the staff engagement questions have all shown improvement.

The 2019 response result is the highest at any time over the last 5 years. It is pleasing to see that the areas who were part of the 2018 Staff Survey Goes Large initiative all had an improved return rate to the survey.

The listening events, improvement in communications and increased staff benefits, car parking, free tea and coffee, special leave etc appear to have had a positive effect on staff morale and this is borne out in the staff survey.

This is a point in time, and we need to continue to build on the momentum of the staff survey over 2020 to be in an even better place for the 2020 staff survey.

Monitoring arrangements

Staff Survey action plans are monitored through the Workforce Board, Workforce Assurance Committee and reports are received to executive team meetings and Trust Board.

2.7.9 Off-payroll Engagements

The Trust has not engaged any off-payroll arrangements in 2019/20.

Table 1: For all off-payroll engagements as of 31 Mar 2020, for more than £245 per day and that last for longer than six months	2019/20 Number of engagements
No. of existing engagements as of 31 Mar 2020	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two \and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2019 and 31 Mar 2020, for more than £245 per day and that last for longer than six months	2019/20 Number of engagements
Number of new engagements, or those that reached six months in duration, between 01 Apr 2019 and 31 Mar 2020	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2019 and 31 Mar 2020	2019/20 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	17

The Trust has a policy of using its own payroll for the purposes of employment. Where engagement is required that is off-payroll, this is facilitated through national framework agency providers only. In the event that any further off-payroll arrangements are required, the Trust uses a comprehensive risk assessment form and the HMRC personal service company assessment tool which both seek to test the nature of the engagement, whether the individual is aware of their obligations in respect of payment of tax and require them to provide assurances in this regard before they are engaged. Following completion of the risk assessment, approval is sought of the director of finance and director of workforce in order to finalise the arrangement.

2.7.10 Exit packages

No exit packages were agreed by the Trust in 2019/20, whether through compulsory redundancy, voluntary redundancy, or any other type of agreed exit package.

2.7.11 Equality, Diversity and Inclusion

The Trust has a longstanding commitment to ensuring that our services and employment practices are fair, accessible and appropriate for all patients, visitors and carers in the community we serve, as well as the talented and diverse workforce we employ. The Trust Board receives a comprehensive annual report of equality and diversity information, the last of which was in 2019.

The Trust remains committed to providing an environment equally welcoming to people of all backgrounds, cultures, nationalities and religions. Our 'We Care' standards, behaviours and commitments have been developed into a suite of new values in 2018/19 to help us to achieve this aim.

The Executive Workforce lead and the patient services lead for Equality, Diversity and Inclusion are both members of the Workforce and Development Assurance Committee which is responsible for overseeing equality, diversity and inclusion for the Trust.

Supporting the local staff survey outcomes, regional and national requirements (Workforce Race Equality Standard and Equality Delivery System 2) and Public Sector Duties of the Equality Act 2010, an equality, diversity and inclusion forum was established in 2015 which oversees matters in this sphere of activity and acts as a steering group for both our workforce and patient care and experience. Engagement with Milton Keynes Council and Milton Keynes CCG has been built into the terms of reference of the group and mutual benefits have already resulted from our approach in this regard.

In 2018/19 the Trust achieved the 'Employer' standard for the government's Disability Confident scheme. The first Workforce Disability Equality Standard (WDES) report was submitted and in 2019/20 the 'Pride@MKUH' staff network continued its growth with awareness stands at MK Pride and in key hospital public spaces. Furthermore, the Trust commenced inclusive staff networks for Women, Disabled and Black and Minority Ethnic groups. In line with statute, the Trust also collates and publishes its Gender Pay Gap data report in support of improvement on an annual basis. The equality, diversity and inclusion agenda of the Trust supports all of the protected characteristics and is recognised as being critical to retention and the experience of our staff. To this end, the Trust has recently appointed its first Head of Equality, Diversity and Inclusion which will enable greater benefit to be derived for colleagues across the Trust and patient care outcomes.

2.7.12 Workforce Resourcing

The Trust continues to improve and develop its resourcing activity. Over the last year, under the Workforce Strategy and Programme, specific improvements have been made to the onboarding of staff, reward packages, time to hire and staff retention have been delivered with a positive impact on quality feedback, retention and staff engagement metrics.

- Continued attendance at national and local job fairs, complemented by our own successful recruitment events.
- Introduction of psychometric testing for Senior appointments
- One to one pre-employment appointments with new staff to ensure all new joiners feel supported and valued during recruitment checks
- Extensive work ready day one programme which ensures new staff attend induction on their first day and have ID and smartcards/IT logins
- Monthly systems and compliance reporting to capture recruitment metrics and transformational initiatives
- Weekly payroll for our temporary staff and additional bank shifts
- Engaged with underrepresented groups in our community to promote our permanent and temporary roles
- Monthly monitoring and review of 'hard to recruit and/or retain' posts, and continuous review of recruitment and retention premia.
- Introduction of 'self-billing' for agency shifts, reducing costs and invoicing errors
- Continue to apply evidence based enhanced bank rates in critical areas in order to reduce reliance on high cost agency alternatives
- Improved compliance with NHS Improvement agency rules and more efficient weekly reporting system through automation of data extraction from systems
- Continued use of social media to increase visibility of campaigns, open days and the #TeamMKUH brand. Extensive use of Facebook, Twitter and Instagram and all roles are published to LinkedIn
- Introduction of staff benefits portal, these include a car leasing scheme, purchase of electrical goods, enhanced Employee Assistance Programme and health and wellbeing support.

The Trust continues to build its reputation as an employer of choice and views its resourcing challenge as an opportunity to reach out to our community and build a diverse workforce which reflects the community we serve. The Trust issues an increasing number of honorary contracts to visitors who want to find out more about the work we do in the Trust, along with placements of students, work experience, observerships and apprenticeships helping to build regional reputation and promote the employment offering.

The Temporary Staffing function is working towards full interoperability with hospital administrative systems to streamline process, reduce inefficiency and reduce cost, achieving this by further improvements to use of e-rostering, wider visibility of shifts and sustained recruitment of temporary administration and clinical staffing. These measures have allowed the Trust to once again meet its agency ceiling financial targets throughout 2019/20.

"The Trust continues to build its reputation as an employer of choice and views its resourcing challenge as an opportunity to reach out to our community and build a diverse workforce which reflects the community we serve."

2.7.13 Statutory and mandatory training

Statutory training is that which an organisation is legally required to provide as defined by law or where a statutory body has instructed organisations to provide training based on legislation.

Mandatory Training is that determined essential by an organisation for the safe and efficient running in order to reduce organisational risks, comply with policies, and meet government guidelines. MKUH Mandatory training competencies are mapped to the Core Skills Training Framework.

There has been a steady improvement in statutory and mandatory training – the table below shows the compliance rate by year and at the end of each quarter.

	Q1	Q2	Q3	Q4
2014/2015	81%	81%	85%	87%
2015/2016	86%	87%	88%	89%
2016/2017	89%	89%	90%	91%
2017/2018	91%	89%	90%	89%
2018/2019	90%	89%	90%	93%
2019/2020	93%	92%	94%	94%

Mandatory training is reported at Workforce Board, Workforce and Development Assurance Committee (quarterly) and Management Board (monthly). During 2019 ESR self-service became operational and staff can book their mandatory training on line. There is a plan to move away from workbooks and deliver more mandatory training through e leaning, since March 2020 staff have been supported to complete the majority of their mandatory training via e learning.

2.7.14 Learning & Development

A great deal of work was undertaken during 2019/20 to improve appraisal compliance within the Trust. Reminder letters were sent to all staff who were 'out of date' or due their appraisal within the following 3 months. These letters reminded staff of the importance of receiving an appraisal and the fact it is a Trust requirement for all staff. Overall this had a positive effect across the Trust resulting in a significant increase in compliance rates during this period.

The table below illustrates that although the appraisal compliance rate fluctuated slightly over the past year it was maintained at 90%+ at the end of each quarter, as below: -

	Q1	Q2	Q3	Q4
2018/2019	84%	85%	85%	85%
2019/2020	95%	91%	93%	94%

The Trust was allocated education funding of £121,897 from Health Education England for the continuing development of non-medical staff within bands 5-9. This funding enabled approximately 120 staff to access some form of further education, increasing both their knowledge and skills within their specific roles.

A wide variety of personal development programmes and workshops were run throughout this period, ranging from yearlong leadership programmes to one day basic skills workshops. These offerings are open to all staff to attend and continue to be well received.

2.7.15 Widening Participation

Approximately 45 apprentices commenced programmes over the last year. Uptake for clinical apprenticeships is due to increase as areas such as Pathology, Therapies, and Imaging are due to have their first-degree apprentice's commence in September 2020.

COVID-19 will have a negative impact on forecast spend and projected starts for the next few months. A planned cohort of 8 Trainee Nurse Associates has been deferred until the autumn; there may be a further impact as we were due to recruit for 14 further candidates over the summer, but this will depend on restrictions at the time. The Apprenticeship Manager is working with HEE to provide evidence to lobby the EFSA to extend the period that funds can expire and for relaxation of rules for those who are due to enter the EPA gateway. This will allow apprentices to qualify in the timescale originally planned.

The Trust hosted 133 work experience students in 19/20 and engaged with nearly 1,000 school children during careers outreach visits. This could not have been possible without the support of several teams throughout the trust. Feedback from students has been exceptionally positive, with many going on to study a healthcare qualification and some have joined the Trusts volunteer workforce.

Demand for work experience placements continues to far exceed capacity, with other educational placement programmes impacting clinical areas ability to host work experience students.

3. Code of Governance disclosures

Monitor Code of Governance

Milton Keynes University Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

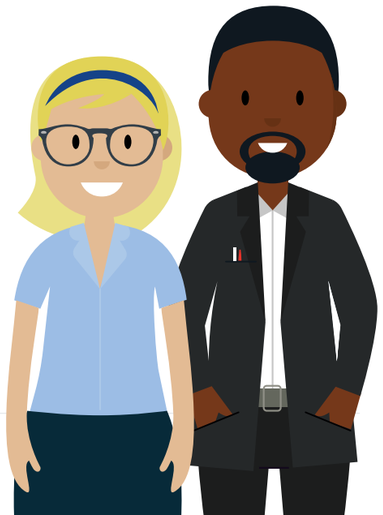
The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers that it was compliant with the provisions of the revised Monitor NHS Foundation Trust Code of Governance, with the following three exceptions:

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead governor meets with the chairman and can raise issues on behalf of the Council. The senior independent director also meets informally with governors to discuss issues and governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the nominations committee.	The Council of Governors believe that the Non-Executive Director appointment committee (formally the Nominations Committee) should be chaired by a member of the Council of Governors, as the Council of Governors has a responsibility for the appointment of Non-Executive Directors. This has been in effect since 2008/9 and is reflected in the Trust's Constitution.
B2.9 An independent external adviser should not be a member of or vote on the nominations committee(s)	The Nominations Committee has always valued the input of the independent external adviser, particularly as the Trust has usually selected a serving Chair or non-executive director of another trust to act in this capacity.

As per 'The NHS Foundation Trust Code of Governance' (updated July 2014),

'the board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.'



3.10 NHS England/NHS Improvement Oversight Framework

NHS England/NHS Improvement's oversight framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

3.11 Segmentation

As of April 2019, the Trust is in segment 2. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

3.12 Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

		Score	
Area	**Metric**	**Year End 2019/20**	**Year End 2018/19**
Financial sustainability	Capital service capacity	1	4
	Liquidity	4	4
Financial efficiency	Income and expenditure margin	4	4
Financial controls	Distance from financial plan	1	1
	Agency spend	1	1
Overall Scores		**3**	**3**

3.13 Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given accounts directions which require Milton Keynes University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Milton Keynes University Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

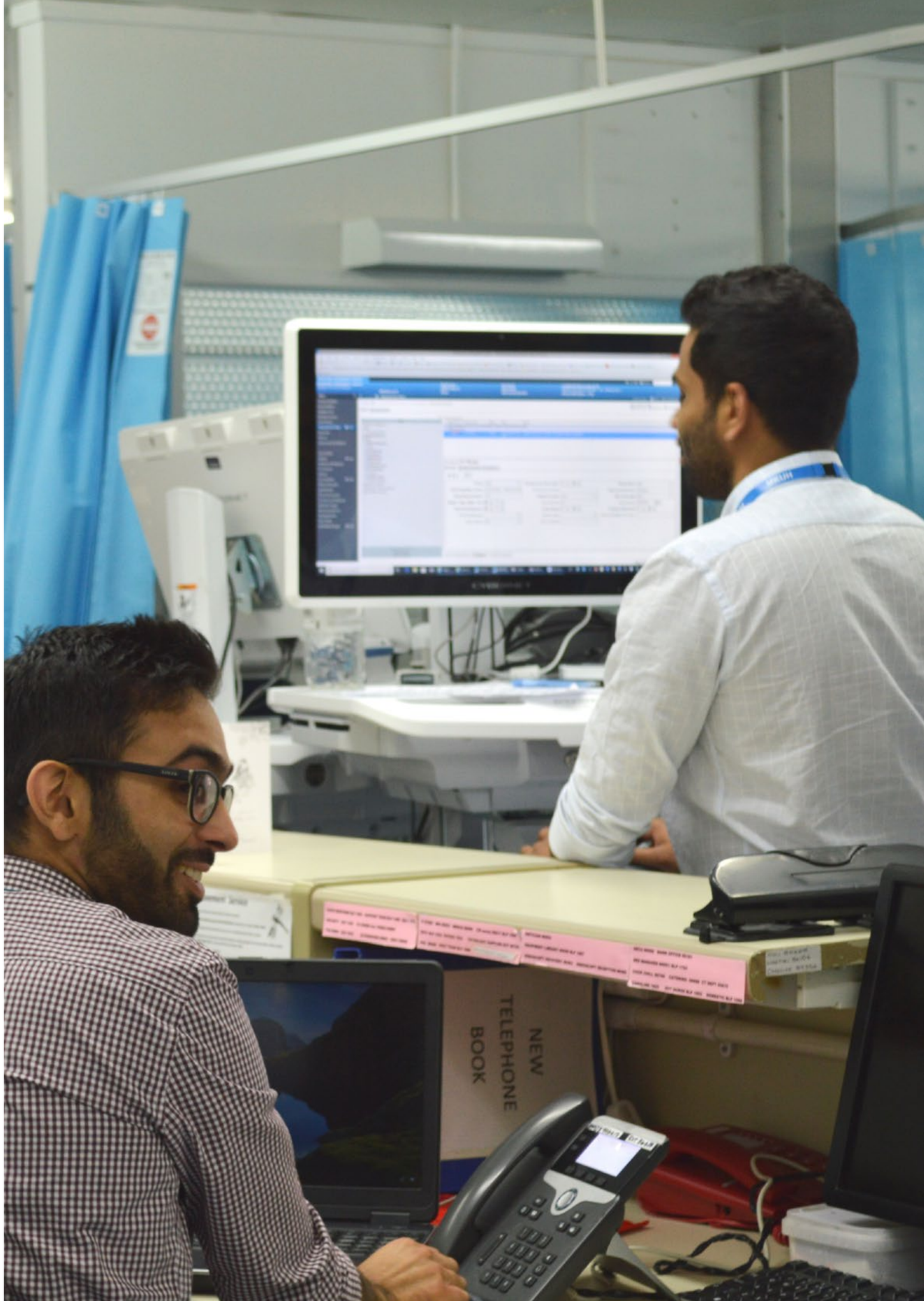
The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is not relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Joe Harrison
Chief Executive

Date: 11th June 2020



4. Annual Governance Statement 2019/20

Annual Governance Statement 2019/20

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Milton Keynes University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Milton Keynes University Hospital NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership of the risk management process:

Board of Directors

The Board of Directors (Board) has overall responsibility for the identification and effective management of principle risks to the achievement of the Trust's strategic objectives. These risks are captured on and managed through the Board Assurance Framework (BAF). The Trust has ten primary strategic objectives; namely:

1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Deliver key targets
5. Develop a robust and sustainable future
6. Develop robust and innovative teaching and research
7. Become well-governed and financially viable
8. Improve workforce effectiveness
9. Make the best of the estate
10. Develop as a good corporate citizen

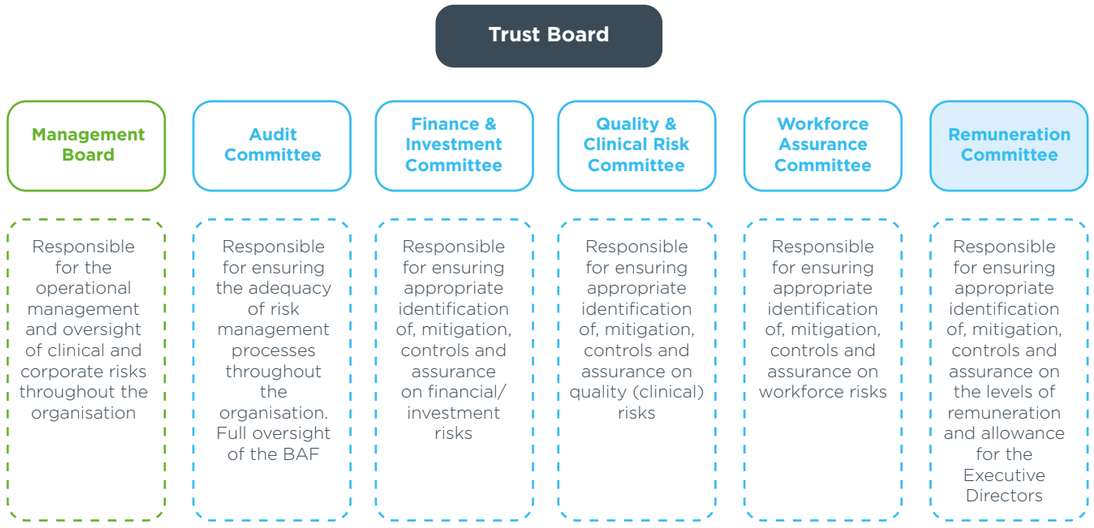
The breadth of these objectives means that the BAF contains a broad spectrum of risks of which the Board has oversight.

Board Sub Committees

The Board delegates the testing of assurance and management controls on the BAF to its Sub Committees.

Each Committee is responsible for risks to the achievement of objectives within its terms of reference. In addition, the Quality and Clinical Risk Committee has a wider oversight role on the effective management of clinical risk.

The Audit Committee has a wider oversight role on the effective management of corporate risk and provides assurance to the Board on the adequacy of the systems and processes surrounding the management of risk throughout the organisation.



Executive Leadership and Management Oversight

The Director of Corporate Affairs is the executive lead for risk management. The Trust's Senior Information Risk Owner (SIRO) is the Deputy Chief Executive, who is responsible for, and oversees all information risks within the Trust. The Trust's Caldicott Guardian is the Medical Director, who is ultimately responsible for the correct use of patient identifiable information. Both the SIRO and the Caldicott Guardian have undertaken the required training to discharge their responsibilities effectively.

All directors and divisional managers have a leadership responsibility for risk management within their own areas and are accountable to the trust Board via general and specific reports. The Trust has an established Risk and Compliance Board (RCB) which meets monthly and is chaired by the Director of Corporate Affairs. The RCB reviews risks rated 15 and above on the significant risk register (SRR). It challenges the control measures and actions being taken; assesses risk score; approves corporate risks; reviews linked risks across specialties/ departments and divisions; reviews the aggregated risk profile; and reports each month to the Management Board.

Divisional and departmental risk registers are also reviewed on a rotational basis to ensure that the risks are relevant and appropriate; that risks are being effectively identified, assessed, mitigated and managed. The RCB receives reports on the number of overdue incidents, audit compliance, trust documentation and reports on other compliance reports e.g. CQC/ regulatory guidelines and other relevant statutory, legislative, or regulatory compliance requirements or guidance.

Equipping and Training Staff to Manage Risk and Learning from Good Practice

The identification, assessment and management of risk is the responsibility of all staff. The Trust's mandatory training programme, which forms part of the staff induction, includes responsibilities and processes relating to risk management which encompasses fire safety, health and safety and clinical risk. Levels of compliance with mandatory training are reported to the Board as part of the monthly performance dashboard. Further guidance on risk management issues is disseminated to staff through briefing systems either electronically including the intranet or via meetings.

Learning from Good Practice

The Trust's central risk management team work effectively with the Trust's internal auditors to continually challenge and improve risk management processes as part of the annual development and audit programme. The central risk team holds regular dedicated sessions on improving practice; using external reports on good practice and industry recommendations to facilitate ongoing improvements to risk management. This includes and involves divisional risk and governance leads.

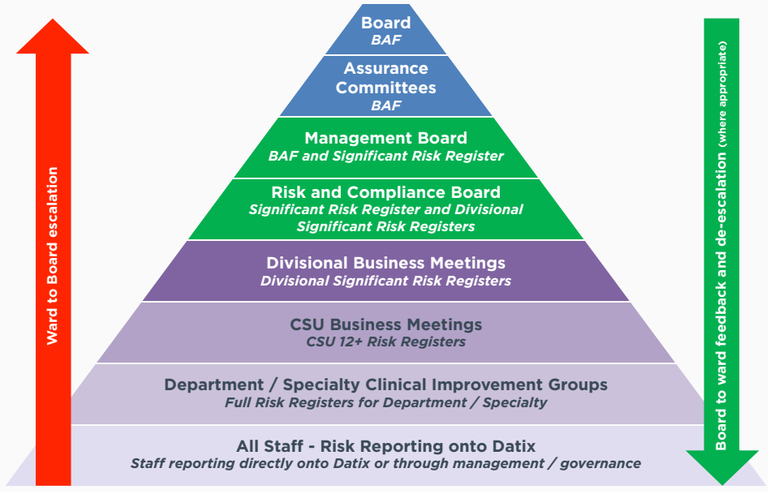
Organisationally, good practice and learning identified through risk assessments and incidents is shared through routine communications, training, meetings, briefing and de-briefing sessions and committees.

The Risk and Control Framework

Risk Management Strategy

Risk management is an integral part of the Trust's management, governance structure and internal control processes. It is the process through which the Trust identifies, assesses and analyses the risks inherent to and arising from its activities; whether clinical or non-clinical, including strategic, financial, workforce or any other; and ensures robust and effective controls and assurances are in place.

The Trust has a Risk Management Strategy (updated and approved in the reporting period), which sets out a delegated governance structure through which risks are monitored and managed. It sets out a systematic process for the identification, recording and management of risk through its specialty, divisional and significant risk registers and clearly defines the escalation and de-escalation of risk as detailed in the diagram below:



The Risk Management Strategy sets out how risk appetite is determined, with the Board of Directors setting risk appetite against the Trust's ten strategic objectives during annual risk appetite development and review.

Quality Governance Arrangements

The Trust operates within the NHS Foundation Trust statutory and regulatory environment and its quality governance arrangements are regularly reviewed to ensure compliance with relevant regulatory (and other legal or professional) standards. This includes the NHS Improvement and Care Quality Commission combined Well-Led Framework. The Trust was inspected under the Well Led Framework by the CQC and NHS Improvement in the reporting period and received a rating of Good overall. The Trust has undertaken work with Deloitte during the reporting period to complete an independent assessment against the Well Led Framework. This work was due to have completed by the end of March 2020 but was paused due to the Covid-19 pandemic.

The Trust has a well-defined quality governance structure in place, designed to provide 'ward to Board' visibility, reporting and assurance across the quality agenda.

The executive and the Trust Board seek information and assurance on compliance. Improvements in the reporting period include an assurance rating against performance information reported to the Board, based on data quality confidence levels. The Trust also has an established Data Quality Compliance Board to provide scrutiny, challenge and assurance on all aspects of data quality which reports to the Audit Committee.

The Trust ensures compliance with CQC registration requirements is monitored and assessed through its governance structure. This includes compliance monitoring at the Risk and Compliance Board; proactive assessment through the Clinical Quality Board; proactive assessment through the clinical divisional management; and independent peer review (e.g. Healthwatch enter and view). Compliance is assured through the Quality and Clinical Risk Committee.

The Foundation Trust is compliant with the registration requirements of the Care Quality Commission.

The Board has sought assurance on the management of risks to data security, with reports and presentations to the Audit Committee and to the Board during 2019/20. Data security (compromise through deliberate attack; and breach through inadequate controls) are risks on the Board Assurance Framework which are actively monitored and assurance-assessed through the Board sub-committees.

Emergency preparedness, resilience and response

The Trust has a vital role in responding to major and business continuity incidents. As a Category 1 responder under the Civil Contingencies Act 2004 the Trust has a duty to be prepared and ensure planning arrangements are in place to enable the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies. These emergencies can range from major incidents, such a serious road traffic accidents involving multiple casualties, to business continuity following a cyber-attack. The Trust's major and business continuity incident planning arrangements are regularly reviewed and tested to ensure they are inline with legislation and best practice. As such, in partnership with other local health and public sector resilience groups, the Trust can ensure there is a robust multi-agency response to any future incident. As part of NHS England annual core standards assurance process the Trust has been rated as 'substantial'.

Major Risks

The Board Assurance Framework reflects the principle risks against the achievement of the Trust's strategic objectives, including clinical and non-clinical risk. The following risks were identified on the Board Assurance Framework at the end of the 2019/20 financial year:

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Quality & Clinical Risk	COO	Strategic failure to manage demand for emergency care	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Tactical failure to manage demand for emergency care	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Ability to maintain patient safety during periods of overwhelming demand	5x4=20	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	Medical Director	Failure to appropriately embed learning and preventative measures following Serious Incidents, complaints, claims and inquests [Reviewed March 2020]	4x4=16	4x3=12	4x2=8	Avoid

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Quality & Clinical Risk	Medical Director	Failure to recognise and respond to the deteriorating patient [Reviewed March 2020]	4x4=16	4x2=8	4x2=8	Avoid
Quality & Clinical Risk	Deputy CEO	Failure to manage clinical risk during significant digital change programmes	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	COO	Failure to provide sufficient capacity to match demand for elective care (as evidenced by average waiting times, appointment slot issues (ASI) and non-RTT backlog).	5x4=20	4x4=16	4x2=8	Avoid
Board of Directors	COO	Ability to cope with the demand for ITU and inpatient care due to the Covid-19 pandemic	5x4=20	5x3=15	5x2=10	Avoid
Board of Directors	COO	Harm to patients due to the suspension of elective activity during the Covid-19 pandemic	4x4=16	4x3=12	4x2=8	Avoid
Quality & Clinical Risk	Chief Nurse	Failure to achieve improvements in the patient survey	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	COO	Failure to embed learning from poor patient experience and complaints	4x4=16	4x3=12	4x2=8	Avoid
Trust Board	CEO	Deterioration in patient experience of clinical oncology (radiotherapy) pathways, deterioration in access to treatment and reputational damage.	5x4=20	4x4=16	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Failure to evidence compliance with the annual clinical audit programme	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Failure to embed learning and evidence action plans following clinical audit	4x4=16	4x3=12	4x2=8	Minimal
Quality & Clinical Risk	Director Corp Aff	Lack of assessment against and compliance with NICE guidance	3x4=12	3x4=12	3x2=6	Minimal
Executive Management	COO	Failure to meet the 4-hour emergency access standard	4x4=16	4x4=16	4x2=8	Minimal
Executive Management	COO	Failure to meet the key elective access standards - RTT 18 weeks, non-RTT and cancer 62 days	4x4=16	4x4=16	4x2=8	Minimal
Audit	Deputy CEO	Failure to ensure adequate data quality leading to patient harm, reputational risk and regulatory failure	4x4=16	4x3=12	4x2=8	Minimal
Audit	Deputy CEO	Failure to adequately safeguard against major IT system failure (deliberate attack)	5x2=10	4x2=8	4x2=8	Minimal
Finance & Investment	Deputy CEO	Failure to adequately safeguard against major IT system failure (inability to invest in appropriate support systems/infrastructure)	5x2=10	4x2=8	4x2=8	Minimal
Executive Management	Deputy CEO	Failure to maximise the benefits of EPR	4x4=16	4x3=12	4x2=8	Minimal
Finance & Investment	DOF	There is a risk that the constraints on the NHS capital expenditure limit (CDEL) lead to delays in the Trust receiving its approved capital funding or other restrictions being placed on the Trust's capital programme	5x4=20	4x2=8	4x2=8	Cautious
Finance & Investment	DOF	There is a risk that the Trust does not receive timely confirmation that its historical revenue loans due for repayment within 12 months have been refinanced or written off leading to a potential breach of the DHSC loan agreements and/or a going concern/cashflow risk to the Trust.	5x3=15	4x3=12	4x2=8	Cautious

Oversight Committee	Executive Lead	Risk Description	Inherent Risk Rating	Current Risk Rating	Target Risk Rating	Risk Appetite
Finance & Investment	DOF	There is a risk that the Trust is unable to achieve the required efficiency improvements through the transformation programme leading to an overspend against plan and the potential loss of the £5.1m of Provider Sustainability Funding in the event the Trust's control total is not met.	5x5=25	3x3=9	3x2=6	Cautious
Finance & Investment	DOF	There is a risk that the Trust's guaranteed income contract does not deliver the benefits expected and/or leads to an opportunity cost to the Trust in respect of unfunded activity.	5x4=20	3x3=9	3x2=6	Cautious
Workforce	Director Workforce	Inability to retain staff employed in critical posts	4x4=16	4x3=12	4x2=8	Cautious
Workforce	Director Workforce	Inability to recruit to vacancies in short term (0-18 months)	4x3=12	4x2=8	4x2=8	Cautious
Workforce	Director Workforce	Inability to recruit to vacancies in medium to long term (19+ months)	4x4=16	4x4=16	4x3=12	Cautious
Quality & Clinical Risk	Medical Director	Removal of up to 11 trainees from the department of obstetrics and gynaecology as a result of various concerns about the training environment. [Reviewed March 2020]	4x5=20	4x4=16	4x2=8	Cautious
Workforce	Board of Directors	Ability to maintain a safe working environment during the Covid-19 pandemic	4x4=16	4x3=12	4x2=8	Cautious
Finance & Investment	COO	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	4x3=12	4x3=12	4x2=8	Cautious
Charitable Funds	Director Corp Aff	Failure to achieve the required level of investment (including appeal funds) to fund the Cancer Centre	4x2=8	4x2=8	4x2=8	Cautious
Board of Directors	CEO	Inability to progress the Milton Keynes Accountable Care System and wider ACS/STP programme	4x3=12	4x2=8	4x2=8	Cautious
Board of Directors	COO	Insufficient preparedness for disruption to workforce or supplies (including medications) following withdrawal from the European Union	5x2=10	5x2=10	5x2=10	Avoid

Detailed information on how risks are controlled (mitigated) and the assurance against the controls is contained within the Board Assurance Framework. This document is actively scrutinized in every Board sub-Committee and at the Board (every quarter). The Board holds a minimum of two risk and assurance plenary sessions every year to enable risk appetite to be effectively reviewed and assessed and for principle risks against the achievement of the Trust's strategic objectives to be assessed and reviewed holistically. This includes risks to compliance with the Trust's licence; and compliance assessments and risks are also embedded in Board reporting. The Board formally reviews compliance against its licence during its annual declarations and in line with statutory and regulatory requirements.

Every principle risk has an executive risk owner, responsible for the active and ongoing management of that risk; including assessment of risk likelihood and severity (5x5 matrix), proximity, controls, assurance of controls (three lines of defence) and additional mitigating actions required. The executive director presents the risks they take ownership for at the relevant Board sub-Committee (all risks are assigned to a sub-Committee). The sub-Committee chair includes his/ her views on assurance and any matters for escalation to the Board in the upward report from the sub-Committee to the Board. The Board then reviews both the sub-Committee reports on risk; the Board Assurance Framework and corporate risk profile and is able to challenge executive risk owners at each meeting.

The Trust self certifies against the Corporate Governance Statement, required under NHS Foundation Trust Condition 4 (8)(b)] based on information and assurance received at the Board and its sub-Committees.

Covid-19 and the Risk and Control Environment

The Trust's responded earlier than most others to the emerging global Covid-19 pandemic when it assumed responsibility with NHS England and Improvement for opening and running a repatriation centre for British nationals returning from Wuhan Province in China at the beginning of February. The facility at the Kents Hill Hotel and Conference Centre in Milton Keynes, saw the Trust staff and run an isolation centre for more than 100 guests for over a fortnight, working with NHS England and Improvement, Public Health England, the Foreign Office, the Department of Health and Social Affairs, Milton Keynes Council, Milton Keynes CCG and a plethora of other statutory and voluntary agencies.

The Trust established a Gold - Silver - Bronze command structure, which is the recognised hierarchical framework for managing major incidents and operations across emergency services and public bodies, to run the Kents Hill facility; and retained this command structure for the duration of the Covid-19 response (declared a Level 4 national incident by NHS England and Improvement and the UK Government on 3 March 2020). The command cells have met multiple times a day to manage the Covid-19 response effectively.

The Trust adapted its governance structure to ensure that the command structure could work as set out in its major incident and emergency planning policies; ensuring clear reporting and decision-making structures and processes both for the pandemic and in remaining day-to-day business. The Trust also responded to changes in the regulatory and national control environment – for example on procurement – to ensure compliance. The Trust has been able to respond promptly and effectively throughout the crisis, with its established command structures and control environment adapting and working effectively throughout.

The Trust has adopted all national guidance around the suspension of routine planned activity and so business continuity and service impact has been thoroughly assessed, planned and is in line with all other acute Trusts. The Trust has enabled significant numbers of staff to work from home through a responsive digital operational plan, which has enabled business continuity across support functions.

Overall the Trust has responded quickly and effectively to an unprecedented healthcare emergency and would like to recognise the extraordinary efforts of its staff in enabling acute hospital provision and service continuity for the Milton Keynes community.

Incident Reporting

In addition to the framework for risk management; the Trust places a strong emphasis on incident reporting; evidenced through a year-on-year improvement in the percentage of staff feeling confident to report incidents. The Trust has a Serious Incident Review Group, which meets weekly, to provide objective review of potential serious incidents and moderate harm incidents. The Trust has also established 'summits' for falls and pressure ulcers to ensure rapid dissemination of learning and understanding of causal or contributory factors. This is embedded in the Trust's governance structure; reporting upwards to Board sub-Committees (Corporate/ Divisional Management Board; Quality and Clinical Risk Committee) and to the Board; and downwards through the divisional and clinical specialty unit structures to ensure appropriate briefing and learning.

Stakeholder Involvement in Risk Management

The Trust recognises that effective risk management relies on contributions from outside the organisation as well as from within, and there are therefore arrangements in place to work collaboratively with key external stakeholders and partner organisations, including Milton Keynes CCG, Milton Keynes Council and Healthwatch Milton Keynes. The Trust also contributes to the identification and management of risk in the Bedfordshire, Luton and Milton Keynes Integrated Care System. These arrangements cover operational and strategic issues such as service planning and commissioning, performance management and scrutiny, research, education and clinical governance. Commentary and issues arising from this engagement are captured within the Trust's risk processes and taken into account in the risk grading matrix referred to above.

These and other stakeholders have opportunities to raise issues relating to risks which impact upon them, including:

a. Patients and public

- Participation in the "15 steps" process (an assessment of patient areas by patients, non-executive directors and Governors)
- Involvement with and by the Milton Keynes Health and Wellbeing Board
- Attendance at the Trust's Annual Members' Meeting
- Structured and ad hoc engagement with and from Healthwatch MK
- Patient-Led Assessments of the Care Environment (PLACE)
- Representation from Milton Keynes Council, Healthwatch MK, MKCCG and community groups on the Council of Governors
- Patient stories delivered at Board meetings

b. Staff

- Messages emerging from the annual staff survey
- Chief Executive led staff roadshows
- Questions submitted by members of staff to the Chief Executive via the "Ask Joe" section of the Trust intranet
- Quarterly staff magazine
- Annual Event in the Tent
- Appointment of Freedom to Speak Up Guardians in January 2017 as conduits through whom staff may raise concerns and make protected disclosures under the Public Interest Disclosure Act 1998

c. Health partners

- Regular performance review meetings with the system partners, including other providers, CCGs, GPs, Ambulance Trusts and Local Authorities with whom the Trust has working relationships
- Active involvement in the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System, which involves all of the NHS commissioner and provider organisations, as well as local authority social care providers across the three areas.
- Attendance at the Milton Keynes Health and Wellbeing Board and Integration Board

The foundation trust has published on its website an up-to-date **register of interests, including gifts and hospitality**, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS22 guidance.

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

Control measures are in place to ensure that all the organisation's obligations under **equality, diversity and human rights** legislation are complied with, including completion and publication of the Workforce Racial Equality Standards.

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

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

Information governance

The Trust has regular liaison with the Information Commissioner's Office to ensure that any incident meeting the criteria for reporting is reported and investigated in a timely way. There have been no serious incidents reported in this reporting year. The Trust has a publication scheme and information about how it complies with the General Data Protection Regulations, Freedom of Information Act and other relevant legislation on its website.

Data quality and governance

Data quality is inherently a risk that will always exist to some degree and the challenge is to minimise the impact of this risk through appropriate governance arrangements and the development of a learning culture. The Trust has recognised the importance of data quality as a key component to support the continuous delivery of improved patient care and clinical quality. Consequently, data quality is a Trust objective and an Executive Director has responsibility for leading on the over-arching delivery of continued improvement in data quality, supported by the other Executive Directors and governance committees.

In 2017/18 the Trust laid the foundation for these governance arrangements; recognising that significant improvement was needed and immediate action required. The Data Quality Compliance Board (DQCB), established the year before, oversaw these improvements; firstly, by embedding an importance on data quality in the organisational culture and then supporting it through a new audit and compliance programme. This was furthered by the introduction of the new eCare Patient Management System in May 2018; a system designed to enhance the clinical functionality to support the delivery of patient care and consequently increasing the clinical interaction with the Trust Patient Management system.

This was the most significant clinical and data/information change programme that had ever been undertaken at the Trust. Since that time, work has continued to identify and resolve data quality issues through improving workflows, and reinforcing policies and procedures used to collect data. Given the scale and pace of change, data quality remains a risk recorded on the Board Assurance Framework.

2020/21 will see the delivery of the third phase of eCare development (Phase C) and the Trust will also go live with a new 'Revenue' Patient Administration System (RPAS). – The latter is designed to help prevent clerical staff from making key data quality errors that continue to impact upon performance and operational reporting. As a precursor to the implementation of RPAS, a series of data quality scripts were used to correct existing data quality issues. Since there were potential governance and data quality issues arising from this work which would impact operational practices and patient experience, the RPAS project was also monitored by the DQCB. A number of decisions with respect to actions required an additional layer of ratification by the Trust Executive team, recognising the importance of the impact of the work.

As the Trust moves forward with its preparations for both the implementation of RPAS and eCare Phase C, the identification and resolution of data quality issues becomes increasingly important. Phase C contains important upgrades to clinical functionality that will ultimately improve data quality. With the increasing use and complexity of Patient Management systems, it is evident that new risks are introduced as both administrative and clinical staff members get acquainted with a new way of working and data workflows. The Trust has invested significant resources over the last 18 months in preparing to implement eCare Phase C and RPAS, to ensure that implementation during FY20/21 is not impacted in any detrimental manner.

Consequently, there is a continuous need to ensure that adequate governance arrangements are in place for data quality and that these are maturing to meet the growing demands placed upon them. To support the Trust in this process, it has also sought independent assurance proactively. One such area reviewed in 2019/20 by our Internal Auditors has been the quality of information used for reporting. Our Internal Auditors reviewed the operational procedures and process underpinning the compilation of the Trust Board Scorecard, with a focus on HR performance indicators. Internal Audit concluded that there was significant assurance underpinning the derivation, calculation and reporting of these indicators.

It is also recognised that management of data quality issues are central to any lasting change and in FY19/20 this has involved strengthening teams dedicated to audit, compliance and systems and training. Having these teams in place has created a robust control for the management of data quality issues with a combination of system expertise and policy knowledge. This in turn has supported a reduction in the risks around data quality; ultimately monitored by the DQCB and the Risk and Compliance Board.

In March 2019, NHS England/NHSI (NHSE/I) published a Clinically Led Review of Access Standards which outlined a proposal to replace the existing 18-week waiting time standard with a new service model based on the average waiting time target. Twelve NHS Trusts were selected to field test the proposed changes of which Milton Keynes University Hospital (MKUH) was one of the chosen Trusts. In October 2019, NHSEI conducted a site visit to MKUH to understand if and how the change to average waiting time has altered organisational behaviour.

Feedback provided by NHSI after the visit, recognised that the Trust had made positive changes to its organisational behaviour in favour of improved data quality through targeted validation which in turn supports the reduction in the average waiting time.

The Trust will continue, supported by the Executive Team and associated committees and management teams to improve upon the work from last year and ensure that patients can continue to expect excellent patient care delivered using the best information possible.

Review of effectiveness

As Accounting 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 and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and clinical risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control during 2019/20 was maintained and reviewed by the Board throughout the year via:

- Reliance upon the Audit Committee for assurance that the system of internal control is sound
- Assurances from the Quality and Clinical Risk Committee on issues relating to clinical governance, clinical risk and quality governance
- The structure, nature and content of the Board meetings during 2019/20 which enabled the Board to provide adequate challenge on and fain suitable assurance in relation to issues including performance, quality and safety
- The engagement of an effective internal and external audit plan; with an internal audit programme designed to target areas where the control environment could be further developed and strengthened
- A prioritised clinical audit programme, covering national statutory and mandatory audits
- An external independent Well Led review, undertaken by Deloitte
- Regulatory review throughout the year (including a Care Quality Commission inspection)

Board of Directors

The governance framework of the Trust is defined in the information on the Trust Board and its sub-committees and the Council of Governors in Section 2 of the Annual Report. It explains the scope of each committee and the issues reported to it. The attendance of non-executive directors and executive directors at Board and committee meetings is detailed on page ??? of the Report.

The Audit Committee

The Audit Committee provides assurance to the Board on:

- The effectiveness of the organisation's governance, risk management and internal control systems;
- The integrity of the Trust's financial statements, the Trust's Annual Report and in particular the statement on internal control;
- The work of internal and external audit and any actions arising from their work.

The Audit Committee has oversight of the internal and external audit functions and makes recommendations to the Board and to the Nominations Committee of the Council of Governors where appropriate on their reappointment.

The Audit Committee reviews the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

The executive directors have provided all the information contained in the Annual Report and accounts. The non- executive directors have had an opportunity to comment on the draft document and the audit committee reviews the report and considers it fair, balanced and understandable.

The Finance and Investment Committee

The Finance and Investment Committee focuses on financial and investment issues and takes an overview of operational activity and performance against national and local targets.

Internal Audit

The Audit Committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

RSM (appointed in May 2018) are the providers for internal audit and for 2019/20 the Head of Internal Audit opinion was that the Trust has an adequate and effective framework for risk management, governance and internal control. However, RSM's work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

In 2019/20 RSM completed 12 internal audit reports:

The areas the reports covered are as follows:

- Risk management
- Financial planning and delivery
- Key financial controls
- Follow Up
- Cyber Security
- Clinical Audit
- Data Quality – Performance Indicators
- Learning from Incidents
- Management of Temporary Staffing
- Contract Management and Procurement Processes
- Recruitment
- Governance – Implementation of eCare

External Audit

Deloitte LLP, the external auditor provides assurance to the Trust on an ongoing basis by attending all Audit Committee meetings and by undertaking the annual audit of the accounts and Annual Report and a limited assurance review of the Quality Account. For 2019/20, the external auditor has concluded that:

- The financial statements give a true and fair view of the state of the Trust's affairs, and have been properly prepared in accordance with the accounting policies directed by NHS Improvement, and in accordance with the National Health Services Act 2006;
- Their opinion in respect of the use of resources is to be qualified on the basis that the steps taken by management during 2019/20 to improve governance over the quality of its data have not had a full year effect, and the Trust incurred a deficit of £5.1m to the year ended 31 March 2020, and has a planned deficit of £1.0m for 2020/21.

Conclusion

Based on my review, I am aware of on-going internal control issues regarding financial sustainability and data quality. Except for these matters, there are no other significant internal control issues which have been identified.
The Trust is committed to the continuous improvement of its processes for internal control and assurance, and this had already led to the lifting by NHS Improvement of historical conditions that had been placed on the Trust's licence. Although the Trust remains in deficit, it has met and exceeded its control total, and robust governance arrangements are now in place to continue to assure data quality across the organisation. I am confident that these will lead to continued sustainable improvements in 2020/21, building on work in the prior year.

Joe Harrison
Chief Executive

Date: 11 June 2020

As Accountable Officer, I am satisfied the Accountability Report is a fair and balanced account of the areas that it covers.

Joe Harrison
Chief Executive

Date: 11 June 2020

Appendices

Appendix 1: Constituencies and Governors 2019/20

		Constituency	No.	Governors	Term of Office	
					From	To
PUBLIC (ELECTED)	A	Bletchley & Fenny Stratford, Denbigh, Eaton Manor & Whaddon	2	Babs Lisgarten	2 Sept 2019	1 Sept 2022
				Alan Hastings	3 June 2015	21 Nov 2021
	B	Emerson Valley, Furzton, Loughton Park	2	William Butler	26 Oct 2017	25 Oct 2020
				VACANT		
	C	Linford South, Bradwell, Campbell Park	2	Ekroop Kular	23 Oct 2018	22 Oct 2021
				Akin Soetan	14 Mar 2018	13 Mar 2021
	D	Hanslope Park, Olney, Sherington, Newport Pagnell	2	Brian Lintern	7 Nov 2018	6 Nov 2021
				Alan Hancock	1 Mar 2016	28 Feb 2022
	E	Walton Park, Danesborough, Middleton, Woughton	2	Niran Seriki	24 Apr 2020	23 Apr 2023
				Clare Hill	14 Mar 2017	13 Mar 2023
	F	Stantonbury, Stony Stratford, Wolverton	2	Ann Thomas	24 Apr 2020	23 Apr 2023
				VACANT		
	G	Outer catchment area	2	Lucinda Mobaraki	2 Sep 2019	1 Sep 2022
				Amanda Anderson	14 Mar 2018	13 Mar 2021
	H	Extended area	1	VACANT		
APPOINTED STAFF (ELECTED)	I	Doctors and Dentists	1	Raju Thomas Kuzhively	24 Apr 2020	23 Apr 2023
	J	Nurses and Midwives	2	VACANT		
				VACANT		
	K	Scientists, technicians and allied health professionals	1	VACANT		
	L	Non-clinical staff groups e.g. admin & clerical, estates, finance, HR, management	3	Michaela Tait	14 Oct 2018	13 Oct 2021
				David Barber	24 Apr 2020	23 Apr 2023
				VACANT		
	N	Milton Keynes Business Leaders	1	Andrew Buckley	16 Apr 2019	15 Apr 2022
	O	Healthwatch Milton Keynes	1	Maxine Taffetani	29 Aug 2017	28 Aug 2020
	P	Community Action:MK	1	Clare Walton	23 Aug 2017	22 Aug 2020
	Q	Milton Keynes Council	1	Andy Reilly	15 Nov 2019	14 Nov 2019

Appendix 2: Council of Governors' attendance

	16 April 2019	16 July 2019	07 November 2019	12 February 2020	All Meetings	NED appointments Committee
Babs Lisgarten	N/A	N/A	x	x	0	
Alan Hastings	1	1	1	1	4	1
Alan Hancock	1	x	1	1	3	
Peter Skingly	1	1	N/A	N/A	2	
Clive Darnell	1	1	N/A	N/A	2	
William Butler	x	1	1	1	3	
Douglas Campbell	x	1	N/A	N/A	1	
Ekroop Kular	1	1	1	x	3	
Akin Soetan	1	1	x	x	2	
Brian Lintern	1	1	1	1	4	
Clare Hill	1	1	1	1	4	1
Carolyn Peirson	x	1	x	N/A	1	
Robert Johnson Taylor	x	1	x	1	2	
Lucinda Mobaraki	N/A	N/A	1	x	1	
Amanda Anderson	x	1	1	1	3	
John Ekpa	x	x	x	x	0	
Michaela Tait	1	1	1	1	4	
Andrew Buckley	1	1	1	1	4	1
Maxine Taffetani	1	1	1	1	4	
Clare Walton	x	x	x	x	0	
Andy Reilly	N/A	N/A	N/A	1	1	
Richard Alsop	N/A	1	1	x	2	
Amanda Jopson	1	N/A	N/A	N/A	1	

Appendix 3: Glossary

AO	Accountable Officer	A person responsible to report or explain their performance in a given area.
APR	Annual Plan Return	Submission of the annual plan to the regulator
BAF	Board Assurance Framework	Board document to assure the Board that risks to strategic priorities are being managed
BoD	Board of Directors	Executive Directors and Non-Executive Directors who have collective responsibility for leading and directing the foundation trust
CCG	Clinical Commissioning Group	Led by local GPs to commission services
CDiff	Clostridium difficile	A bacterial infection that most commonly affects people staying in hospital
CEO	Chief Executive Officer	Leads the day to day management of the Foundation Trust
CIP	Cost Improvement Programme	Also known as Transformation programme. This is a programme agreed by the trust at the start of the financial year, setting out the savings, usually from efficiencies, that it expects to make during the year.
CoG	Council of Governors	The governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
CQC	Care Quality Commission	Regulator for clinical excellence
CQUIN	Clinical Quality Incentive Scheme	The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.
Datix	Datix	Risk management system
DD	Due Diligence	Is the term used to describe the performance of an investigation of a business or person
DH/DoH	Department of Health	The ministerial department which leads, shapes and funds health and care in England
DoF	Director of Finance	The Board member leading on finance issues in the trust; an executive director
DPA	Data Protection Act	The law controlling how personal information is used
Duty of Candour	Duty of Candour	Consultation on including a contractual requirement for health providers to report and respond to incidents, apologise for errors etc
ED	Emergency Department	Formerly known as Accident & Emergency
EPR	Electronic Patient record	Also known as eCare. The Trust's system of managing and recording interactions patients electronically
FT	Foundation Trust	A part of the NHS in England that provides healthcare to patients/ service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	A measurement of an employee's workload against that of someone employees full time e.g. 0.5 FTE would be someone who worked half the full time hours.
FY	Financial Year	The year used for accounting purposes, in the UK from 6 April to 5 April
Healthwatch	Healthwatch	Local independent health and social care critical friend
HSCA	Health and Social Care Act 2012	an Act of parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSMR	Hospital Standardised Mortality Rate	Number of deaths which is compared with other trusts
ICU	Intensive Care Unit	specialist unit for patients with severe and life threatening illnesses
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
MDT	Multidisciplinary Team	A group of healthcare workers who are members of different disciplines each providing specific services to the patient.
MHA	Mental Health Act	the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital , detained and treated without their consent - either for their own health and safety, or for the protection of other people
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphyloccus Aureus	a bacterium responsible for several difficult-to-treat infections in humans

NED	Non-Executive Director	An often independent member of the board of directors of an NHS trust, who is not an employee of the trust, but is nevertheless partly responsible for its running.
NICE	National Institute for Health and Care Excellence	provides national guidance and advice to improve health and social care
PALS	Patient advice and liaison service	You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.
PLACE	Patient-Led Assessments of the Care Environment	local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance
RCA	Root cause analysis	A method of problem solving used for identifying the root causes of faults or problems
R&D	Research & Development	developing new products or processes to improve and expand
RTT	Referral to treatment	Used as part of the 18 week indicator
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SI	Serious incident	A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care
SID	Senior Independent Director	A non-executive director who sits on the board and plays a key role in supporting the Chair.
SIRG	Serious incident Review Group	to review serious incidents and identify learning points
SRR	Significant risk register	Risks scored 15 and over
WTE	Whole time employees	Member of staff contracted hours for full time
YTD	Year to Date	a period, starting from the beginning of the current year and continuing up to the present day. The year usually starts on 1st January

Annual Accounts 2019/20

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

Milton Keynes University Hospital NHS Foundation Trust

Accounts

Year Ended 31 March 2020

Statement of the chief executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given accounts directions which require Milton Keynes University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Milton Keynes University Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

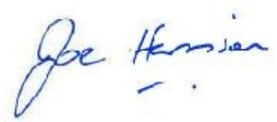
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy

  and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Joe Harrison

Chief Executive

Date: 11th June 2020

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Opinion

In our opinion the financial statements of Milton Keynes University Hospital Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2020 and of the foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which 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 24.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

2. Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

3. Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • NHS revenue and provisions • Property valuation • Management override of controls • Going concern • Arrangements to secure value for money (see matters on which we are required to report by exception – use of resources section) Within this report, key audit matters are identified as follows:

	Newly identified
	Increased level of risk
	Similar level of risk
	Decreased level of risk
Materiality	The materiality that we used for the current year was £5.3m which was determined on the basis of total operating income.
Scoping	Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control. The foundation trust does not have any material subsidiaries and is structured as a single reporting unit and so the whole foundation trust was subject to a full audit scope.
Significant changes in our approach	There have not been any significant changes to our approach.

4. Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

In addition to the matter described in the section on the matters on which we are required to report by exception – use of resources section, we have determined the matters described below to be the key audit matters to be communicated in our report.

5.1. NHS revenue and provisions

Key audit matter description	There can be judgement in the recognition of revenue from care of NHS patients and in the provisioning for disputes with commissioners due to the complexity of the payment by results regime, in particular in determining the level of overperformance and the judgemental nature of accounting for disputes. This includes accrued income, Commissioning for Quality and Innovation (CQUIN) income, partially completed spells (patient episodes that are ongoing at year-end), unsettled over-performance (including the estimation of uncoded activity), together with deductions for contract penalties. Details of the foundation trust's income, including £230.6m (2018/2019:

£206.1m) of Commissioner Requested Services, are shown in note 2.5 to the financial statements. Receivables from NHS and DHSC group bodies of £19.0m (2018/19: £22.6m) are shown in note 12 to the financial statements.

The majority of the foundation trust's income comes from three commissioners, NHS Milton Keynes, NHS England and NHS Bedfordshire, increasing the significance of associated judgements. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year end positions.

How the scope of our audit responded to the key audit matter

We obtained an understanding of the relevant controls over recognition of NHS income.

We selected a sample of amounts against which a provision had been made and obtained evidence to support that this debt is unlikely to be recovered.

We performed detailed substantive testing on a sample basis of the recoverability of unsettled revenue amounts, and evaluated the results of the agreement of balances exercise.

We considered the level of differences between the amounts that the Trust reported as receivable from commissioners, and the amounts that commissioners report that they owe the Trust, in the agreement of balances ("mismatch") report.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

Key observations

We did not identify any material misstatements through our procedures in respect of this key audit matter, and we considered the estimates made by the foundation trust in respect to their recognition of NHS revenue to be within an acceptable range.

5.2. Property valuation

Key audit matter description

The foundation trust holds land, buildings and dwellings assets within Property, Plant and Equipment at a modern equivalent asset valuation of £124m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the use a hypothetical alternative site model, the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, the location of the assets and their remaining lives) and which can be subject to material changes in value.

As detailed in note 1 the valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19, including that at the valuation date, the valuer considers that they can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Further details as to the valuation are provided in Note 1.

How the scope of our audit responded to the key audit matter

We obtained an understanding of relevant controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer.

We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions (including the use a hypothetical alternative site model, the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, the location of the assets and their remaining lives) used in the valuation of the foundation trust's properties.

We have reviewed the disclosures in notes 1 and 9 to the financial statements and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.

We considered the impact of uncertainties relating to the covid-19 pandemic upon property valuations in evaluating the property valuations and related disclosures.

We assessed whether the valuation and the accounting treatment of the revaluation was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

Key observations

While we note the increased estimation uncertainty in relation to the property valuation as a result of Covid-19, and as disclosed in note 1, we consider that the key judgements are within the acceptable range.

There were no other matters arising from our work.

5.3. Management override of controls

Key audit matter description

We consider that there is a risk across the NHS that management may override controls to manipulate fraudulently the financial statements or accounting judgements or estimates. This is due to the tight financial circumstances of the NHS and close scrutiny of the reported financial performance of individual organisations.

In 2019/20, the foundation trust was allocated £24.4m of revenue funding in the form of Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Rule (MRET) funding contingent on achieving financial and operational targets for the year, equivalent to a "control total" for the year of a deficit (adjusted for certain items) of £23.6m. This creates an incentive for reporting financial results that meet or exceed the control total.

The foundation trust incurred a deficit of £5.1m for the year ended 31 March 2020 which was £0.7m below the original control total agreed with NHS Improvement. This adverse variance related to a specific item of additional expenditure as a result of COVID-19 and was accepted by NHSI as an approved variance; as a result the Trust secured the full value of available Provider Sustainability Funding for the year (which was contingent on achieving its financial control total). The foundation trust's deficit of £5.1m is after receiving £24.4m of revenue funding.

NHS Trusts and Foundation Trusts have previously been requested by NHS Improvement to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of

International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, injury cost recovery debtors, partially completed patient spells, bad debt provisions, property valuations, and useful economic lives of assets.

Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.

How the scope of our audit responded to the key audit matter

Manipulation of accounting estimates

Our work on accounting estimates included considering areas of judgement, including those identified by NHS Improvement. We have considered both the individual judgements and their impact individually and in aggregate upon the financial statements. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS.

We tested accounting estimates (including in respect of NHS revenue and provisions and property valuations discussed above), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources.

We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the foundation trust.

Manipulation of journal entries

We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting.

We traced the journals to supporting documentation and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias.

We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements.

Accounting for significant or unusual transactions

We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.

Key observations

Based on the work performed, we found no matters that were reportable to those charged with governance.

5.4 Going Concern

Key audit matter description

International Accounting Standards and the NHS FT Annual Reporting Manual require management to assess, as part of the accounts preparation process, the foundation trust's ability to continue as a going concern. In accordance with the guidance, the financial statements should be prepared on a going concern basis unless informed by the relevant national body of the intention for dissolution of the foundation trust without transfer of services or function to another entity. This is not applicable to the foundation trust and therefore the accounts have been prepared on a going concern basis.

Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the foundation trust, they should be disclosed in the financial statements. In 2018/19, the foundation trust identified that there were material uncertainties with respect to going concern and those material uncertainties were disclosed in the 2018/19 annual report and financial statements. In 2019/20, the foundation trust has performed a going concern assessment and concluded that there are no longer material uncertainties to disclose with respect to going concern. The foundation trust has disclosed the basis for its conclusion in this area in note 1.1 of the financial statements. We have performed procedures to assess the judgements made by the foundation trust with respect to material uncertainties and the adequacy of the disclosure included in note 1.1.

How the scope of our audit responded to the key audit matter

We reviewed the arrangements in place for the preparation and review of management's going concern assessment.

We obtained and challenged the assumptions underpinning management's cash flow forecast for the period of 12 months from the date of our audit opinion. This included assessment of potential alternative scenarios and sensitivities prepared by management.

We agreed opening balances to the accounts, challenged assumptions and considered correspondence and documentation from both management and relevant external stakeholders. We have also considered past performance and the accuracy of past forecasting of the foundation trust.

Key observations

The foundation trust had a deficit of £5.1m for the year ended 31 March 2020 (£9.5m deficit in 2018/19); however, the foundation trust generated cash of £10.1m in 2019/20 (2018/19: £3.7m) and held a cash balance of £16.3m on 31 March 2020 (£6.2m on 31 March 2019).

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 the repayment of existing DHSC interim revenue and capital loans totalling £130.9m held by the foundation trust as at 31 March 2020, will be funded by the issue of Public Dividend Capital (PDC) for which there is no repayment obligation.

A new funding regime has been put in place for the period April 2020 to July 2020 in order to provide a guaranteed income stream to the foundation trust, with amounts paid in advance in order to protect the foundation trust's cashflow position.

On the basis of our assessment we concur with the foundation trust's judgement that there are no material uncertainties to disclose with respect to going concern. We consider these matters to be adequately set out within note 1.1 of the financial statements.

6. Our application of materiality

6.1. Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Foundation Trust financial statements
Materiality	£5.3m (2019: £4.8m)
Basis for determining materiality	1.9% of total operating income (2019: 1.9% of total operating income)
Rationale for the benchmark applied	Total operating income was chosen as a benchmark as the foundation trust is a non-profit organisation, and total operating income is a key measure of financial performance for users of the financial statements.

6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Performance materiality was set at 75% of materiality for the 2019/20 audit (2018/19: 75%). In determining performance materiality, we considered the following factors:

a. the quality and maturity of the control environment;

b. the small number and low size of corrected and uncorrected misstatements identified in the previous audit;

c. the relatively stable business environment throughout the year;

d. the low turnover of management and key accounting personnel; and

the relatively low risk of material fraud in the organisation

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £265k (2018/2019: £240k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

7.1. Identification and scoping of components

Our audit was scoped by obtaining an understanding of the foundation trust and its environment, including internal controls, and assessing the risks of material misstatement at the foundation trust level.

7.2. Our areas of our audit scope

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

9. Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

12. Matters on which we are required to report by exception

12.1. Use of resources

We are required to report to you if, in our opinion the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

In 2018/19, we identified weaknesses in the Trust's arrangements to ensure the quality of performance data as evidenced by our limited assurance report on the content of the quality report and mandated performance indicators which contained a qualified conclusion because of errors identified which affected the Accident and Emergency 4 hour wait and 62 Day Cancer performance indicators in 2018/19.

The 2019/20 assurance requirements on the quality report have been removed and so we have not performed testing in this area in the current year. However, as our 2018/19 findings were raised in May and June 2019, these weaknesses were present for part of 2019/20. Based on discussions with management, and the timing of the prior year audit findings, we have concluded that weaknesses were present in the Trust's data quality arrangements for at least part of 2019/20 and therefore have identified an exception to our value for money conclusion in this regard.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and performance information to support informed decision making and performance management

The foundation trust incurred a deficit of £5.1m for the year ended 31 March 2020 which was £0.7m below the original control total agreed with NHS Improvement. This adverse variance related to a specific item of additional expenditure as a result of COVID-19 and was accepted by NHSI as an approved variance; as a result the Trust secured the full value of available Provider Sustainability Funding for the year (which was contingent on achieving its financial control total). The Trust's 2020/21 plan showed a forecast deficit of £1.0m for 2020/21 after capital donations of £1.0m and provider sustainability, marginal rate emergency tariff and financial recovery funding of

£23.0m which reflects an underlying deficit of £24.2m. Whilst the initiatives and announcements by NHS Improvement indicate that they will provide support to the Trust in FY21, the Trust is not expected to have the necessary arrangements in place to achieve an underlying break-even position in the foreseeable future.

These issues are evidence of weaknesses in proper arrangements to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Milton Keynes University Hospital NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

12.2. Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

12.3. Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Milton Keynes University Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding, FCA (Senior statutory auditor)

For and on behalf of Deloitte LLP

Statutory Auditor

St Albans, UK

11 June 2020

FOREWORD TO THE ACCOUNTS

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Milton Keynes University Hospital NHS Foundation Trust ("the Trust") acts as an acute Hospital for Milton Keynes.

These accounts for the year ended 31 March 2020 have been prepared by Milton Keynes University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Joe Harrison

Chief Executive

Date: 11th June 2020

Statement of Comprehensive Income For the Year Ended 31 March 2020

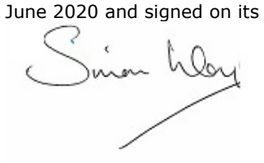
	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	2.1-2.5	234,918	212,491
Other operating income	2.2	47,127	40,890
Operating expenses	3-6	(284,935)	(259,909)
		(2,890)	**(6,528)**
FINANCE COSTS			
Finance income	7.1	111	54
Finance expenses	7.2	(2,223)	(2,053)
PDC dividends payable		(122)	(1,019)
NET FINANCE COSTS.		**(2,234)**	**(3,018)**
DEFICIT FOR THE YEAR		**(5,124)**	**(9,546)**
Other Comprehensive Income			
Will not be reclassified subsequently to surplus or deficit:			
Impairments		(9,878)	(20,379)
Revaluations		0	0
Total other comprehensive income		(9,878)	(20,379)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(15,002)**	**(29,925)**

The notes to the accounts are on pages 146-183

Statement of Financial Position As at 31 March 2020

	Note	31 March 2020 £000	31 March 2019 £000
NON-CURRENT ASSETS			
Intangible assets	8	16,180	14,150
Property, plant and equipment	9	143,154	147,420
Other investments / financial assets	22.1	175	0
Trade and other receivables	12	729	457
TOTAL NON-CURRENT ASSETS		**160,238**	**162,027**
CURRENT ASSETS			
Inventories	11	3,394	3,577
Trade and other receivables	12	25,582	29,561
Cash and cash equivalents	13	16,286	6,175
TOTAL CURRENT ASSETS		**45,262**	**39,313**
CURRENT LIABILITIES			
Trade and other payables	14.1	(38,947)	(28,858)
Deferred Income	14.2	(2,272)	(1,706)
Borrowings	15	(131,347)	(80,161)
Provisions	17	(1,477)	(1,569)
TOTAL CURRENT LIABILITIES		**(174,043)**	**(112,294)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**31,457**	**89,046**
NON-CURRENT LIABILITIES			
Borrowings	15	(5,815)	(53,031)
Provisions	17	(1,553)	(826)
TOTAL NON-CURRENT LIABILITIES		**(7,368)**	**(53,857)**
TOTAL ASSETS EMPLOYED		**24,089**	**35,189**
FINANCED BY			
Public dividend capital		105,258	101,356
Revaluation reserve	18	48,410	58,288
Income and expenditure reserve		(129,579)	(124,455)
TOTAL TAXPAYERS' EQUITY		**24,089**	**35,189**

The Financial Statements and notes on pages 146-183 were approved by the Board and authorised for issue on 11th June 2020 and signed on its behalf by:



Simon Lloyd
Chairman

Joe Harrison
Chief Executive

Mike Keech
Director of Finance

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2020

Trust

	Note	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
		£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019		**101,356**	**58,288**	**(124,455)**	**35,189**
Deficit for the year		0	0	(5,124)	**(5,124)**
Impairments	7.3	0	(9,878)	0	**(9,878)**
Public Dividend Capital received		3,902	0	0	**3,902**
Taxpayers' and others' equity at 31 March 2020		**105,258**	**48,410**	**(129,579)**	**24,089**
Taxpayers' and others' equity at 1 April 2018		**99,154**	**78,667**	**(114,909)**	**62,912**
Deficit for the year		0	0	(9,546)	**(9,546)**
Revaluations	7.3	0	(20,379)	0	**(20,379)**
Public Dividend Capital received		2,202	0	0	**2,202**
Taxpayers' and others' equity at 31 March 2019		**101,356**	**58,288**	**(124,455)**	**35,189**

Statement of Cash flows For the Year Ended 31 March 2020

	2019/20	2018/19
	£000	£000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating deficit from continuing operations	(2,890)	(6,528)
Operating deficit	**(2,890)**	**(6,528)**
Non-cash income and expense:		
Depreciation and amortisation	9,254	8,817
Impairments and reversals of impairments	7,448	6,743
Income recognised in respect of capital donations (cash and non-cash)	(2,476)	(5,010)
Decrease/(Increase) in receivables and other assets	3,431	(5,831)
Decrease/(increase) in inventories	183	(320)
Increase in payables	6,834	617
Increase in other liabilities	566	69
Increase/(Decrease) in provisions	636	(128)
Other movements in operating cash flows	0	(4)
Net cash from/(used in) operating activities	**22,986**	**(1,575)**
Cash flows from investing activities		
Interest received	111	54
Purchase of financial assets / investments	(175)	0
Purchase of intangible assets	(3,747)	(4,954)
Sale of intangible assets	0	38
Purchase of property, plant, equipment	(17,538)	(10,853)
Sale of property, plant & equipment	480	346
Receipt of cash donations to purchase capital assets	2,476	5,010
Net cash used in investing activities	**(18,393)**	**(10,359)**
Cash flows from financing activities		
Public dividend capital received	3,902	2,202
Loans Repaid to the Department of health	(1,413)	(954)
Loans Received from the Department of Health	5,300	18,125
Capital element of finance lease rental payments	(211)	(146)
Interest on DHSC loans	(1,918)	(1,669)
Interest paid on finance lease liabilities	(296)	(307)
PDC dividend refunded/(paid)	154	(1,649)
Net cash generated from financing activities	**5,518**	**15,602**
Increase/(decrease) in cash and cash equivalents	**10,111**	**3,668**
Cash and cash equivalents at 1 April	**6,175**	**2,507**
Cash and cash equivalents at 31 March	**16,286**	**6,175**

NOTES TO THE ACCOUNTS

1.0 Accounting policies and other information

These accounts for the year ended 31 March 2020 have been prepared by the Trust in accordance with the National Health Service Act 2006.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Operating Segments
The Board of Directors are of the opinion that the Trust's operating activities fall under the single heading of "Healthcare" for the purposes of segmental reporting in accordance with International Financial Reporting Standard 8.

Consolidation
From 1 April 2014, the NHS has had to apply IFRS 10,'Consolidated Financial Statements' in respect of consolidating Charitable Funds. The Trust has reviewed the criteria under IFRS 10 and it meets the criteria in respect of having an interest and control of MK Hospital NHS charity and ADMK Limited (ADMK) and it directly benefits from the activities of the charitable funds and ADMK. However, it has not consolidated the charitable funds or ADMK into these accounts because the Trust does not consider them to be material. The Charitable fund's income and expenditure represents only 0.2% of the Trusts position and ADMK only 3.2% so they are not material to the accounts of the Trust.

From the 1 April 2014, the NHS has applied IFRS 11, 'Joint Arrangements' and IFRS 12, 'Disclosure of Interests in Other Entities,' however the Trust has decided not to recognise the Milton Keynes Urgent Care Services in these accounts due to this position not being material to the Trusts accounts. See Note 10.

Critical 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 the estimates, but the underlying assumptions are regularly updated. Revisions to accounting estimates, which only affect that period, are recognised in the period in which the estimate is revised. If the revision affects both current and future periods it is recognised in the period of the revision and future periods.

Critical judgements in applying accounting policies:
There are no 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.

Key sources of estimation uncertainty
The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting year, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuations of Land and Buildings
The most significant estimate within the accounts is the value of land and buildings. In accordance with International Accounting Standards, a full property valuation is carried out on the Trust's land and buildings every five years, with an interim valuation after three years. The Trust has as at the 31st March 2020 undertaken a valuation on an alternative site basis after taking advice from a RICS qualified valuer, the District Valuer Services (DVS), on suitable indices to apply to reflect changes in the building costs and local land price movements since the date of the last valuation. The Trust continues to judge it appropriate to use its assumptions regarding the location of a hypothetical site for the hospital when performing the modern equivalent asset valuation and as a result, it estimated that there had been a

reduction in the value of its assets by £17m which was reflected as a decrease in non-current assets. The next full revaluation is due March 2024.
Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Valuations do not take into account future potential changes in market value which cannot be predicted with any certainty therefore, between valuations, management reviews the values for any material changes and make judgements about market changes and assesses whether the carrying amount does not differ materially from that which would be expected using fair value at the end of the reporting period. The review of the estate values carried out in 2019/20 resulted in an overall decrease in the revaluation reserve of £10m.

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

1.1 Going concern

IAS 1 requires management to undertake an assessment of the NHS Foundation Trust's ability to continue as a going concern. These accounts have been prepared on a going concern basis as there has been no application to the Secretary of State for the dissolution of the NHS Foundation Trust and the Directors currently believe there is a realistic alternative to doing so. The Directors have therefore prepared these financial statements on a going concern basis.

The economic environment for all NHS trusts and NHS foundation trusts continues to be challenging with on-going internal efficiency gains necessary; cost pressures in respect of national pay terms and conditions; and non-pay and drug cost inflation. In addition, as a result of the COVID-19 pandemic (declared by the World Health Organisation on 11 March 2020) there is, and remains, significant uncertainty about the likely demand for hospital services and the impact COVID-19 will have on the costs incurred by NHS organisations. In response the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) have announced a series of measures to ensure the continuity of services, including the provision of additional funding to NHS trusts and foundation trusts to cover additional costs relating to the COVID-19 pandemic.

In its internal planning the Trust had assumed it will receive at least £19.8m of Financial Recovery Funding (FRF) and £3.2m of Marginal Rate Emergency Tariff (MRET) funding in 2020/21 (in accordance with the Trust's original allocations); however, as a result of the COVID-19, the Trust expects the changes to the funding regime to result in additional payments by way of a national 'top-up' fund in order to maintain the Trust's planned breakeven position. At present, these additional payments are not expected to be contingent on achievement of a financial control total as would have been the case in the pre-COVID-19 regime.

The Trust expects this to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue operating until adequate plans are in place to achieve financial sustainability for the Trust without reliance on Financial Recovery Funding. Whereas in previous years there were material uncertainties that cast significant doubt over whether the Trust would continue to exist in its current form, and over its ability to discharge its liabilities in the normal course of business, the Directors of the Trust believe that there is no longer a material uncertainty regarding Trust's ability to continue as a going concern. The Directors have considered the following matters in reaching this conclusion:

1. The Trust had a financial deficit of £5.1m for the year ended 31 March 2020 (£9.5m deficit in 2018/19); however, in cash terms, the Trust generated positive cash of £10.6m in 2019/20, with positive earnings before interest, tax, depreciation and amortisation of £10.1m (£4.0m in 2018/19);

2. On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans totalling £130.9m held by the trust as at 31 March 2020, will be extinguished and replaced with the issue of Public Dividend Capital (PDC) for which there is no repayment obligation. This announcement has removed the material uncertainty regarding loans that were previously due for repayment within 12 months of the Trust's financial year end;

3. The Trust held a cash balance of £16.3m on 31 March 2020 (£6.2m on 31 March 2019) which provides a reserve

to sustain the cashflow of the organisation and support continued investment in the Trust's estate, equipment and infrastructure;

4. Prior to the COVID-19 pandemic the Trust had put in place plans to achieve its control total set by NHS England and NHS Improvement and in doing so secure the Financial Recovery Funding. While the COVID-19 outbreak has led to uncertainties about the deliverability of this plan in its original form, NHS England and NHS Improvement have given assurance that additional costs incurred in respect of COVID-19 will be reimbursed. In addition, the funding regime for the period April 2020 to July 2020 has changed in order to provide a guaranteed income stream to the Trust, with amounts paid in advance in order to protect the Trust's cashflow position. While there remains uncertainty about the funding and contracting regime beyond July 2020, the Directors are of the view that additional resources will be made available centrally in the event that the Trust is not able to operate business as usual plans due to on-going pressures from COVID-19.

For these reasons, the financial statements do not include any adjustments that would result if the going concern basis were not appropriate, nor has the Trust identified material uncertainties which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore its ability to realise its assets and discharge its liabilities in the normal course of business.

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 and certain financial assets and financial liabilities.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

Payment terms are standard reflecting cross government principles.

Revenue from NHS contracts

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

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over

the course of the multi-year contract. In these cases, it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

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

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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

1.4 Expenditure on goods and services

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

1.5 Expenditure on employee benefits

Short –term employee benefits

Salaries, wages and employment-related payments, including termination benefits, are recognised in the period in which the service is received from employees. Annual leave entitlement is actively encouraged to be taken in the year that it is earned, however there are exceptional circumstances when the annual leave entitlement may be carried forward into the following year. Untaken leave is accrued on an average five days carry forward for medical staff, excluding junior doctors and registrars in training. All other staff are accrued based on annual data collection of untaken hours applied to their hourly rate of pay. The cost of this annual leave entitlement earned but not taken at the end of the financial year is recognised in the financial statements.

Pension costs-NHS Pension Scheme

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

each scheme is taken as equal to the contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

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:

Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 20, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

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

Scheme Liabilities
The liabilities of the pension scheme as at 31 March 2019 were £533.3 billion. The national deficit of the scheme was £19.4 billion as per the last scheme valuation by the Government Actuary as at 31 March 2016. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. Tiered employer contribution rates were recommended and those applicable from the 1 April 2015 to 31 March 2021 were: a lower limit of 5% and an upper limit of 14.5% of pensionable pay. Employers' pension cost contributions are charged to operating expenses as and when they become due. The expected value of the trusts' employer's pension contributions for 2019/20 is £22.0m (£14.5m 2018/19)

During 2019/20, NHS employers have been paying an employer contribution of 14.38% to the NHS pension scheme. However, from 1 April 2019, the employers' pension contribution is actually 20.68%. The difference of 6.3% has been funded and paid to the NHS BSA centrally by NHS England. The value of this additional pension payment included in in the value above is £6.7m

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

Pension costs-NEST Pension Scheme
From the 1 October 2013 the Trust has participated in the Government's Auto Enrolment Pension scheme. It has auto enrolled those employees who are not eligible for the NHS Pensions scheme into an alternative pension scheme run by National Employers Savings Trust (NEST).

The employer's contributions for all eligible staff is 3%. The Trust currently has, at the 31 March 2020, 84 employees enrolled into NEST and the employer's contributions for the current financial year have been £29k.

1.6 Property, Plant and Equipment

Recognition
Property, Plant and Equipment (PPE) is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and
- the item has a 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, have broadly simultaneous purchase dates, and are anticipated to have simultaneous disposal dates and are under single managerial control

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

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replace is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
The Trust capitalises assets that individually have a cost of at least £5,000 or form a group of assets which individually have a cost of more than £250 and collectively have a cost of at least £5,000, where the assets are: functionally interdependent; have broadly simultaneous purchase dates; are anticipated to have simultaneous disposal dates and are under single managerial control.

Assets will also be capitalised if they form part of the initial set-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost. In accordance with IAS23, borrowing costs directly attributable to the financing of PPE are also capitalised up until all the activities necessary to prepare the asset for its intended use are complete.

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

Valuation
All property, plant and equipment assets 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 current value.

The carrying value of fixtures and equipment are written off over the remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

Land and buildings are re-valued where a movement in current values is considered to be material. Current values are determined as follows:

- Land and non-specialised operational assets – Existing use value.
- Specialised assets – depreciated replacement cost applying the modern equivalent asset principle.

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

In any event, professional valuations are carried out every five years, together with a three-year interim/desk top valuation. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Standards Manual.

The Trust has as at the 31st March 2020 undertaken a desktop valuation after taking advice from a RICS qualified valuer from District Valuer Services (DVS) on suitable indices to apply, to reflect changes in the building costs and local land price movements since the date of the last valuation. As a result, it estimated that there had been a reduction in the value of its assets by £17m which was reflected as a decrease in non-current assets. The next full revaluation is due March 2024.

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

The DVS is the commercial arm of the Valuation Office Agency, which is an executive agency of HM Revenue & Customs (HMRC). It provides professional property advice across the public sector in England, Wales and Scotland.

Buildings are valued at depreciated replacement cost on a modern equivalent asset basis for buildings which qualify as a specialised operational property asset which is consistent with IAS 16, with regard to the suitable indices that reflect changes in the building costs.

Non-specialised operational property, including land, is assessed at existing use value whilst non-operational property, including surplus land is valued on the basis of market value. 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. Until 31 March 2008, plant, machinery, vehicles, furniture and fittings were carried at replacement cost, based on indexation and depreciation of historic cost. New assets are carried at depreciated historic cost, unless this is considered to be materially different from fair value due to significant volatility in asset values.

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

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

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, dwellings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset based on assessments by the Trust's professional valuers. Leasehold buildings are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the following estimated lives:

Asset Category	**Estimated life (in years)**
Buildings excluding dwellings	8 to 90
Dwellings	40
Plant and Machinery	5 to 20
Transport Equipment	7
Information Technology	2 to 8
Furniture and Fittings	5 to 10
Leased assets	Over the lease term

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

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

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

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

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains. Where impairment arises from a clear consumption of economic value, this is taken in full to operating expenses.

De-recognition
Assets intended for disposal, are reclassified as 'Held for sale' once all the following criteria are met:

- The sale must be highly probable and the asset available for immediate sale in its present condition.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's life is adjusted. The asset is de-recognised when scrapping or demolition occurs.
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Donated and grant funded assets
Government grants are grants from Government bodies other than income from CCG's or NHS Trusts for the provision of services. Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.7 Intangible Assets

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

Internally Generated
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and is recognised as an operating expense in the period that it is incurred.

Expenditure on development is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software
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.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale..

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

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

Asset Category	Estimated life in years
Purchased computer software & Licences	2 to 8
Development	2 to 8
Internally generated IT	2 to 10

1.8 Inventories

Inventories comprise mainly of drugs and consumable medical products which are held at the lower of cost or net realisable value. The cost formula is determined by using the latest cost price from suppliers. Due to the high turnover of inventories and the low value held, the Trust considers this method to be an appropriate basis of measurement. Net realisable value is the estimated selling price less estimated costs to achieve a sale.

1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

1.10 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense are recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

1.11 Financial assets and financial liabilities

Recognition

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

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

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets are recognised on the Statement of Financial Position 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 liabilities classified as subsequently measured at amortised cost 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.

De-recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities are classified as "fair value through profit or loss" or as "other financial liabilities"

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

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

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through income and expenditure:

- Loans and receivables

Impairment of financial assets

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

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

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

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

1.12 Leases

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

Finance Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease, thereafter the asset is accounted for as an item of property, plant and equipment and the lease liability is de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating Leases
Other leases are regarded as operating leases and the rentals are charged to the operating expenses on a straight-line basis over the term of the lease. Lease incentives are recognised initially in other liabilities on the statement of financial position as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component if it is considered to be material and the classification for each is assessed separately.

The Trust as lessor
Finance leases - Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating 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 as an expense on a straight-line basis over the lease term.

to be material and the classification for each is assessed separately.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount at the statement of financial position date, for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate of the expenditure can be made. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate. The rate for salary related provisions i.e. injury benefit provisions is minus 0.5% and long-term provisions is 1.99% in real terms is applied.

Clinical Negligence
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS resolution, which in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the trust is disclosed at note 17 but is not recognised in the Trust's accounts.

Non-Clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies

Recognition
Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control. They are not recognised as assets but are disclosed in note 20 unless the probability of a transfer of economic benefit is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public Dividend Capital

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

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

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i)

donated and grant funded assets, (ii) average daily cash held with Government Banking Service excluding cash balances held in GBS account that relate to a short-term working capital facility and any (iii) PDC dividend balance receivable or payable.

The relevant net assets are adjusted for any liabilities or assets which the trust has as at the end of the accounting year but may only have held for a short period close to the end of the accounting year.
In accordance with the requirements laid down by the Department of Health and Social Care (DHSC) as issuer of PDC, the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 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.

1.17 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which a corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.18 Foreign Exchange

The functional and presentational currencies of the Trust are sterling**.** A transaction which is denominated in a foreign currency is translated into sterling at the exchange rate ruling on the dates of the transaction.

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

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

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

1.19 Third Party Assets

Assets belonging to third parties in which the Trust has no beneficial interest, such as money held on behalf of patients, are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Finance Reporting Manual (FReM).

1.20 Losses and Special payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis.

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

1.21 Gifts

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

1.22 Early adoption of standards, amendments and interpretations

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

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

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted.

IFRS 16 Leases

IFRS 16 Leases The purpose of this new standard is to eliminate the classification of leases as either operating leases or finance leases for a lessee. Instead all leases will be treated in a similar way to finance leases applying IAS 17. Leases are 'capitalised' by recognising the present value of the lease payments and showing them either as lease assets (right-of-use assets) or together with property, plant and equipment. If lease payments are made over time, a company will also recognise a financial liability representing its obligation to make future lease payments. The trust currently has circa £1.7m of operating leases and it is not expected that this will have a material impact. The effective date was due to be 2020/21 but due to the Covid-19 crisis adoption has been delayed by HM Treasury until 2021/22

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts This standard establishes the principles for the recognition, measurement, presentation and disclosure of Insurance contracts within the scope of the Standard. The objective of IFRS 17 is to ensure that an entity provides relevant information that faithfully represents those contracts. This information gives a basis for users of financial statements to assess the effect that insurance contracts have on the entity's financial position, financial performance and cash flows. It is not expected that that this will have a material impact on the Trust. The effective date was due to be 2020/21 but due to the Covid-19 crisis adoption has been delayed by HM Treasury until 2022/23.

2. Operating Income

IFRS 8 requires the disclosure of results of significant operating segments, the Trust considers that it has only one operating segment, Healthcare.

2.1 Operating Income from Activities arising from Commissioner Requested Services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested services and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that the commissioners believe would need to be protected in the event of provider failure.

The Trust's commissioner requested services is the total income from activities excluding private patient income and non–protected clinical income. Non protected income relates to overseas patients, the NHS Injury Scheme and other Non NHS bodies.

	2019/20 £000	2018/19 £000
Income from services designated (or grandfathered) as commissioner requested services	224,661	206,887
Income from services not designated as commissioner requested services	10,257	5,604
Total	**234,918**	**212,491**

2.2 Operating Income from patient Care Activities (By Nature)

	2019/20 £000	2018/19 £000
Income from activities		
Elective income	26,542	28,470
Non-elective income	76,780	70,737
First outpatient income	20,392	19,310
Follow up outpatient income	24,589	22,875
A & E income	14,737	12,489
Other NHS clinical income	61,621	53,006
Private patient income	507	507
Agenda for Change pay award central funding*	0	2,308
Additional pension contribution central funding**	6,656	0
Other Non-NHS clinical income	3,094	2,789
Total income from activities	**234,918**	**212,491**

	2019/20 £000	2018/19 £000
Other operating income from contracts with customers:		
Research and development	902	801
Education and training	8,249	8,634
Non-patient care services to other bodies	1,930	2,048
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET)***	24,838	17,960
Car parking	1,485	1,616
Staff Accommodation	1,101	1,376
Catering	733	708
Salary income	822	891
Other income	4,591	1,846
Other non-contract operating income		
Receipt of capital grants and donations	2,476	5,010
Total other operating income	**47,127**	**40,890**

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

**The employer contribution rate for NHS pensions increased from 14.38% to 20.68% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** Changes were made to the financial architecture of the NHS in 2019-20 and a simplified financial framework was introduced. The £1.8 billion Provider Sustainability Fund (PSF) which was made available to NHS providers in 2017-18, linked to the achievement of financial controls and performance targets, continued for the 2019-20 financial year. However, the ability to earn additional PSF funds, previously linked to performance and reward schemes, was removed and replaced by a new Financial Recovery Fund (FRF) created to support the sustainability of essential services.

Additionally, the funding route for marginal rate emergency tariff (MRET), previously funded through the Clinical Commissioning Groups (CCG's), was changed to be delivered centrally. There are no in year financial or other performance requirements linked to the receipt of MRET funding.

The amount of funding included in the above for the 2019-20 are:

PSF core and incentive funding £5.1m, £1.2m respectively.

FRF funding £16m

MRET funding £3.2m

The Trust can confirm that there are no fees or charges raised under legislation, where the full cost exceeds £1 million, or the service is otherwise material in relation to the accounts.

2.3 Provision of goods and services for the purposes of health service

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

	2019/20 £000	2018/19 £000
Income from the provision of goods and services for the purposes of the health service	224,661	206,887
Income from the provision of goods and services for any other purpose	57,384	46,494
Total	**282,045**	**253,381**

2.4 Private patient income

The Health and Social Care Act from the 1st October 2012 repealed the statutory limitation on private patient income in section 44 of the National Health Services Act 2006. The Trust earned 0.2% of total patient care income from private patients in 2019/20 and 0.3% in 2018/19.

2.5. Operating Income from Patient Care Activities (by source)

Income from patient care activities received from:	**2019/20 £000**	**2018/19 £000**
CCGs and NHS England	230,576	206,108
Local authorities	1,747	1,632
Department of Health	0	2,308
Other NHS foundation trusts	770	786
NHS trusts	4	0
NHS other	147	1
Non-NHS: private patients	507	507
Non-NHS: overseas patients (chargeable to patient)	173	257
NHS injury scheme (was RTA)	991	867
Non-NHS: other	3	25
Total income from activities	**234,918**	**212,491**
Of which:		
Related to continuing operations	234,918	212,491

The responsibility for the commissioning of Healthcare services is from two main NHS Bodies, Clinical Commissioning Groups (CCG's) and NHS England. The major CCG for the Trust is Milton Keynes CCG which accounts for 68% of the Trust's clinical income.

NHS England commissions nationally for a number of specialist services which includes HIV, Neonatology and Specialist Cancers and screening. The Trust received £27.9m 2019/20 in respect of these services (£27.1m 2018/19). The Trust also received an additional £2m 2019/20 (£1.2m 2018/19) from the Cancer Drugs Fund.

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

	2019/20 £000	**2018/19 £000**
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	881	800
Total	**881**	**800**

2.7 Transaction price allocated to remaining performance obligations

	31 March 2020 £000	**31 March 2019 £000**
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	844	881
after one year, not later than five years	0	0
after five years	0	0
Total revenue allocated to remaining performance obligations	**844**	**881**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

2.8 Analysis of overseas visitors' income

	2019/20 £000	**2018/19 £000**
Income recognised this year	**173**	**257**
Cash payments received in-year	184	106
Amounts added to provision for impairment of receivables	104	158
Amounts written off in-year	**187**	**124**

3. Operating expenses

3.1 Operating expenses (by Type)

	2019/20 £000	**2018/19 £000**
Purchase of healthcare from NHS and DHSC bodies	4,683	4,756
Purchase of healthcare from non-NHS and non-DHSC bodies	6,521	4,642
Staff and executive directors' costs	179,826	162,319
Remuneration of non-executive directors	139	137
Supplies and services - clinical (excluding drugs costs)	17,781	16,722
Supplies and services - general	4,050	3,847
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,834	21,244
Inventories written down (net including drugs)	0	33
Consultancy costs	58	17
Establishment	1,883	2,138
Premises	14,523	13,159
Transport (including patient travel)	640	498
Depreciation on property, plant and equipment	7,348	7,720
Amortisation of intangible assets	1,906	1,097
Net impairments	7,448	6,743
(decrease)/Increase in provision for impairment of receivables	(456)	28
Increase in other provisions	0	63
Change in provisions discount rate(s)	100	0
Audit fees payable to the external auditor		
Audit services- statutory audit	84	84
Other auditor remuneration (external auditor only)	42	6
Internal audit costs	61	113
Clinical negligence	7,039	7,323
Legal fees	1,049	783
Insurance	115	143
Research and development	1,011	702
Education and training	5,220	3,970
Rentals under operating leases	398	300
Car parking & security	37	40
Hospitality	23	1
Losses, ex gratia & special payments	249	267
Other services	531	521
Other	(208)	493
Total	**284,935**	**259,909**
Of which:		
Related to continuing operations	284,935	259,909

Operating lease includes rentals for premises, a variety of medical equipment as well as photocopiers and lease cars

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	1,135	111
- later than one year and not later than five years;	1,515	33
- later than five years.	444	0
Total	**3,094**	**144**

4. Staff costs

4.1 Staff costs

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	138,536	127,341
Social security costs	14,803	13,887
Apprenticeship levy	694	654
Employer's contributions to NHS pensions	15,321	14,562
Pension cost - employer contributions paid by NHSE (6%)	6,656	0
Temporary staff	8,957	9,676
Total gross staff costs	**184,967**	**166,120**

These costs exclude those for Non-Executive Directors' remuneration and benefits in kind and include the additional 6% increase in employer's pension contribution which is being funded by NHS England on behalf of providers.

4.2 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liability of this ill-health retirement is £13k (£35k in 2018/19).

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

4.3 Employee Benefits

Employee benefits relate to payments made over and above salary costs. There were no employee benefits paid in the year or in the previous financial year.

4.4 Termination Benefits

There were no termination benefits during the year (Nil in 2018/19) and there were no non-compulsory departures agreed in 2019/20 or 2018/19.

4.5 Salary and pension entitlements of Directors

The aggregate amounts payable to directors were:

	2019/20 £000	2018/19 £000
Salary	1,443	1,301
Taxable benefits	0	0
Employer's pension contributions	97	108
Total	**1,540**	**1,409**

Further details of directors' remuneration can be found in the remuneration report.

4.6 Highest paid Director Analysis

Reporting Bodies are required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Milton Keynes University Hospital NHS Foundation Trust in the financial year 2019/20 was £205,000-£210,000 (2018/19 £200,000-£205,000). This was 6.5 times (2018/19 6.6 times) the median remuneration of the workforce which was £32,123 (2018/19 £30,376).

In 2019/20 and 2018/19 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £12,000 to £207,500 (2018/19 from £6,000 to £194,800).

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The median remuneration has been calculated using the full time equivalent annualised salary costs taken from the March payroll data, excluding the highest paid director but including agency and bank costs.

The Trust's highest paid Director was the Chief Executive and the remuneration costs that have been used in the calculation are the banded, full time equivalent annualised total remuneration costs. The previous year's highest paid director was the Chief Executive.

5. Better Payment Practice Code

5.1 Better Payment Practice Code- measure of compliance

	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Total trade invoices paid in the year	67,647	146,115	69,586	127,441
Total trade invoices paid within 30 days	55,077	128,135	52,054	108,754
Percentage of total trade invoices paid within 30 days	81%	88%	75%	85%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. There were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest Act 1998 (2018/19 £0).

6. Audit Fees

The Trust incurred statutory audit fees totalling £84,000 including irrecoverable VAT, (£84,000 in 2018/19) and £41,514 other auditor remuneration in 19/20 excluding recoverable VAT, (£6 in 18/19). Other auditor remuneration is detailed below.

6 Audit Fees	Trust	
	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
All assurance services not falling within items above	42	6
Total	**42**	**6**

6.1 Limitation on auditor's liability

There is a £500k limitation on auditor's liability for external audit work carried out for the financial years 2019/20 and 2018/19.

7. Finance income and expense

7.1 Finance Income

	2019/20	2018/19
	£000	£000
Interest on bank accounts	111	54
Total	**111**	**54**

7.2 Finance Expenses

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health	1,927	1,746
Finance leases	296	307
Total interest expense	**2,223**	**2,053**

7.3 Impairment of Assets (PPE)

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	369	0
Changes in market price	7,079	6,743
Total net impairments charged to operating surplus / deficit	**7,448**	**6,743**
Impairments charged to the revaluation reserve	9,878	20,379
Total net impairments	**17,326**	**27,122**

In 2018/19 the Trust adopted a modern equivalent asset principle which reflected an alternative site valuation. In adopting the Modern Equivalent Asset – with alternative site approach, the valuation of land and buildings reflects the extent of estate required for the provision of the same service as already provided by the existing estate but not in the same form or location.

Following an assessment from the Trust's valuer, valuing the estate on an alternative site valuation basis has led to a lower reported Current Value for accounting purposes. This arises from better configuration of the hospital estates (reducing circulation space) and a reduction in the land valuation.

8. Intangible Assets

8.1 Intangible assets – 2019/20

	Software & licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**9,946**	**9,576**	**1,891**	**3,157**	**24,570**
Additions	1382	909	0	1,645	**3,936**
Reclassifications	412	563	0	(975)	**(0)**
Disposals / de-recognition	0	0	0	0	**0**
Gross cost at 31 March 2020	**11,740**	**11,048**	**1,891**	**3,827**	**28,506**
Amortisation at 1 April 2019 - brought forward	**4,303**	**5,447**	**670**	**0**	**10,420**
Provided during the year	1,170	483	253	0	**1,906**
Reclassifications	0	0	0	0	**0**
Amortisation at 31 March 2020	**5,473**	**5,930**	**923**	**0**	**12,326**
Net book value at 31 March 2020	**6,267**	**5,118**	**968**	**3,827**	**16,180**
Net book value at 1 April 2019	**5,643**	**4,129**	**1,221**	**3,157**	**14,150**

Note 8.2 Intangible assets - 2018/19

	Software & licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	**5,237**	**7,273**	**621**	**6,246**	**19,377**
Additions	2,553	0	0	2,888	**5,441**
Reclassifications	2,157	2,303	1,270	(5,940)	**(210)**
Disposals / de-recognition	(1)	0	0	(37)	**(38)**
Valuation/gross cost at 31 March 2019	**9,946**	**9,576**	**1,891**	**3,157**	**24,570**
Amortisation at 1 April 2018 - as previously stated	**3,805**	**5,069**	**449**	**0**	**9,323**
Provided during the year	498	378	221	0	**1,097**
Disposals / de-recognition	0	0	0	0	**0**
Amortisation at 31 March 2019	**4,303**	**5,447**	**670**	**0**	**10,420**
Net book value at 31 March 2019	**5,643**	**4,129**	**1,221**	**3,157**	**14,150**
Net book value at 1 April 2018	**1,432**	**2,204**	**172**	**6,246**	**10,054**

9. Property, Plant and Equipment

Property, plant and equipment as at 31st March 2020 is broken down in the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**3,841**	**124,454**	**855**	**5,973**	**29,361**	**169**	**11,059**	**457**	**176,169**
Additions	0	1,827	0	15,978	2,053	0	583	447	**20,888**
Impairments	0	(23,978)	30	0	0	0	0	0	**(23,948)**
Reclassifications	0	17,398	0	(17,589)	332	(143)	2	0	**0**
Revaluation	0	0	0	0	0	0	0	0	**0**
Disposals / de-recognition	0	(385)	0	(92)	(105)	0	0	(1)	**(583)**
Valuation/gross cost at 31 March 2020	**3,841**	**119,316**	**885**	**4,270**	**31,641**	**26**	**11,644**	**903**	**172,526**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**2,218**	**14**	**0**	**18,117**	**26**	**8,098**	**275**	**28,748**
Provided during the year	0	4,554	27	0	1,971	14	756	26	**7,348**
Impairments	0	(6,772)	(40)	0	190	0	0	0	**(6,622)**
Reclassifications	0	0	0	0	14	(14)	0	0	**0**
Disposals/ de-recognition	0	0	0	0	(103)	0	0	0	**(103)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**1**	**0**	**20,189**	**26**	**8,854**	**301**	**29,371**
Net book value at 31 March 2020	**3,841**	**119,316**	**884**	**4,270**	**11,452**	**0**	**2,790**	**602**	**143,155**
Net book value at 1 April 2019	**3,841**	**122,236**	**841**	**5,973**	**11,244**	**143**	**2,961**	**182**	**147,420**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**25,167**	**127,689**	**855**	**4,861**	**26,626**	**26**	**9,685**	**427**	**195,336**
Additions	**0**	**2,794**	**0**	**4,567**	**2,423**	**143**	**577**	**28**	**10,532**
Impairments	**(21,326)**	**(8,155)**	**0**	**0**	**0**	**0**	**0**	**0**	**(29,481)**
Reclassifications	**0**	**2,391**	**0**	**(3,385)**	**405**	**0**	**797**	**2**	**210**
Disposals / de-recognition	**0**	**(265)**	**0**	**(70)**	**(93)**	**0**	**0**	**0**	**(428)**
Valuation/gross cost at 31 March 2019	**3,841**	**124,454**	**855**	**5,973**	**29,361**	**169**	**11,059**	**457**	**176,169**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**14**	**26**	**0**	**16,169**	**26**	**6,990**	**248**	**23,473**
Provided during the year	**0**	**4,525**	**26**	**0**	**2,034**	**0**	**1,108**	**27**	**7,720**
Impairments	**0**	**(2,321)**	**(38)**	**0**	**0**	**0**	**0**	**0**	**(2,359)**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals/ de-recognition	**0**	**0**	**0**	**0**	**(86)**	**0**	**0**	**0**	**(86)**
Accumulated depreciation at 31 March 2019	**0**	**2,218**	**14**	**0**	**18,117**	**26**	**8,098**	**275**	**28,748**
Net book value at 31 March 2019	**3,841**	**122,236**	**841**	**5,973**	**11,244**	**143**	**2,961**	**182**	**147,421**
Net book value at 1 April 2018	**25,167**	**127,675**	**829**	**4,861**	**10,457**	**0**	**2,695**	**179**	**171,862**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned	3,541	94,776	284	4,270	11,000	0	2,790	602	**117,263**
Finance leased	300	5,674	600	0	363	0	0	0	**6,937**
Government granted	0	12,723	0	0	0	0	0	0	**12,723**
Donated	0	6,143	0	0	89	0	0	0	**6,232**
Total at 31 March 2020	**3,841**	**119,316**	**884**	**4,270**	**11,452**	**0**	**2,790**	**602**	**143,155**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned	3,541	100,903	251	5,973	10,764	143	2,961	182	**124,718**
Finance leased	300	5,643	590	0	366	0	0	0	**6,899**
Government granted	0	13,041	0	0	0	0	0	0	**13,041**
Donated	0	2,649	0	0	114	0	0	0	**2,763**
Total at 31 March 2019	**3,841**	**122,236**	**841**	**5,973**	**11,244**	**143**	**2,961**	**182**	**147,421**

9.1 Analysis of Plant, Property and Equipment

The Trust does not have any government granted or donated assets which have any restrictions or conditions imposed on them.

The Trust can disclose that there have been no disposals in year of land and building assets used for the delivery of commissioner requested services (CRS). In addition, as at 31 March 2020, the Trust had no land and buildings valued at open market value.

9.2 Capital commitments

There is one capital commitment, (£0.3m) under intangible capital expenditure relating to the eCARE digital programme.

10. Investments Carrying Amount

Associate entities are those over which the Trust has the power to exercise a significant influence, but not control over the operating and financial management policy decisions. This is generally demonstrated by the Trust holding in excess of 20% but no more than 50% of the voting rights.

With effect from August 2009 the Trust has an associate investment in Milton Keynes Urgent Care Services, a community interest company (CIC) and holds an equity investment of 40% voting rights. The sum of the investment was £40. The entity is incorporated in the UK and accounted for at cost.

The Trust has chosen not to reflect any surplus or deficit from the associate in the Trust accounts as the Trust deems the impact of its share to not be material. In the event of any impact becoming material, the Trust will review the position and reflect this as appropriate.

11. Inventories

	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
As at 1 April 2019	**1,218**	**2,299**	**60**	**3,577**
Additions	22,836	20,283	13	**43,132**
Write-down of inventories recognised as an expense	0	0	0	**0**
Inventories consumed (recognised in expenses)	(22,835)	(20,467)	(13)	**(43,315)**
As at 31st March 2020	**1,219**	**2,115**	**60**	**3,394**
As at 1 April 2018	**1,158**	**2,045**	**54**	**3,257**
Additions	21,244	18,670	22	**39,936**
Write-down of inventories recognised as an expense	0	(33)	0	**(33)**
Inventories consumed (recognised in expenses)	(21,184)	(18,383)	(16)	**(39,583)**
As at 31st March 2019	**1,218**	**2,299**	**60**	**3,577**

12. Trade and Other Receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	25,104	28,077
Allowance for impaired contract receivables / assets	(1,494)	(2,411)
Prepayments (non-PFI)	841	2,645
PDC dividend receivable	283	559
VAT receivable	848	691
Total current trade and other receivables	**25,582**	**29,561**
Non-current		
Contract receivables	763	626
Allowance for impaired contract receivables / assets	(335)	(169)
Clinician pension tax provision reimbursement funding from NHSE	301	0
Total non-current trade and other receivables	**729**	**457**
Of which receivables from NHS and DHSC group bodies:		
Current	18,731	22,585
Non-current	301	0

NHS receivables are considered recoverable because the majority of trade is with CCG's, as commissioners for NHS patient care services. CCG's are funded by the Government to purchase NHS patient care services, therefore no credit scoring of them is considered to be necessary. However, the Trust has recognised an impairment for receivables which relates to CCG income. Similarly, other receivables with related parties are with other Government bodies, so no credit scoring is considered necessary.

Trade and Other Receivables includes £0.8m for the value of partially completed patient episodes as at 31st March 2020 (31st March 2019 £1.6m).

At the Statement of Financial Position date there were no material concentrations of risk, the maximum exposure to credit risk being the carrying values of trade receivables.

12.1 Allowance for credit loss

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2019 - brought forward	**2,580**	**0**
New allowances arising	433	0
Reversals of allowances	(889)	0
Utilisation of allowances (write offs)	(295)	0
Allowances as at 31 Mar 2020	**1,829**	**0**

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**2,942**	**2,942**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	0	(2,942)
New allowances arising	2,100	0
Reversals of allowances	(2,072)	0
Utilisation of allowances (write offs)	(390)	0
Allowances as at 31 Mar 2019	**2,580**	**0**

The provision for impairment of receivables decreased in 2019/20. The main reduction was due to compensation recovery cases and NHS debtors.

13. Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20	2018/19
	£000	£000
At 1 April	**6,175**	**2,507**
Net change in year	10,111	3,668
At 31 March	**16,286**	**6,175**
Broken down into:		
Cash at commercial banks and in hand	61	53
Cash with the Government Banking Service	16,225	6,122
Total cash and cash equivalents as in SoFP	**16,286**	**6,175**
Total cash and cash equivalents as in SoCF	**16,286**	**6,175**

14. Liabilities

14.1 Trade and other payables

	31 March 2020	31 March 2019
	£000	£000
Current		
Trade payables	14,574	10,426
Capital payables	5,317	2,063
Accruals	11,755	9,935
Social security costs	2,279	2,080
VAT payables	7	0
Other taxes payable	1,969	1,829
Other payables	3,046	2,525
Total current trade and other payables	**38,947**	**28,858**
Of which payables from NHS and DHSC group bodies:		
Current	4,297	4,727
Non-current	0	0

14.2 Other liabilities

	31 March 2020	31 March 2019
	£000	£000
Current		
Deferred income: contract liabilities	2,272	1,706
Total other current liabilities	**2,272**	**1,706**

15. Borrowings

	31 March 2020	31 March 2019
	£000	£000
Current		
Loans from the Department of Health	131,125	80,005
Obligations under finance leases	222	156
Total current borrowings	**131,347**	**80,161**
Non-current		
Loans from the Department of Health	0	47,224
Obligations under finance leases	5,815	5,807
Total non-current borrowings	**5,815**	**53,031**

In year the Trust took out the following additional loan funding with the Department of Health.

- £2.6m in interim revenue loans,
- £2.7m in respect of capital funding.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Outstanding interim loans totalling £131.3m interim loan principal and interest accrual as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The current loan profile along with the current repayment details are show in the table below

Category of Loan	Amt of Original Loan £m	Balance Outstanding as at 31st March 2020 £m	Original Term	Interest Rate	Principal Repayment	Interest Payments
Interim Revenue Loan for 14/15	£25.3m	25.30	5 years	1.50%	Revised date: Nothing until in full Sept 2020	From Sept 2015 to Mar 2020
Interim Revenue Loan for 15/16	£31.2m	31.20	3 years	1.50%	Revised date: Nothing until in full Sept 2020	From Mar 2016 to Mar 2020
Revolving Revenue Working Capital Facility Conversion Loan 2016/17	£15.2m	15.20	3 years	1.50%	Revised date: Nothing until in full Jul 2020	from July 2017 to Jan 2020
Uncommitted Term Revenue Loan - Feb 2017	£3.2m	3.20	3 years	1.50%	Revised date: Nothing until in full Aug 2020	From Aug 2017 to Mar 2020
Uncommitted Term Revenue Loan - March 2017	£3.9m	3.90	3 years	1.50%	Revised date: Nothing until in full Sept 2020	From Sept 2017 to Mar 2020
Uncommitted Term Revenue Loan - May 2017	£2.3m	2.30	3 years	1.50%	Nothing until in full May 2020	From Nov 2017 to May 2020
Uncommitted Term Revenue Loan - June 2017	£1.8m	1.80	3 years	1.50%	Nothing until in full June 2020	From Dec 2017 to June 2020
Uncommitted Term Revenue Loan - July 2017	£2.1m	2.10	3 years	1.50%	Nothing until in full July 2020	From Jan 2018 to July 2020
Uncommitted Term Revenue Loan - Sept 2017	£1.1m	1.10	3 years	1.50%	Nothing until in full Sept 2020	From Mar 2018 to Sept 2020
Uncommitted Term Revenue Loan - Oct 2017	£1.0m	1.00	3 years	1.50%	Nothing until in full Oct 2020	From Apr 2018 to Oct 2020
Uncommitted Term Revenue Loan - Nov 2017	£1.5m	1.50	3 years	1.50%	Nothing until in full Nov 2020	From May 2018 to Nov 2020
Uncommitted Term Revenue Loan - Dec 2017	£1.9m	1.90	3 years	1.50%	Nothing until in full Dec 2020	From June 2018 to Dec 2020
Uncommitted Term Revenue Loan - Jan 2018	£4.4m	4.40	3 years	1.50%	Nothing until in full Jan 2021	From July 2018 to Jan 2021
Uncommitted Term Revenue Loan - Feb 2018	£2.6m	2.62	3 years	1.50%	Nothing until in full Feb 2021	From Aug 2018 to Feb 2021
Uncommitted Term Revenue Loan - May 2018	£2.0m	2.00	3 years	1.50%	Nothing until in full May 2021	From Nov 2018 to May 2021
Uncommitted Term Revenue Loan - June 2018	£1.6m	1.60	3 years	1.50%	Nothing until in full June 2021	From Dec 2018 to June 2021
Uncommitted Term Revenue Loan - Sept 2018	£0.5m	0.50	3 years	1.50%	Nothing until in full Sept 2021	From March 2019 to Sept 2021
Uncommitted Term Revenue Loan - Oct 2018	£2.8m	2.80	3 years	1.50%	Nothing until in full Oct 2021	From April 2019 to Oct 2021
Uncommitted Term Revenue Loan - Nov 2018	£3.7m	3.70	3 years	1.50%	Nothing until in full Nov 2021	From May 2019 to Nov 2021
Uncommitted Term Revenue Loan - Dec 2018	£2.2m	2.20	3 years	1.50%	Nothing until in full Dec 2021	From June 2019 to Dec 2021
Uncommitted Term Revenue Loan - Jan 2019	£0.6m	0.60	3 years	1.50%	Nothing until in full Jan 2022	From July 2019 to Jan 2022
Uncommitted Term Revenue Loan - Feb 2019	£1.1m	1.08	3 years	1.50%	Nothing until in full Feb 2022	From August 2019 to Feb 2022
Uncommitted Term Revenue Loan - Mar 2019	£1.4m	1.42	3 years	1.50%	Nothing until in full Mar 2022	From Sept 2019 to Mar 2022
Uncommitted Term Revenue Loan - April 2019	£2.0m	1.54	3 years	1.50%	Nothing until in full Apr 2022	From Oct 2019 to Apr 2022
Uncommitted Term Revenue Loan - Jul 2019	£0.6m	0.60	3 years	1.50%	Nothing until in full Jul 2022	From jan 2020 to July 2022
Total Revenue Loans	£116m	£115.6m				
Capital IT Loan for 10/11	£4.0m	0	10 years	4.00%	Aug 2011 through to Feb 2020	Dec 2010 to Feb 2020
Interim Capital Loan for 15/16	£5.3m	4.2	17 years	1.84%	Nov 16 through to Nov 2032	May 2016 to Nov 2032
Uncommitted Term Capital Loan 16/17	£1.9m	1.3	10 years	0.61%	Sept 17 through to Mar 2027	From Sept 2017 to Mar 2027
Uncommitted Term Capital Loan 17/18	£9.8m	9.8	10 years	1.23%	Aug 2020 through to Feb 2028	From Aug 2018 to Aug 2028
Total Capital Loans	£21.0m	£15.3m				

15.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2019	**127,229**	**5,963**	**133,192**
Cash movements:			
Financing cash flows - payments and receipts of principal	3,887	(211)	**3,676**
Financing cash flows - payments of interest	(1,918)	(296)	**(2,214)**
Non-cash movements:			
Additions	0	285	**285**
Application of effective interest rate	1,927	296	**2,223**
Carrying value at 31 March 2020	**131,125**	**6,037**	**137,162**

16. Finance Lease obligations

The finance lease items include the Trust's Accommodation Block, Beds, Multi-Function Devices (Printers) and car park equipment.

The accommodation block has no option to extend or purchase in the current lease agreement. The Trust entered the 7-year extension period of the beds lease in 2016/17, with no option to purchase under the current lease terms.

The Trust has the option to extend the lease for the Multi-Function Devices to the end of the useful economic life of the equipment, with no option to purchase under the current lease agreement.

The Trust entered into a four-year lease for the car park equipment, with 2 options to extend for a period of one year at each option. The Trust has exercised the option to extend at the first point and committed to a term of 5 years in total with the equipment passing to the Trust at the end of the contract.

	Minimum Lease Payments	
	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**9,924**	**10,140**
of which liabilities are due:		
- not later than one year;	502	450
- later than one year and not later than five years;	1,603	1,558
- later than five years.	7,819	8,132
	9,924	10,140
Finance charges allocated to future periods	(3,887)	(4,177)
Net lease liabilities	**6,037**	**5,963**
of which payable:		
- not later than one year;	222	156
- later than one year and not later than five years;	611	521
- later than five years.	5,204	5,286
	6,037	**5,963**

17. Provisions

	Pensions Early departure costs	Pensions Injury benefits	Other* legal claims	Clinician pension tax	Other**	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**43**	**824**	**666**	**0**	**862**	**2,395**
Change in the discount rate	9	79	0	0	12	**100**
Arising during the year	0	0	577	301	813	**1,691**
Utilised during the year	(7)	(34)	(182)	0	0	**(223)**
Reversed unused	0	0	(437)	0	(495)	**(932)**
At 31 March 2020	**45**	**869**	**624**	**301**	**1,192**	**3,031**
1Expected timing of cash flows:						
- not later than one year;	7	34	624	0	813	**1,478**
- later than one year and not later than five years;	29	137	0	0	379	**545**
- later than five years.	9	698	0	301	0	**1,008**
Total	**45**	**869**	**624**	**301**	**1,192**	**3,031**

***** Other legal claims include contractual changes £0.4m

****** Other claims include contractual changes £0.8m, contractual dilapidation and building removal costs £0.4m and Clinicians pension tax reimbursement £0.3m

	Pensions- Early departure costs	Pensions - Injury benefits	Other* legal claims	Other**	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**42**	**876**	**1,341**	**264**	**2,523**
Change in the discount rate	8	(18)	0	10	**0**
Arising during the year	0	0	424	588	**1012**
Utilised during the year	(7)	(34)	(150)	0	**(191)**
Reversed unused	0	0	(949)	0	**(949)**
At 31 March 2019	**43**	**824**	**666**	**862**	**2,395**
Expected timing of cash flows:					
- not later than one year;	7	34	666	862	**1,569**
- later than one year and not later than five years;	27	134	0	0	**161**
- later than five years.	9	656	0	0	**665**
Total	**43**	**824**	**666**	**862**	**2,395**

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event and it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the obligation.

Pension provisions
The above provision for pension costs relate to:

- additional pension liabilities arising from early retirements whereby, unless due to ill-heath, these are not funded by the NHS Pension Scheme, as noted within note 1.5 the full amount of such liabilities is charged to the income and expenditure account at the time the Trust commits itself to the retirement and
- reimbursement of clinician's pension tax liability.

Legal provisions
The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 1.23% combined OBR CPI (Office of Budget Responsibility Consumer Price Index) inflation and discount rates.

NHS Resolution
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, and all clinical negligence claims are recognised in the accounts of the NHSR, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is £137.6m (year ended 31 March 2019 £102.3m). No contingencies or provisions are in the accounts at 31 March 2020 in relation to these cases, even though the legal liability for them remains with the Trust.

Other schemes
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to the NHSR and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

18. Revaluation Reserve

	Property, plant and equipment £000
Revaluation Reserve at 1 April 2019	**58,288**
Impairment losses property, plant and equipment	(9,878)
Other reserve movements	0
Revaluation Reserve at 31 March 2020	**48,410**
Revaluation Reserve at 1 April 2018	78,667
Impairment losses property, plant and equipment	(20,379)
Other reserve movements	0
Revaluation Reserve at 31 March 2019	**58,288**

19. Post Balance Sheet events

In 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £131.1m interim loan principal and interest accrual as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

20. Contingent Liabilities

The Trust has reviewed its liabilities and it does not consider that it has any material contingent liabilities for the forthcoming financial year. The provisions that the Trust has made for liabilities and charges are disclosed in note 17 including provisions held by the NHSLA as at 31 March 2020 in respect of clinical negligence liabilities of the NHS Foundation Trust.

21. Related Party Transactions

The Trust is a body corporate established by the Secretary of State for Health. Government departments and their agencies are considered by HM Treasury as being related parties. During the year, the Trust has had a significant number of material transactions with other NHS bodies and in the ordinary course of its business with other Government departments and other central and local Government bodies. Most of these transactions have been with HMRC in respect of deductions and payment of PAYE, NHS Pensions Agency, Milton Keynes Council in respect of payment of rates and Milton Keynes CCG which is the Trust's local commissioner of NHS services. There are additional related parties of NHSI and the Milton Keynes Urgent Care Service, with which there have been no significant transactions in year.

The key management personnel of the Trust are all directors of the Trust. Their remuneration is disclosed in note 4.5. During the year none of the members of the key management personnel, or parties related to them, have undertaken any material transactions with the Trust.

21 Related parties

	2019/20			
	Payments to related party £000 exp	Receipts from related party £000 inc	Amts owed to related party £000 payable	Amts due from related party £000 receivable
Department of Health	0	0	0	0
NHS Bodies	2,642	3,956	864	1,650
Buckinghamshire Healthcare NHS Trust	1,925	79	671	54
NHS Milton Keynes CCG	27	158,836	1,584	1,314
NHS Bedfordshire CCG	0	15,222	45	305
NHS England	22	57,900	4,105	17,055
NHS Buckingham CCG	0	12,516	9	393
NHS Nene CCG	0	4,376	251	13
Bedford Hospital NHS Trust	124	326	186	94
Oxford University Hospital NHS FT	1,719	1,792	819	198
NHS Resolution	7,039	15	0	0
Central and North West London NHS Foundation Trust	611	985	125	309
Luton and Dunstable University Hospital NHS Foundation Trust	244	10	243	6
Health Education England	71	5,218	0	0
Other WGA Bodies				
Other WGA Bodies	34	70	17	84
NHS Blood and Transplant (outside DH Group)	1,203	0	8	16
Local Authorities	103	4,228	0	0
HMRC	15,526	0	4,248	848
NHS Pensions	21,977	0	2,242	0
MK Charity	0	323	0	0
ADMK Ltd	10,100	38	108	14
Total	**63,367**	**265,890**	**15,525**	**22,353**

Note Related parties

	2018/19			
	Payments to related party £000 exp	Receipts from related party £000 inc	Amts owed to related party £000 payable	Amts due from related party £000 receivable
Department of Health	0	3,676	0	0
NHS Bodies	2,360	3,056	1,291	1,586
Buckinghamshire Healthcare NHS Trust	1,807	71	706	41
NHS Milton Keynes CCG	195	146,702	1,971	6,503
NHS Bedfordshire CCG	0	13,640	61	869
NHS England	12	47,306	531	12,128
NHS Buckingham CCG	0	9,867	11	500
NHS Nene CCG	0	4,471	10	863
Bedford Hospital NHS Trust	213	178	234	140
Oxford University Hospital NHS FT	1,583	1,912	631	226
NHS Resolution	7,453	2	0	0
Central and North West London NHS Foundation Trust	584	1,008	10	141
Luton and Dunstable University Hospital NHS Foundation Trust	196	319	207	9
Health Education England	16	5,286	10	4
Other				
Other WGA Bodies	20	0	28	65
NHS Blood and Transplant (outside DH Group)	891	7	0	16
Local Authorities	21	7,642	0	0
HMRC	14,541	0	3,909	691
NHS Pensions	14,562	0	2,057	0
MK Charity	0	650	0	0
ADMK Ltd	3,000	0	0	1
Total	**47,454**	**245,793**	**11,667**	**23,783**

22. Financial Instruments

	31 March 2020 £000	31 March 2019 £000
Cash	16,286	6,715
Total Capital	**16,286**	**6,715**
Total Equity	16,286	6,715
Borrowings (excluding interest)	137,162	133,192
Overall financing	**153,448**	**139,907**
Capital to overall financing ratio	**11%**	**5%**

Capital Risk Management

The Trust's capital management objectives are:

- to ensure the Trust's ability to continue as a going concern; and
- to provide an adequate return to reinvest in healthcare services by providing healthcare services commensurately with the level of risk of receiving income for those services provided.

The Trust monitors capital on the basis of the carrying amount of Public Dividend Capital less cash presented on the face of the balance sheet.

The Trust sets the amount of capital in proportion to its overall financing structure, i.e. equity and financial liabilities. The Trust manages the capital structure and makes adjustments to it in light of changes in economic conditions and the risk characteristics of the underlying assets.

Interest Rate Risk

The Trust is not exposed to significant interest rate risk as the Borrowings are all at a fixed rate of interest.

Liquidity Risk

The Trust's net operating income is mainly incurred under legally binding contracts with the local CCGs, which are financed from resources voted annually by Parliament. Under Payment by Results, the Trust is paid for the activity on the basis of nationally set tariffs. For contracted activity, the Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the liquidity risk.

22.1 Financial assets by category

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2020		
Trade and other receivables excluding non-financial assets	24,239	**24,239**
Other investments / financial assets	175	**175**
Cash and cash equivalents	16,286	16,286
Total at 31 March 2020	**40,700**	**40,700**

	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019		
Trade and other receivables excluding non-financial assets	25,615	**25,615**
Other investments / financial assets		
Cash and cash equivalents	6,175	**6,175**
Total at 31 March 2019	**31,790**	**31,790**

22.2 Financial liabilities by category

	Held at amortised cost 2019/20 £000	Held at amortised cost 2018/19 £000
Carrying values of financial liabilities as at 31 March		
Loans from the Department of Health and Social Care	131,125	127,229
Obligations under finance leases	6,037	5,963
Trade and other payables excluding non-financial liabilities	4,289	4,727
Other financial liabilities	30,402	18,129
Provisions under contract	2,115	1,529
Total at 31 March	**173,968**	**157,577**

22.3 Maturity of Financial Liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	167,474	104,545
In more than one year but not more than two years	201	19,830
In more than two years but not more than five years	788	18,039
In more than five years	5,505	15,163
Total	**173,968**	**157,577**

23. Third Party assets

The Trust held no third-party assets at the end of financial year 2019/20.

24. Losses and special payments

There were 201 cases at 31 March 2020 of losses and special payments totalling £316,000 approved during the year (133 cases to 31 March 2019 totalling £339,000) These payments are the cash payments made in the year and are calculated on an accrual's basis. There were no compensation payments recovered during the year. Details of the payments are shown below.

	31 March 2020 Total number of cases	31 March 2020 Value £000	31 March 2019 Total number of cases	31 March 2019 Value £000
LOSSES:				
1. Losses of cash due to:				
a. theft, fraud etc.	0	0	0	0
b. overpayment of salaries etc.	44	23	13	4
2. Fruitless payments and constructive losses	0	0	0	0
3. Bad debts and claims abandoned in relation to:				
a. private patients	7	1	3	0
b. overseas visitors	56	187	50	124
c. other	48	1	16	1
4. Damage to buildings, property etc. (including stores losses) due to:				
b. stores losses	24	94	25	199
Total Losses	**179**	**306**	**107**	**328**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	0	0	0	0
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	10	1	13	4
g. other	12	9	13	7
Total Special Payments	**22**	**10**	**26**	**11**
Total Losses and Special Payments	**201**	**316**	**133**	**339**

NHS

Milton Keynes University Hospital

NHS Foundation Trust

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