North Cumbria Integrated Care NHS Foundation Trust

Annual Report and Accounts

2019/20

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

Contents

Chair and Chief Executive Welcome

There is no doubt that the 2019-2020 financial year was a challenge for our organisation as we took on the task of merging two long standing organisations to create North Cumbria Integrated Care, a process that is never easy, especially when bringing together two distinct cultures and experiences.

Whilst we still have work to do to complete elements of the merger, we have learned a lot about ourselves in the process. We know there is much more to do to build an NCIC that represents the values, commitment, and quality that we see, every day, in the care and compassion that our staff provide.

There is no better representation of these values that our response to Covid-19, a once in a lifetime pandemic event.

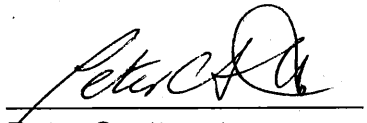
Every member of staff has risen to this challenge with energy, belief and often extraordinary actions and we are proud to have the opportunity to lead such a group of staff, and we should all be proud of how we have supported our patients, families and community through this time.

The change that we achieved during Covid, be it using technology in outpatients, reforming our care planning or realigning our community support, shows us what we are capable of doing: **together**.

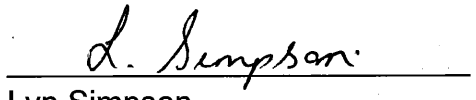
We still have a lot to do to make NCIC a sustainable NHS organisation, from both a quality and financial perspective, and we should not be under any illusion that this will take time, energy and sheer hard graft, but together, we can make NCIC a great place to work, a united organisation with a set of common goals and one that is clinically-led as its core.

As we go into 2020/21, we have begun establishing our transformation programme, mitigating our key clinical risks and starting to address those core development issues, most particularly our culture. This will take time, but this is a programme that will recognise the skills and experience of our 6525 members of staff, across 15 key sites, and more than 70 services. Everyone has a part to play in this change, and how we rise to this challenge will define our future.

So, let's make 2020/21 the year that builds NCIC into what we all want. Never have our values of ***Kindness, Respect, Ambition and Collaboration*** felt so important.



Peter Scott
Chair
23rd June 2020



Lyn Simpson
Chief Executive
23rd June 2020

1. PERFORMANCE REPORT

1.1 Overview

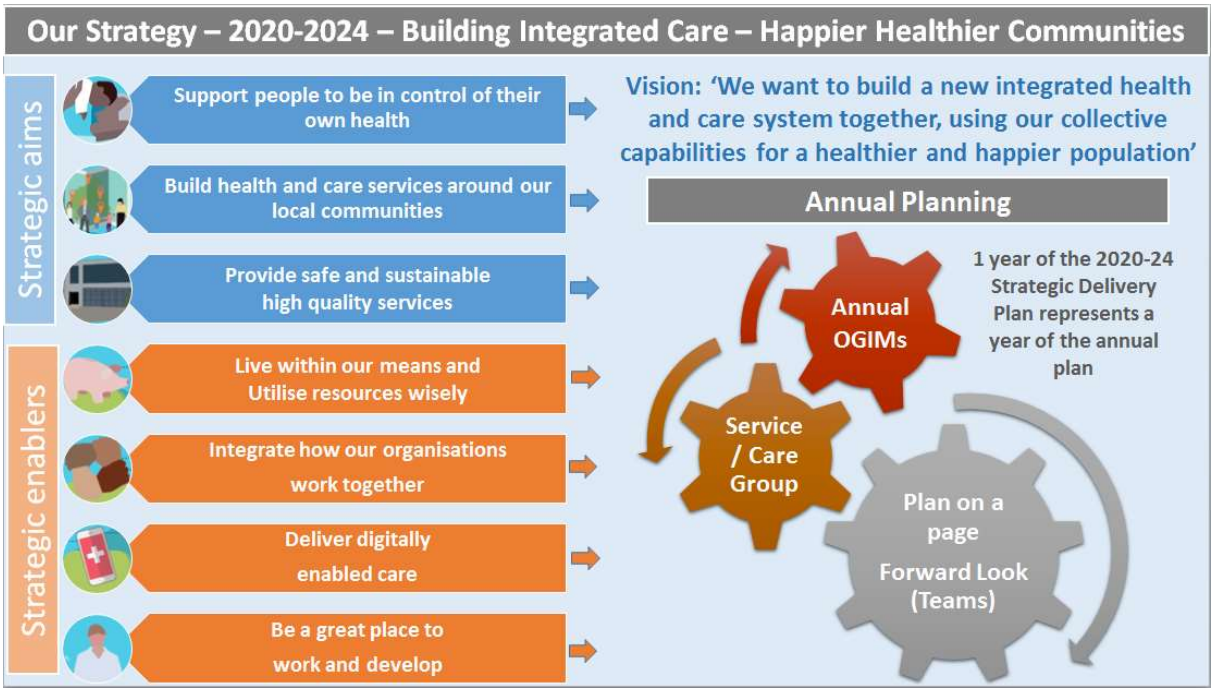
The purpose of the Overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

The format and content of the Annual Report and Accounts for 2019/20 has been prepared in line with the revisions published in the Foundation Trust Annual Reporting Manual 2019/20 in April 2020.

The Organisation

North Cumbria Integrated Care NHS Foundation Trust (NCIC) provides hospital and community health services to a half a million people. We're responsible for delivering over 70 services across 15 main locations and we employ 6,525 members of staff (4,915 whole time equivalents).

Our vision is shared by our partners in the north cumbria health and care system **to build a new integrated health and care system to create healthier and happier communities.**



Aim or Enabler	Strategy Aim/ Enabler	Annual Planning OGIMs (Objectives, Goals, Iniatives and Measures)
Aims	Support people to be in control of their own health	Population Health
	Build health and care services around our local communities	ICCs & PCN : improving health & wellbeing across key areas
		Improving Pathways including End of Life Care
	Provide Safe & Sustainable High Quality Services	Deliver improvements and innovations for Urgent Care pathways and operational patient flow
		Deliver improvements and innovations for Elective Care and diagnostics in Secondary Care
		Improve prevention, access treatment and outcomes for all patients requiring our Cancer Services
		Deliver safe, personalised services that are joined up for Children & Families
		Build sustainable External Networks for services that require them
		Improve Safety & Quality across the system
		Deliver Cancer, WCH and Community Hospitals Capital Programmes
Enablers	Be a Great Place to Work	Be a Great Place to Work
	Deliver Digitally Enabled Care	Deliver Digitally Enabled Care
	Integrate how health and care organisations work together	Integrate how health and care organisations work together
	Live within our means and utilise our resources wisely	Live within our means and utilise our resources wisely

In March 2019, we launched our shared values system, which guide the way we work every day from board to ward. Each value has a series of behaviours behind it that we're building into everything we do, from our appraisals to our policies and procedures.

Kindness

Kindness and compassion cost nothing, yet accomplish a great deal.

Respect

We're respectful to everyone and are open, honest and fair.

Ambition

We set goals to achieve the best for our patients, teams, organisation and partners.

Collaboration

We're stronger and better working together with and for our patients.

As an integrated care organisation, we work side by side with partners and the wider community to join up health and care for patients.

Before NCIC was formed on 1 October 2019, the former CPFT and NCUH worked with partners in the wider North Cumbria Health and Care System to become one of the first 14 areas nationally to be confirmed as an Integrated Care System.

Now working as a single Trust, we want to become more embedded in our local community. Not just caring for people but improving their wellbeing too.

In June 2019 a North East and North Cumbria Integrated Care System was created. This means we're able to work together more easily across the region on shared challenges such as sustaining services. Our shared strategy was published in January 2020.

We currently have three care groups, specialist services, integrated care pathways and integrated care communities which provide a range of services including acute services in north cumbria at the Cumberland Infirmary and West Cumberland Hospital and community services.

Key risks and associated controls

Key risks to the delivery of our objectives and associated controls are set out in our Board Assurance Framework (BAF). The BAF is reviewed on a quarterly basis, with the framing of top strategic risks being reviewed on at least an annual basis, usually during quarter 3. Details of the key risks can be found in the Annual Governance Statement.

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the aligned performance framework. Risk reporting and measurement are actioned through our Oversight Framework, quality

and safety dashboards, and via the risk management information system (Ulysses) - all of which enables a line of sight to risk management performance at all levels throughout the Trust. Examples of significant operational and clinical risks affecting us can be found in the Annual Governance Statement.

Statement on going concern

The Trust is required to assess whether its financial accounts should be prepared on a going concern basis. In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support. During 2019/20 the Trust delivered a deficit of £37.8m and increased borrowing from the Department of Health & Social Care by £41.2m to £301.9m. (Borrowing of £256.5m transferred from the North Cumbria University Hospitals NHS Trust at the point of its acquisition.)

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affects loan principal totalling £299.3m as at 31 March 2020. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Trust submitted a draft financial plan for 2020/21 to NHS Improvement to deliver a deficit of £50.1m (inclusive of £11.3m of PSF and FRF funding) which included the delivery of a £24.7m CIP programme. The plan also included revenue and capital support loans of £17.4m. Due to the need for the NHS to focus on responding to the COVID-19 pandemic the 2020/21 contracting and financial planning processes were suspended in March and a COVID-19 financial framework put in place to cover the period to 31 July 2020 in the first instance. This framework ensures that providers receive block payments in advance to reduce the need for invoicing between NHS bodies and to support cashflow. In addition, providers are receiving "top up" income to achieve financial breakeven for this period. However, the Trust does not have final signed contracts with its commissioners for 2020/21 and it is unclear what the contracting arrangements will be for 2020/21 and beyond. This represents a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern.

The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and Clinical Commissioning Group (CCG) allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are still expected to be commissioned. DHSC has also confirmed that temporary revenue support arrangements will continue in order to support providers who are demonstrating cash needs.

Taking these factors into account therefore, and in accordance with the GAM 2019/20 and the Treasury FReM, the Trust's accounts have been prepared by the directors on a going concern basis. The Trust has not included the adjustments that would result if it was unable to continue as a going concern.

1.2 Performance Analysis

Measuring performance

We measure our performance through a mix of key performance indicators and metrics relating to quality, safety, financial performance, and compliance. Board-level performance reports include metrics relating to compliance against the former Monitor risk assessment framework and current NHS England and NHS Improvement's Oversight Framework, and also metrics that enable us to monitor our quality governance. This report was run in shadow form in 2018/19 as a joint performance report monitoring the performance of the NCUH and CPFT and since October 2019 is the Performance report for the newly merged Trust. Performance is monitored and managed through the Joint Trust Management Board and overseen by the Board Committee, Finance Investment and Performance Committee.

We measure our performance against the core CQC domains of responsive, caring, effective, safe and well led. These are included across the core Oversight Framework domains and across the operating plan objectives.

Performance during 2019/20

We use the following performance indicators within our Board level performance reports. Performance breakdowns are provided separately for the 1st 6 months of the year (pre-merger) and for the 2nd 6 months of the year (post-merger and Mental Health Services transfer).

NHS England and NHS Improvement's Oversight Framework

	Measure	National Standard	Trust actuals (All provisional for April - September 19/20) 17/18	18/19	19/20 (Apr-Sep only)	RAG comparisons Compared to National standard	Compared to 18/19	Compared to 17/18
A&E	% of patients who waits 4 hours (Type 3)	95%	95.3%	99.9%	**99.9%**			
IAPT	Recovery Rate	50%	55.1%	54.4%	**55.9%**			
	People with common mental health conditions referred to the programme will be treated within 6 weeks of referral	75%	72.3%	99.7%	**99.9%**			
	People with common mental health conditions referred to the programme will be treated within 18 weeks of referral	95%	99.7%	100.0%	**100.0%**			
Waiting times	% of patients treated within 18 weeks from Referral to Treatment	92%	90.8%	96.3%	**94.4%**			
	% of patients receiving a diagnostic test within 6 weeks of referral	99%	100.0%	100.0%	**99.9%**			
EIP	People experiencing a first episode of psychosis treated with a NICE approved care package within 2 weeks of referral	53%	68.4%	69.2%	**53.7%**			
CYPMH	Improving Access to CYPMH	34%	n/a	n/a	**34.7%**		n/a	n/a

Comparisons key:	
	Significantly worse than
	Slightly worse than
	Same as or better than

	Measure	National Standard	Trust actuals (All provisional for October - January 20) 17/18	18/19	19/20 Oct-Jan only)	RAG comparisons Compared to National standard	Compared to 18/19	Compared to 17/18
A&E	% of patients who waits 4 hours (Type 1 & 3)	95%	n/a	86.8%	**77.4%**			n/a
Cancer	% of Cancer patients seen within 2 weeks from a GP referral	93%	94.6%	91.9%	**92.4%**			
	% of Cancer patients treated within 31 days from decision to treat.	96%	97.6%	95.5%	**96.1%**			
	% of Cancer patients treated within 62 days from GP referral	85%	85.4%	81.9%	**71.9%**			
Waiting times	% of patients treated within 18 weeks from Referral to Treatment	92%	n/a	78.0%	**73.7%**			n/a
	% of patients receiving a diagnostic test within 6 weeks of referral	99%	n/a	95.3%	**86.9%**			n/a

Comparisons key:	
	Significantly worse than
	Slightly worse than
	Same as or better than

We have informed our Regulators and Commissioners of our progress against their performance frameworks throughout the year, and have provided them with details of our improvement plans and trajectories for compliance.

Internally improvement plans are managed through the Care Group Senior Management Team meetings which are as a sub group of the Clinical Management Group, and are closely monitored at Board level through the Finance Investment and Performance Committee.

Workforce performance

Recruitment and the use of temporary staff

We, along with our partners in the Cumbria health and social care system, continue to face significant challenges in the ability to recruit people into Cumbria with the right skills and experience to fill vacancies in our specialist roles. We continue to work together with our local partners and with leaders in the regional major transformation programmes to find workable solutions to this challenging problem.

Throughout the first part of the year CPFT worked collaboratively with North Cumbria University Hospitals NHS Trust (NCUH) on a number of attraction initiatives. After the merger this collaborative work continued with North West Ambulance Service (NWAS), work which has been recognised with a number of prestigious award nominations for 'Recruiting for the system, not just ourselves'.

Examples include:

- Attendance at various national recruitment fayres with partners including attendance at the Royal College Radiology Annual Conference.
- 20 + university nursing events.
- Various Health Service Journal events in collaboration with North West Ambulance Service NHS Trust (NWAS) sharing expertise and costs.
- Local recruitment events.
- Use of social media to promote specialist vacancies.
- International recruitment for clinical posts (including successful trips to Poland for nurses and India for doctors, who are now in post) and an exploratory trip to Italy.
- On-site Collaborative Nurse/Midwife and Paramedic Recruitment Days, held in conjunction with the North West Ambulance Service NHS Trust and University of Cumbria.
- Joint British Medical Journal Adverts.

We have actively sought to recruit into vacant posts during the year, but where vacancies exist we ensure safe staffing levels by first looking to use bank staff, before approaching temporary recruitment agencies via the Health Trust Europe (HTE) framework.

Agency spend and management has been managed by the NCIC in-house team. This team's work has been recognised by NHSE/I who described the team's work as a 'national exemplar'. Although saving money and delivering efficiencies is a priority, processes are committed to patient safety improvements and the team has worked closely with NHS Counter-Fraud to advise on reference and time-sheeting security.

The booking of agency workers is now linked to the requirement to action permanent or fixed term recruitment to ensure that the most cost-effective staffing solution is identified.

Spend (particularly agency nurse spend) has increased since October due to the continued situation of escalated beds (un-funded and non-establishment staffed) which is in part due to challenges within social care and the inability to discharge safely.

Sickness absence

Sickness absence is reported at Board level on a monthly basis. Our sickness absence level has been above our internal target level of 4% throughout the year. Sickness absence rates are consistently higher in clinical roles than in non-clinical roles; whilst long term sickness absence accounts for the majority of the overall days lost through sickness. Anxiety/stress/depression or other psychiatric illness is the top reason for sickness absence. We have an Attendance Management policy and a number of programmes in place to support staff.

Staff survey

Cumbria Partnership NHS Foundation Trust (CPFT):

The CPFT response rate for the 2019 NHS staff survey was 40% compared to a national median of 48%. One theme, 'Morale', has the lowest score nationally. The results show that staff engagement has dropped to 6.8; Staff recommendation of the Trust as a place to receive treatment is lower than average at 60.8% (average is 67.5%) and recommendation as a place to work is lower than average at 54.4%, (average is 62.4%). The theme for Equality, Diversity and Inclusion remains above the national average.

North Cumbria University Hospitals NHS Trust (NCUH):

The NCUH response rate for the 2018 NHS staff survey was 34% compared to a national median of 47%. Eight of the 11 themes have the lowest score nationally. The results show that staff engagement has dropped to 6.1; staff recommendation of the Trust as a place to receive treatment is 39.7%, which is the worst score nationally (average is 70.5%) and recommendation as a place to work is 36%, which is the worst score nationally (average is 62.5%).

You can find further details about the staff survey results, and other ways we engage with our staff, in the Staff Report.

Learning and Development

The Learning and Development function continues to adapt and develop to meet the changing demands associated with supporting staff both within the Trust and across the wider health and care system to meet their learning needs.

As part of our work for 2019/2020 we have recognised the need to improve our approach to statutory and mandatory training by raising the quality of training and linking it explicitly to the quality and safety of patient care and to professional standards. Work has been underway to develop a single revised Learning Needs Analysis (LNA) based on 3 levels that are linked to the quality and safety of patient care and to professional standards – Core Skills Framework subjects, Organisation Essential Learning and Role Essential Learning. The compliance target for 2019/20 is 90% and compliance is measured and reported upon on a monthly basis. The Trust achieved 80% compliance for Core Skills Framework subjects as at the end of March 2020.

Our apprenticeship offer continues to grow. There are currently 195 apprentices on programme across a range of occupations including Registered Degree Nurse, Operating Department Practitioner, Senior Leadership and Advanced Clinical Practitioner. Levy is being transferred to local GP practices to facilitate development of their staff in Nurse Associate and Advanced Clinical Practice apprenticeships.

We have achieved Fair Train Quality Standard Silver Award for our work experience opportunities across the organisation. As part of the Talent for Care programme, our Step into Work continues to offer a successful route into healthcare roles for local unemployed people. We continue to support a range of accredited vocational training programmes covering: ILM (Institute of Leadership and Management) Level 3 Leadership and Management, Health Level 3, Business Administration Level 2 and Level 3 Vocational Qualifications.

The integrated Clinical Skills team continues to develop and offer a range of clinical skills training and competency development across our health and care system. The team have been involved in the roll out of the Stop and Watch Tool, a project supported by the Academic Health Science Networks (AHSN) and designed to support spotting signs of deterioration and early intervention. Staff across the system have attended clinical skills workshops on dementia awareness, ear care, pressure ulcer awareness and Aseptic Non-Touch Technique (ANTT). These workshops have also been delivered to non-registered staff working in primary care. Work to develop a competency hub at Maryport Hospital supports staff in the community to gain skill competency and this initiative recently won the Innovation in Education category at the Bright Ideas in Health Awards. Further work is underway to develop competency hubs across our localities.

A single Corporate Induction programme is now underway and incorporates essential components of both culture and compliance. Our newly started non-registered workforce

continue to complete the Care Certificate and revised extended development programme as part of the mandatory requirements of their induction into the Trust.

Appraisals

We have launched a new approach to performance management. This consists of 4 conversation a year covering Talent, Appreciation which included values, Learning and Development, Service improvement and Wellbeing. Objectives can be set for short, medium or long term and the conversations build on each other.

This approach is to continue our aims, to ensure that:

- All staff to have a meaningful appraisal that is linked to our values and translates the work of the Trust to individual objectives.
- All staff to have a personal development plan (PDP) but also recognise how they learn on the job.
- Supporting performance through a coaching culture.

The Trust has an appraisal window which links with the business planning cycle to ensure objectives are aligned to the Trusts priorities and staff can understand how they are contributing. The Trust increased its target over the course of the financial year from 85% to 90% by March 2020 of all staff to have an appraisal within the last 12 months. The rate was 62.5% at the end of March. This reduction has been attributed to organisational change, restructure, high service demands and latterly the COVID-19 incident.

An additional review of the approach was carried out in quarter 4 2019/20 to review how the Quarterly TALKS appraisal process was being used and how it is perceived. A sample of staff were surveyed, the conclusion of which was that the Quarterly TALKS approach generally seems to be accepted as a good methodology for structuring a frequent one-to-one conversation. However the structure of the meeting can be made simpler and less repetitive. There is still a sense of the appraisal process being 'tick box' in nature although the quality of the one-to-one conversations varies widely which is in line with feedback from previous appraisal processes. As a result of the this the Trust is simplifying the process and providing revised training for managers to enhance their skills around psychologically safe conversations and the importance of regular supervision.

Delivery of 2019/20 Annual Business Plan

Our 2019/20 Annual Business Plan, developed in accordance with NHS Long Term Plan, was produced in partnership across North Cumbria with North Cumbria Integrated Care, North Cumbria Clinical Commissioning Group and input from other partners. The Board received quarterly updates on delivery against the plan and the majority of the business plan objectives have been completed or were close to completion at the year end.

A proposed set of objectives for 2020/21 had been drafted ready for sign off by the end of March 2020, however, the Covid-19 outbreak has meant that some of these development priorities were delayed whilst we focussed on our response to this pandemic. These proposed objectives are now being reviewed so that we can ensure that the priorities are in line with the new government guidelines on Covid-19 and how we respond to the pandemic locally.

Care Group / Support Service	Red	Amber	Green/ Complete	Grand total
Population Health	2	2	1	5
Integrated Patient Pathways	1	1	0	2
Safe & Sustainable Services	0	1	0	1
ICCs, Primary Care & Communities	1	3	1	5
Integration	1	1	0	2
People	0	3	0	3
Elective Care	1	1	3	5
Cancer	0	2	1	3
Urgent & Emergency Care	0	4	0	4
Children & Families	1	2	1	4
Safety & Quality (including GiRFT)	0	1	3	4
Estates	0	6	2	8
Digital & Business Intelligence	2	2	1	5
Grand total				51

Financial performance

The 2019/20 financial climate was particularly challenging for the Trust. The Trust experienced severe operational pressures in Q3 and Q4 resulting in periods where over 100 beds were occupied with patients staying more than 21 days. The Trust also responded to the COVID-19 incident in March. The Trust deficit for the year (excluding impairments, donations and transfer by absorption) was £37.8m against a control total of £7.8m before Provider Sustainability Funds (PSF) and Financial Recovery Funds (FRF), £30m slippage. The Trust failed to qualify for all of its core PSF and FRF but was, however, able to access a further £16.9m of FRF incentive funds at the year-end following

a national re-distribution of funds. These funds do not score against the control total but support cash flow.

The financial challenge will continue across the north Cumbria health and social care economy during 2020/21 and beyond. The planning process for 2020/21 has been disrupted due to the need to focus on the COVID-19 incident .The Trust's control total for 2020/21, set before the COVID-19 incident, is a deficit is £47.1m. The Trust's Executive Directors have recommended setting budgets, pending a steer from the regulator as COVID-19 exit plans evolve, with slippage of £14.3m (including loss of Marginal Rate for Emergencies Tariff (MRET) funding), giving a Trust deficit plan for budget purposes of £61.4m before FRF and PSF of £11.3m.

Achievement of this plan and delivery of sustainable services in the long term will be challenging and will require significant efficiencies from both internal programmes and continued system wide transformational change.

In recent years the Trust has utilised revenue support loans from the Secretary of State for Health and Social Care to fund its operating deficits. Total borrowing from DHSC at 31 March 2020 was £301.0m. On 2 April 2020 the Secretary of State announced that all interim revenue and capital funding will be exchanged during 2020/21 for public dividend capital (PDC). This will result in £299.3m of the Trust's loans being converted to PDC.

The Trust awaits further information on how providers with ongoing deficits access cash support going forward but it is possible that further borrowing from DHSC will be required until the Trust is able to stabilise its financial position.

Details of the Trust's financial performance for 2019/20 is set out in the annual accounts that accompany this Annual Report.

Environmental considerations

We are committed to being an environmentally friendly and socially responsible organisation and recognises that some of our activities can have a significant impact on the environment. We continue to take action to ensure these activities are managed effectively to minimise any impact and to ensure that we comply with, or exceed, relevant statutory requirements. We have continued to implement measures during 2019/20 to reduce greenhouse gas emissions and drive forward opportunities for cost savings.

Social, community and human rights issues

As a public sector organisation we have to comply with public sector equality duty, which is part of the Equality Act 2010. Our policies reflect social, community and human rights issues, for example information governance and safeguarding of vulnerable persons. Our five year Clinical Strategy 2019-2024 informs how we will work with community groups on

the development and implementation of our services. We also have an equality and diversity policy and procedures for assessing impacts of significant change to our services on all those affected or vulnerable groups. In 2019/20 we have taken steps to ensure we meet the Trust's responsibilities under the Modern Slavery Act 2015, further detail can be found under Voluntary disclosures.

You can find out more about the measures we have taken, and our achievements during the year, in the Directors' Report.

We have systems in place to identify whether any incidents or complaints have occurred relating to human rights, equality, and diversity issues, and for initiating investigations accordingly. Board level reports include information around reported incidents and complaints as part of the performance management reporting framework.

Significant events since the end of the financial year
COVID-19 caused significant disruption and impacted our performance during latter stages of 2019/20 and into quarter 1 of 2020/21. At the time of writing we are phasing back into operation services which had been paused or scaled back due to COVID-19. This is being done in a planned and risk-based manner to ensure the safety of our patients, staff and others affected by our services.

Overseas operations
We do not have any overseas operations.

Signed ..... Date: 23rd June 2020

Lyn Simpson
Chief Executive

2. ACCOUNTABILITY REPORT

This comprises the following reports:

- Directors' Report
- Remuneration Report
- Staff Report
- NHS Foundation Trust Code of Governance – Disclosures
- NHS Oversight Framework
- Statement of Chief Executive Officer's Accounting Responsibilities
- Annual Governance Statement
- Voluntary Disclosures comprising:
    - Equality and Diversity
    - Modern Slavery Act 2015

Signed L. Simpson..... Date: 23rd June 2020

Lyn Simpson
Chief Executive

2.1 Directors' Report

NHS England and NHS Improvement's Well-Led Framework
As an NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulator, NHS England and NHS Improvement (NHSE/I), in Monitor's NHS Foundation Trust Code of Governance (2010, revised 2014). The Code of Governance requires us to have a comprehensive framework in place to ensure we are managed and governed properly. We strive to comply with the provisions of the Code and will continue to observe the spirit of the Code in everything we do.

Our business is managed by the Board of Directors (the Board), which exercises all the powers of the Trust subject to any contrary provisions of the National Health Service Act 2006 and Health and Social Care Act 2012. The Board is responsible for approving the Annual Report and Accounts. In preparing the Annual Plan, they take into account the views of the Governors' Council which contains information about the Trust's forward planning.

The Board of Directors gives specific attention to:

- Active monitoring of quality indicators
- Assurance based on evidence
- Contact with frontline services
- Formal consideration of our compliance with NHSE/I's Well Led Framework and Code of Governance

The Quality Report describes our quality plans in more detail and outlines our achievement of quality over a number of specific areas. You can find out more about our quality governance, the challenges encountered and action taken during 2019/20 in the Annual Governance Statement.

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and with our Standing Orders.

There were a number of changes to Board membership during the year which can be found in the Remuneration Report. You can find out more about the background and experience of all individual Board members as at 31 March 2020 later in this report.

All NEDs, the Chief Executive and a maximum of six other Executive Directors were able to exercise one full vote in 2019/20. The Chair has a second, casting vote on occasions where decisions are tied.

The Board meets formally in public every two months and monthly in private. There were no extra-ordinary meetings of the Board held during the year in addition to scheduled

meetings. A summary of decisions made by the Board is provided at each public Board of Directors meeting. The Board is responsible for:

- Exercising powers and the performance of the Trust
- Providing active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Compliance with the NHS Provider Licence issued by NHSE/I, the sector regulator for health services in England
- Compliance with the Trust's Constitution
- Providing high quality and safe healthcare services, education, training and research
- Implementing effective governance measures
- Ensuring the Trust exercises its functions effectively, efficiently and economically
- Setting the Trust's vision, values and standards of conduct and ensuring that its obligations to its Members, service users and other stakeholders are understood and met
- Setting Trust policy
- Setting strategy for service development and improvement
- Preparing a statement of accounts for each financial year
- Managing performance.

The Board has a schedule of matters reserved for it that is detailed within our Standing Orders and the Reservation and Delegation of Powers, and Standing Financial Instructions. This clarifies which type of document requires approval by the Board and which can be approved and executed by executive management, under a delegated authority. The Board may also delegate executive powers to Committees or through the Chief Executive to individual officers.

To undertake detailed consideration of specific areas of operation, the Board utilised the following Committees throughout the reporting period:

- Audit and Risk (A&R) Committee
- Quality Improvement and Safety (QIS) Committee
- Finance, Investment and Performance (FIP) Committee
- Charitable Funds Committee
- Remuneration Committee

All NEDs are members of at least one Board level Committee. Executive Directors' involvement in Board level Committees relates to their particular operational responsibilities.

As a unitary board, all Executive and NEDs have joint responsibility for every decision of the Board and share the same liability. This does not impact upon the particular responsibilities of the Chief Executive as Accountable Officer to Parliament, for ensuring that the Trust operates consistently within national policy and public service values.

All Directors have responsibility for the preparation of the financial statements. The Directors consider whether the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for service users, regulators and stakeholders to assess our performance, business model and strategy.

As part of the evolution of the North Cumbria Integrated Health and Care System, prior to the merger between Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals Trust (NCUHT) on 1st October all Executive Directors held responsibility for both Trusts. Four Non-Executive Directors (NEDs) including the Chair held appointments in both Trusts. 'Cross-directorships' did not compromise independence as conflicts were minimal as the interests of the two Trusts align. Before and after merger all NEDs were and are considered to be independent in character and judgement and have no other cross directorships or significant links which could materially interfere with the exercise of their independent judgements. Arrangements are in place to manage any potential conflicts associated with 'joint' NED appointments. The Chair had no other significant commitment during the year and therefore there was no requirement to report on this issue to the Governors' Council. You can find out more about our collaborative working with NCUH in the Annual Governance Statement section of this annual report.

All Directors on the Board and the Lead Governor on the Governors Council are required to meet the 'fit and proper persons' test as described in the NHS Provider Licence issued by NHSE/I. You can view the updated Register of Board of Director Interests on our website
https://www.ncic.nhs.uk/trust/publications

Table 3.1 shows members of the Board, their roles and attendance at Board and Governors Council general meetings during the year. Regular attendance at meetings of the Governors Council provides the opportunity for members of the Board to gain an understanding of the views of governors and members. The Board and Governors Council undertake a programme of joint visits to Trust services. This programme enables NEDs and governors to listen to the views of staff and observe service delivery.

The Chair is responsible for ensuring that NEDs have the necessary skill set and experience. The Chief Executive is responsible for the performance appraisals of Executive Directors. The performance of the Chief Executive and NEDs is reviewed by the Chair, and the performance of the Chair is reviewed by a combination of the NEDs, governors and Executive Directors. The Senior Independent Director leads the Chair process with the arrangements agreed by the Governors Council.

All NED vacancies are managed by the Governors Council's Nominations Committee to ensure the Board has the necessary skills and experience required and that the Board is well balanced. The terms of office for both Chair and NEDs is reviewed regularly to ensure succession planning is adequate and effective. In January 2020 Robin Talbot resigned from his position as Chair with effect from 31 March 2020. Activity to recruit his

successor began in January 2020 but was paused in March 2020 due to COVID-19 disruption. Peter Scott took up post as interim Chair on 1st April 2020 and will continue in post until a substantive Chair appointment is made during 2020/21.

All Executive Director positions, covering issues of recruitment, accountability and performance, are managed by the Chief Executive in line with the Trust's organisational policies. The current appointment terms of Non-Executive Directors, and the contract start dates of Executive Directors and their remuneration can be found in the Remuneration Report. The appointment of a NED may be terminated in line with guidance issued by our regulator NHSE/I. The accounting policies for pensions and other retirement benefits are set out in note 1.8 to the accounts.

Table 3.1 Board of Directors and attendance at Board and Governors' Council General meetings 1 April 2019 – 31 March 2020

Name	**Attendance – Board of Director meetings (max 13) (actual/potential)**	**Attendance* – Governors' Council General meetings (max 6) (actual/potential)**
Current Non-Executive Directors		
Peter Scott	n/a	n/a
Dr Louise Nelson PhD	11/11	2/6
George Liston	10/11	4/6
Malcolm Cook	11/11	6/6
Jeff O'Neill	5/5	4/6
David Allen	5/5	1/2
Susan Mckenna	3/4	0/1
Other Non- Executive Directors in post during 2019/20		
Prof. Robin Talbot, PhD, BA, Cert Ed	8/11	6/6
Alan Moore, BSc (Hons), CEng, MIMechE, MBA, FAPM	4/6	2/4
Heike Horsburgh, MBE	5/6	2/4
Brian Hetherington BSc(Hons) MSc MBA(Comm) CEng FIMechE DipIM FCMI MIoD	4/6	1/4
Current Executive Directors		
Lyn Simpson	/3	1/1
Prof. John Howarth MBBS, DTM&H, FRCGP, FFPH	9/11	4/6
Dr Rod Harpin	n/a	n/a
Ramona Duguid	9/11	3/6
Mandy Nagra	6/11	0/6
Michael Smillie, BSc (Hons), FCPFA	9/11	1/6
Anna Stabler	4/5	0/1
Justine Steele	n/a	n/a
Other Executive Directors in post during 2019/20		

Name	Attendance – Board of Director meetings (max 13) (actual/potential)	Attendance* – Governors' Council General meetings (max 6) (actual/potential)
Prof. Stephen Eames	7/8	3/5
Dr Vince Connolly	9/11	0/6
Gary O'Hare	6/7	1/4
Alison Smith	4/9	0/5
Judith Toland	6/7	0/3
Peter Rooney	6/7	2/2
Mike Proctor	1/4	n/a
Mike Wright	2/3	n/a

* There is not a requirement for Board members to attend the Governors' Council meetings. However there is an open invitation. Attendance reflects the number of meetings they attended in the year, out of the total number that they could have attended, based on their appointment or departure date.

Director profiles

Non-Executive Directors

Peter Scott

Interim Chair

I was appointed as Interim Chair to lead the Trust's Board of Directors and Governors' Council in April 2020.

My previous positions include working at various levels of the NHS locally at North Cumbria Acute Hospital, Cumbria Clinical Commissioning Group and Newcastle Hospitals together with national roles at the Department of Health.

Malcolm Cook

Non-Executive Director / Vice Chair

I was appointed to the Board in October 2019 and appointed Vice Chair in November 2019. I was previously appointed to the Board of NCUH in December 2013 and CPFT in August 2018.

I worked for British Telecom (BT) for 27 years in a variety of roles, including Head of Service Excellence and Customer Research.

At BT, I led a team that negotiated the largest human resources outsource contract ever seen. I received an international business outsourcing award for Customer Relationship of the Year in recognition of my work.

Between 2007 and 2013, I was a Vice Chair and Non-executive Director at NHS County Durham.

Louise Nelson PhD

Non-Executive Director

I was appointed to the Board in October 2019, previously appointed to the Board of CPFT in March 2018.

I completed my training as a mental health nurse in 1987 and completed an MBA while working as a Senior Manager in the NHS.

Since 2005, I've worked in higher education as a Senior Lecturer and Programme Leader for mental health nursing.

I was Head of Nursing, Health and Professional Practice at the University of Cumbria which I left in September 2019.

I obtained a PhD in 2014, based on service users' experiences of mental health services and in 2018 completed a qualification as an Executive Coach.

George Liston

Non-Executive Director / Senior Independent Director

I was appointed to the Board in October 2019 and appointed as Senior Independent Director in November 2019. I was previously appointed to the Board of NCUH in July 2015 and CPFT in August 2018.

I served in the Royal Air Force for over 30 years including 13 years as a Wing Commander.

During my time in the Royal Air Force, I gained experience in strategic planning and management and was based in a number of countries. I retired from the Royal Air Force in January 2015 and I'm currently President and Chair of Scottish Fencing Ltd.

Jeff O'Neill

Non-Executive Director

I was appointed to the Board in October 2019, previously appointed to the Board of NCUH in November 2018.

I'm a Chartered Accountant and formerly the Global Director of Finance of North Group, an international marine insurance group of companies based in Newcastle.

I am also a Non-executive Director of Justships Ltd which is a wholesale marine insurance broker. I was until 2019 Chairman of RASCALS Ltd, which was a community social enterprise providing affordable childcare in south east Northumberland.

David Allen

Non-Executive Director

I was appointed to the Board in October 2019, shortly after being appointed Chief Executive of Cumbria Council of Voluntary Service in July 2019. I was the Chief Executive of the Faculty of Public Health (2013 to 2018) – one of the professional bodies that form the Academy of Medical Royal Colleges.

I held several senior management positions at the Royal National Institute for Blind People – including Head of Prevention; Head of English Regional Services and Director, Northern Ireland.

I'm a Fellow of the Chartered Management Institute and of the Royal Society of Arts, Manufacturers and Commerce.

Susan Mckenna

Non-Executive Director

I was appointed to the Board in October 2019.

I have spent the last 36 years as a nurse within clinical care or management and leadership roles in both physical and mental health and holds current registration in both.

I retired from my previous role as Chief Operating Officer at South West London and St George's University Hospitals NHS Trust in December 2019. I was previously Chief Operating Officer at Avon and Wiltshire Mental Health Partnership NHS Trust and Director of Nursing, a culmination of many years of operational management.

EXECUTIVE DIRECTORS

Lyn Simpson

Chief Executive

I was appointed as Chief Executive in January 2020.

I have a wealth of clinical and executive director level experience working in the NHS at a local, regional and national level.

I started my career in the NHS as a nurse and I am also a qualified midwife and health visitor.

I have worked as an executive and board director since 1992 across a variety of different NHS sectors of which have included roles such as, director of patient services for Newcastle Hospitals trust, regional nurse / director of operations and workforce for the Strategic Health Authorities and nationally as director of NHS operations at the Department of Health.

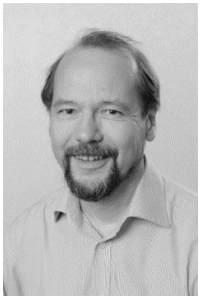
I have led a number of high profile national programmes of work for example coordinating the health service response to the London 2012 Olympics along with national emergency preparedness response, incident specific issues. I was responsible for providing oversight of NHS performance and operations, communications and briefings for NHS operational matters to the director general, ministers and NHS chief executive as well as having national responsibility for the NHS interface with military health.

I was the regional director for the North at the NHS Trust Development Authority which subsequently became NHS Improvement and I was involved in providing leadership and engagement for 70 NHS organisations across the North East and Yorkshire and North

West region including acute, community, mental health and ambulance trusts as well as NHS Foundation Trusts.

Recently I led, on behalf of the region, the early phases of integration and transformation in the Tees Valley, which included designing and executing a clinical services strategy, financial recovery plan and an options appraisal process for organisational form.

I remain passionate about ensuring the delivery of safe, high-quality care for patients as well as developing staff and services and look forward to working with colleagues to continue to build on the good work already done and help improve areas through the engagement of clinicians and staff and partnership working.



Professor John Howarth MBBS, DTM&H, FRCGP, FFPH

Deputy CEO / System Clinical Lead NC / Professor of Primary Care UCLAN / Clinical Lead CLIC

I joined the Board in January 2012 and was appointed as Deputy Chief Executive Officer in September 2017.

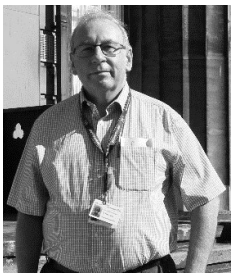
I've been a practicing GP in West Cumbria for over 30 years. I was previously the Clinical Director for Community Services and Elderly Care Lead for NHS Cumbria PCT

Prior to this I spent 7 years as Medical Director of Cumbria's GP out of hours cooperative, chaired the Primary Care Research Group and was a GP trainer for over 10 years. I was medical adviser to the local Hospice at Home charity and co-authored a textbook in palliative care.

During the 1990s, I trained in tropical medicine and worked in 11 different wars and natural disasters zones. I was Medical Director and Head of Operations of an international disaster relief charity.

In 2010 I was a runner up in the national NHS Leadership Awards from over 1000 entries.

In 2011 I received a Fellowship in Public Health through distinction and in 2013 I received a Fellowship to the Royal College of General Practitioners.



Dr Rod Harpin

Interim Executive Medical Director

I am currently Interim Executive Medical Director appointed to the Board April 2020

I am the Trust's Responsible Officer and have been so since January 2017 and previously held the appointment of Executive Medical Director to the Board of NCUH from September 2016 to April 2019.

I am a practising Consultant Anaesthetist and Intensive Care Specialist within the Trust.

I previously practiced medicine in Northland, New Zealand, providing Anaesthesia, Intensive Care, helicopter retrieval and multiple roles in Medical Administration leading groups of elective and acute services as well as diagnostics. I spent many years both in Service Management and as a Clinical Director gaining an Australasian Fellowship in Medical administration leading to my widened range of qualifications: BA, MB BS , MRCP, FRCA, FANZCA FRACMA.

Between 1988 to 1990 and then 1996 to 2001 I worked as a Consultant in Intensive Care and Anaesthetics in Newcastle following my senior registrar training in the Northern Health Authority Rotation. The latter time period included the role of Clinical Director in Newcastle.

Michael Smillie BSc (Hons) FCPFA

Executive Director of Finance, Estates and People

I joined the Board in January 2007 and became joint Director of Finance and Estates during 2018 prior to the Trust merger. Having joined the NHS in 1993 I have worked as an Executive Director on numerous NHS Boards since October 2001.

I have over 25 years' experience working in the NHS and have held posts as a Director of Finance, Director of Commissioning and Director of Business Development in both commissioning and provider organisations in England.

During my time in the NHS, I've been involved in a number of transactions such as Transforming Community Services and other mergers. I'm passionate about making sure services are delivered in the most effective way.

I lead on financial stewardship and forward planning for the Trust and I'm working with our partners to improve the health and care system.

I also lead on ensuring the Trust's estate and facilities are fit for purpose and properly developed to support clinical care.

I ensure that the Trust is adopting digital technology in an effective and safe way as we modernise our services.

Anna Stabler

Interim System Executive Chief Nurse

I joined the Board in December 2019 as Interim System Chief Nurse, after being Deputy System Nurse and Director of Nursing and Quality within NHS North Cumbria Clinical Commissioning Group.

I am a registered nurse and midwife with over 34 years' experience and have also worked as a public health practitioner across acute and community services and within NHS England, including at the former North Cumbria University Hospitals NHS Trust. I am passionate about continuous improvement and the development of both nurses/midwives and the wider workforce both in extending their roles and expanding their skills so that they have a clear career pathway.

Mandy Nagra

Chief Operating Officer (on secondment to NHSE/I)

I joined the Board in 2018 and my post covers NCIC and the wider North Cumbria Health and Care System.

I was previously the Delivery and Improvement Lead for NHS Improvement in Cumbria and the North East. I've been instrumental in improving patient flow across the system and embedding the first phase of integrated care communities.

I've worked in the health and social care system for 24 years in a range of roles, including clinical and managerial, both nationally and regionally.

I bring experience from my work with NHS England and NHS Improvement where a key part of my role was to support North Cumbria.
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Ramona Duguid

Interim Executive Director of Operations

I took up post as Interim Executive Director of Operations in April 2020. Prior to this I was the Executive Director of Strategy for the Trust and the wider North Cumbria Health and Care System. I have worked in a range of roles across the NHS over the last 20 years, including leading improvements in governance, quality and performance within north Cumbria.

I have also led on the wider system integration priorities with our health and care partners across North Cumbria as part of establishing our integrated health and care partnership arrangements.

I was born in Cumbria and I'm passionate about helping to improve and develop our local health and care services for the future with our partners.

Dean Oliver

Interim Executive Director of Performance and Improvement (on secondment from NHSE/I)

I joined the Board in April 2020 as part of its interim management team arrangements.

I have over 30 years of experience of working within and around the NHS having previously worked as a senior manager across a number of acute, community, mental health and primary care sector organisations within NHS; as well as working as a senior management consultant for 14 years where I obtained a blend of commercial and extended health care industry experience. My focus during this time has been largely spent on supporting health care organisations to improve their performance and strategic planning functions. I returned to working for the NHS two and a half years ago when I took on the role of the Regional Productivity Lead working for NHSE/I helping a number of NHS Trusts across the North improve their productivity performance.

I have a Masters in Business Administration (MBA) which I obtained from Durham University Business School along with a Certificate in Health Economics which I obtained from Health Economics Research Unit at the University of Aberdeen. I have also attended a number of management and international leadership training events at both Judges Business School at Cambridge University and at Durham University.

In my spare time I enjoy walking, going to the cinema and listening to music.

Justine Steele

Executive Director of People and Organisational Development

I joined the Board in May 2020 after working at Director Level for over 18 years within both the public and private sectors. My experience is as a generalist within Human Resources and Organisational Development.

Other sectors that I have worked within over the years include: Engineering, the NHS (in Airedale and Pennine area), Police (in Cheshire) and Facilities (in Operon).

Over the years I have been committed to my personal continuous development and have attained a Masters in Strategic HRM and Executive Coaching and Mentoring. I am also a trained mediator and a Fellow of the Chartered Institute of Personnel Development (CIPD).

Volunteering has been a personal focus for me for many years having being a Justice of the Peace for nearly 20 years and chairing the Lancashire branch for the CIPD until recently.

Political or charitable donations

The Trust has not made any political or charitable donations during 2019/20.

Better payment practice code

In July 2015, the Trust renewed its signatory to the Prompt Payment Code. The Prompt Payment Code sets standards for payment practices and best practice and is administered by the Chartered Institute of Credit Management. Compliance with the principles of the code is monitored and enforced by the Prompt Payment Code Compliance Board. The Code covers prompt payment, as well as wider payment procedures.

As a signatory of the code, the Trust undertakes to pay suppliers on time and in accordance with agreed terms; to give clear guidance to suppliers advising them promptly if there is any reason why an invoice will not be paid to the agreed terms; and to encourage good practice.

NHS targets are that all NHS and non-NHS trade payables are paid within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. In order to be compliant at least 95% of invoices should be paid within 30 days or within agreed contract terms. Due to the Trust's ongoing liquidity pressures the target was not achieved in 2019/20.

	Current Year to Date	
	Number	**Value (£000s)**
Non NHS		
Total bills paid in year	54,461	129,916
Total bills paid within target	24,108	85,202
Percentage of bills paid within target	**44.3%**	**65.6%**
NHS		
Total bills paid in year	2,012	25,284
Total bills paid within target	843	17,649
Percentage of bills paid within target	**41.9%**	**69.8%**
Total		
Total bills paid in year	56,473	155,200
Total bills paid within target	24,951	102,851
Percentage of bills paid within target	**44.2%**	**66.3%**

During the year, the Trust paid £8k of interest under the Late Payment of Commercial Debts (Interest) Act 1998.

Quality governance

During the year we have built upon the work described in previous years' annual reports to improve and integrate our governance arrangements with NCUH, culminating with the merger on 1st October to form NCIC. This has included refreshing our organisational and meetings structures and further developing our quality and safety dashboards so that our managers have access to virtually real-time risk and safety related information which aids effective clinical and quality governance.

Our 2019/20 self-assessment against the Well Led framework commenced in Quarter 3 and was due to be approved by the Board in April 2020. Unfortunately conclusion of the 2019/20 well led self-assessment was delayed due to COVID-19 disruption. We anticipate this will be completed during quarter 2 of 2020/21. An external assessment of our arrangements against the Well Led framework is also planned for 2020/21. Delivery of improvement actions from well led self-assessments and other internal and external reviews are monitored through relevant governance forums, with board level oversight of many actions through the Quality Improvement and Safety Committee and Finance Investment and Performance Committee. Further details on NHSE/I's Well Led framework can be found in the Annual Governance Statement.

The 2019/20 internal audit programme considered aspects of quality governance such as risk management, board assurance framework, governance framework, policy management and safety alerts, all of which are intrinsic to the well led framework. Progress with improvement actions identified from audits are monitored by the Audit and Risk Committee.

Our performance management framework was in place throughout 2019/20. The Board received quarterly updates on progress against the 2019/20 annual business plan. The Board also received integrated performance reports on a monthly basis, which compared and analysed information relating workforce, finance and quality. Further details on how the performance management framework and our performance during the year can be found in the Performance Report.

Throughout the year we have reported compliance against the NHS Oversight Framework in accordance with NHS England and NHSE/I's reporting requirements. There have been no exceptions to report during the year. We meet with NHSE/I on a quarterly basis to review performance and quality. You can find out more about our quality governance in the Annual Governance Statement. Details of our performance in relation to key health targets, our financial position, use of resources, achievement of CQUIN (Commissioning for Quality and Innovation) and other locally agreed targets, and progress against our business plan objectives for 2019/20 can be found in the Performance Report. Details of how we are improving information for patients and carers and how we handle complaints, and also how we have responded to patient and staff surveys can be found in the Quality Report which is published separately.

The Board agreed the 2018/19 annual report, including annual accounts and quality report at its meeting in May 2019. The 2018/19 annual report was submitted to NHSE/I and laid before Parliament within the required timeframes, and was presented to Members and the general public at our Annual Members Meeting in September 2019.

There are no material inconsistencies between our Annual Governance Statement, the corporate governance statement, the Quality Report and Annual Report, reports arising from CQC planned and responsive reviews, and action plans we have developed in response to the CQC's reports.

In January 2020 our Emergency Departments (EDs) underwent a formal inspection by the CQC. The report of that inspection was published by the CQC in May 2020. At the time of writing we are awaiting confirmation of when the CQC will conduct a formal Well Led inspection of the trust during 2020/21. Pre-inspection activity commenced by the CQC in February 2020, however the process was paused due to COVID-19. The trust is currently rated as 'Requires Improvement' as both CPFT and NCUH were rated as 'Requires Improvement' at the point of merger. The Board of Directors received regular updates throughout the year on actions taken in response to previous inspections. In the Quality Report (published separately), you can find out more about CQC inspections, details of

any new or significantly revised services, and how we have used information from internal and external sources, such as complaints, patient and staff surveys, and inspection reports, to improve our services.

Strategic partnerships and integrated system-wide care

We continue to be a partner in major transformation programmes covering the Cumbria geographical footprint. During 2019/20 we worked with our partners on the transfer of mental health, learning disability and children and adolescent mental health services on 1 October 2019 to Cumbria, Northumberland Tyne and Wear NHS Foundation Trust and Lancashire and South Cumbria NHS Foundation Trust, in line with changes to commissioning arrangements. We also merged with NCUHT on 1st October 2019 to form North Cumbria Integrated Care NHS Foundation Trust. Following these changes we will continue to deliver some services countywide, such as children's services, neurology and dental services.

Integrated Care Communities (ICCs), introduced in 2018/19 continue to see strong collaboration between system and have had positive benefits in removing or reducing the number of overnight beds in some of our community hospitals and avoiding admissions to hospital enabling improved and different ways for patients to be cared for at home. Through the ICCs, and in collaboration with local Alliance groups, we have implemented changes to services delivered from our community hospitals, reducing or removing inpatient beds in accordance with decisions made by North Cumbria Clinical Commissioning Group in April 2018 following public consultation.

We are a key partner in the System Leadership Board (SLB), working with system partners to develop and implement strategic transformation plans across the North Cumbria IHCS. Our Executive and Non-Executive Directors represent us at SLB meetings, although strategic decisions continue to require approval by our Board. A 5-year (2019-2024) system-wide clinical strategy was formally agreed and launched in February 2020 following a period informing, engaging, involving and where appropriate, consulting with internal and external stakeholders on our service improvement and transformation plans. This includes local groups and third sector organisations, as well as the Local Authority's Health Scrutiny Committee. We will also continue to hear patient and staff stories at our Board meetings to ensure that the patient voice is at the heart of everything we do.

Creating local partnerships

Over the course of the year we have participated in a number of events and community conversations with the population of Cumbria and Morecambe Bay to help ensure that the NHS is aware of local health priorities and can work to support them where possible. We have also engaged with, and provided regular updates to, the Local Authority's Health Scrutiny Committee on merger plans and transfer of mental health, learning disabilities and children and adolescent mental health services.

Statement as to Disclosure to auditors (s418)
The Directors who held office at the date of approval of this report confirm that, so far as they are aware, there is no relevant audit information of which the Trust's auditors are unaware.

Each Director has taken all the steps that they ought to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Provision of goods and services for the purposes of the health service in England
During 2019/20, income from the provision of goods and services for the purpose of health services in England was greater than the income from the provision of goods and services for other purposes.

Other income
Other income is 1.9% of total income in 2019/20 (2018/19: 1.0%) and includes £3.15m of financial support for the PFI scheme at the Cumberland Infirmary in Carlisle. The value of other income, therefore, has no material impact on the provision of goods and services for the purposes of the health service in England.

During the year the Trust has not generated additional income by levying fees and charges for its services where the full cost of providing those services exceeds £1 million or where the income generated has been material to the accounts.

2.2 Remuneration Report

Section One – Annual statement on remuneration

The Trust has a Remuneration Committee whose purpose is to develop, apply and monitor the policy on Executive terms, conditions and remuneration.

The aim is to ensure that there is a transparent process for determining pay for the Chief Executive and other Executive Directors. The Committee also recommends and monitors the level and structure of remuneration for the first layer of management below Board level, albeit that these roles are remunerated within the terms and conditions for Agenda for Change or the Medical and Dental contract terms and conditions. The remit covers salary (including any performance-related elements/bonuses or additional payments), benefits (e.g. lease cars, pensions) and contracted terms of employment (e.g. service contracts, terminations).

Executive team changes

The changes within the Executive team over the past year are outlined below:

Role	Change
Vincent Connolly	Vincent joined the Trust as Executive Medical Director on 1st June 2019
Ramona Duguid	Ramona was appointment as Executive Director of Strategy on 1st April 2019
Stephen Eames	Stephen left the Trust on the 31st December 2019
Dr Rod Harpin	Rod stood down from his role as Interim Medical Director on 31st May 2019
Alison Smith	Alison left the Trust on 31st March 2020
Mandy Nagra System Executive Chief Operating Officer	Mandy went on secondment from the Trust on 1st January 2020
Gary O'Hare	Gary left the Trust on 31st October 2019
Peter Rooney	Peter joined the Trust as Interim Executive Director of Service Improvement from 27th August 2019. Peter took on responsibility for Digital services from 16th October 2019.
Lyn Simpson	Lyn was appointed as Chief Executive on 1st January 2020
Anna Stabler	Anna joined the Trust as Interim Chief Nurse on secondment from 1st January 2020
Michael Smillie	Michael took on responsibility for Workforce & Organisational Development from 16th October in additional to his role as Executive Director of Finance & Estates
Mrs Judith Toland	Judith took on responsibility for Digital services from 1st April 2019 in addition to her role as

Role	Change
	Executive Director of Workforce & Organisational Development. Judith left the Trust on 16th October 2019

Changes to Executive Directors' Remuneration

There were no changes to Executive remuneration in 2019/20.

Non-Executive Directors

The changes within the Non-Executive team over the past year are outlined below:

Role	Change
David Allen	David joined the Trust as Non-Executive Director on 1st October 2019
Brian Hetherington	Brian left the Trust on 30th September 2019
Heike Horsburgh	Heike left the Trust on 30th September 2019
Susan McKenna	Susan joined the Trust as Non-Executive Director on 2nd January 2020
Alan Moore	Alan left the Trust on 30th September 2019
Jeff O'Neill	Jeff joined the Trust as Non-Executive Director on 1st October 2019
Robin Talbot	Robin left the Trust on 31st March 2020

Section Two – Senior managers remuneration policy

Future Policy Table
Directors:

Element	Purpose and Strategy	Operation	Maximum
Salary	To attract and retain high calibre individuals and reflect level of responsibility.	All the Executive Directors are remunerated based on a local VSM scale system which is reviewed annually.	£190,000
Taxable Benefits	To attract and retain high calibre individuals.	This covers the provision of a lease car.	There is no specific maximum set but costs including fuel and insurance excess in the event of an accident are met by the director.
Pension Related Benefits	To attract and retain high calibre individuals.	Directors are eligible for membership of the NHS pension scheme.	In line with the NHS pension scheme.

There is no link between individual performance and salary. However should individual performance fall below the expected standard it would be addressed through performance management. All Directors have clear objectives based upon the Trust business priorities No Director received any annual or long term performance-related bonuses in 2019/20.

Non-Executive Directors:

Fees Payable	Additional Fees Payable	Purpose and Strategy	Operation	Maximum
NEDs: £13,491 per annum Chair: £50,000 per annum	Not applicable Not applicable	To attract and retain high calibre candidates.	Reviewed by the Nominations Committee and any changes are approved by the Governors Council.	No maximum is specified but market rates are considered.

Service contract obligations

Executive Directors' contracts do not have a specific duration and reflect notice periods and associated payments for loss of office as detailed in the following sections. Service contracts incorporate the following remuneration aspects:

- Annual Leave entitlement: 33 days plus 8 bank holidays
- Sick pay entitlement: 6 months full pay, 6 months half pay
- Eligibility for a lease car in line with Trust policy on contribution, usage and associated mileage costs.

Policy on payment for loss of office

All contracts for executive directors are substantive NHS contracts and are subject to the giving either three or six months' notice by either party. Our normal disciplinary and performance management policies apply to senior managers. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

Statement of consideration of employment conditions elsewhere in the foundation trust

This information can be found in Section One - Annual Statement of Remuneration.

Section Three – Annual report on remuneration

Non-Executive Directors and Chair		
	Date Term of Office Commenced	**Date term of Office Ends/Ended**
Peter Scott	April 2020	September 2020
David Allen	October 2020	September 2022
Malcolm Cook	August 2018	December 2020
George Liston	August 2018	September 2021
Susan McKenna	January 2020	December 2020
Louise Nelson	March 2018	September 2021
Jeff O'Neill	October 2020	September 2021

Remuneration Committee

The Remuneration Committee operates in accordance with documented Terms of Reference, as a sub-committee to the Board. This is chaired by the Trust's current Senior Independent Director, George Liston and comprises the other NEDs. It is usual for the Executive Director of Workforce and Organisational Development to attend, accompanied by other Executive Directors if required.

In addition to oversight and agreement of Executive remuneration, the Committee also has oversight of any requests for redundancy payments which either total above £100k or apply to staff of band 8 or above; or both. Similarly the Committee also has oversight of any Mutually Agreed Resignation Scheme (MARS) requests from staff of band 8 or above should the Trust decide to offer such a scheme.
Meetings of the Remuneration Committee are held as deemed necessary by the Chair but not less than twice a year.

Remuneration Committee meetings and attendance details 2019/20

Membership and attendance at the Committee is set out below

Name	**Job Title**	**May 2019**	**June 2019**	**July 2019**	**Aug 2019 Via email**	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Dec 2019**	**Jan 2020 via email**	**Feb 2020**	**March 2020 Via email**	**Meeting Count**	**% Attend**
Professor Robin Talbot	Chair	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	10/11	91%
Mr David Allen	Non-Executive Director					Y	Y	Y	Y	Y	Y	Y	7/7	100%
Mr Malcolm Cook	Non-Executive Director	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	9/11	82%

Name	Job Title	May 2019	June 2019	July 2019	Aug 2019 Via email	Oct 2019	Nov 2019	Dec 2019	Dec 2019	Jan 2020 via email	Feb 2020	March 2020 Via email	Meeting Count	% Attend
Mr Brian Hetherington	Non-Executive Director	N	N	Y	Y								2/4	50%
Ms Heike Horsburgh	Senior Independent Director until 30/09/2019	Y	Y	Y	Y								4/4	100%
Mr George Liston	Senior Independent Director from 01/10/2019	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9/11	82%
Ms Sue McKenna	Non-Executive Director									Y	N	Y	2/3	67%
Mr Alan Moore	Non-Executive Director	N	N	Y	Y								2/4	50%
Ms Louise Nelson	Non-Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11	100%
Mr Jeff O'Neill	Non-Executive Director					Y	Y	Y	Y	Y	Y	Y	7/7	100%
Executive Directors in attendance based on Committee Requirements														
Mr Stephen Eames	Chief Executive		Y				Y						2/2	100%
Dr Rod Harpin	Medical Director	Y											1/1	100%
Ms Michelle McGuigan	Organisational Development & Corporate Services Director, North of England Commissioning Support					Y	Y	Y	Y	Y	Y	Y	7/7	100%
Mrs Lyn Simpson	Chief Executive									Y	Y	Y	3/3	100%
Mr Michael Smillie	Director of Finance, Estates & Digital	Y				Y				Y	Y	Y	5/5	100%
Mrs Judith Toland	Director of People & OD	Y		Y									2/2	100%
In attendance														
Mr Daniel Scheffer	Meeting Administrator	Y	Y	Y	Y	Y	Y						6/6	100%
Mrs Jacky Stockdale	Meeting Administrator							Y	Y	Y	Y	Y	5/5	100%

Governors' Nominations Committee

The Nominations Committee is chaired by the Trust's Chair and comprises of the Lead and Deputy Lead Governors and one elected governor. The Senior Independent Director will deputise and chair the meeting when the Chair is being considered for appointment or the appraisal process is under review. The membership is also supported by two additional elected governors on reserve and trained.

In addition, the Committee also has responsibility for the Removal of the Chair or another Non-Executive Directors which requires the approval of three quarters of the members of the Governors' Council, on the recommendation of its Nominations Committee. This action would only be taken in extreme circumstances once all other opportunities had been utilised to resolve issues.

Meetings of the Nominations Committee are held as deemed necessary by the Chair but not less than once a year.

Membership and attendance at the Governors Nominations Committee is set out below

Name	Job Title	April 2019	May 2019	June2019	June2019	July 2019	Aug2019	Sept 2019	Oct 2019	Jan 2020	March 2020	March 2020	Meeting Count	% Attend
Professor Robin Talbot	Chair	Y	Y	Y	Y	N	Y	Y	Y				7/8	88%
Jane Smith	Lead Governor	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	9/11	82%
Keith Amey	Deputy Lead Governor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11	100%
Linda Radcliffe	Governor Member	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11	100%
Jacqueline Nicol	Reserve Governor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11	100%
Elizabeth Freeman	Reserve Governor Member	Y	Y	Y	N	Y	Y	N	Y	Y	N	Y	8/11	73%
In attendance														
Mr Daniel Scheffer	Meeting Administrator	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	10/11	100%
Mrs Harriet Mouat	Meeting Administrator	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	11/11	100%
Mr George Liston	Senior Independent Director									Y	Y	N	2/3	67%
Mr Neil Mundy	Independent Panel Member						Y						1/1	100%
Ms Heike Horsburgh	Senior Independent Director			Y										

Disclosures required by the Health and Social Care Act
Expenses of the Governors and Directors

	Total Number		Number claiming expenses		2018/19	2019/20
	2018/19	2019/20	2018/19	2019/20	£00s	£00s
Non Executive Directors	7	9	5	7	109	141
Executive Directors	9	13	5	8	44	90
Governors	36	42	19	21	58	94

The information below is subject to audit.

Remuneration for each senior manager who served during the last financial year – Single Total Figure Table

Name and Title	2019/20				2018/19			
	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£	£000	£000	£000	£	£000	£000
Andrew Brittlebank, Executive Medical Director, Lead for Cumbria Partnership NHS Foundation Trust until 31 March 2019					130-135			130-135
Dr Vincent Connolly, Executive Medical Director wef 1 June 2019	150-155	200	365-367.5	520-525				
Mr Malcolm Cook, Non-Executive Director wef 1 August 2018	5-10	200		5-10	0-5			0-5
Mrs Ramona Duguid, Director of System Integration wef 24 May 2018 and Executive Director of Strategy wef 1 April 2019	95-100	200	42.5-45	140-145	45-50		22.5-25	70-75
Mr Stephen Eames, Chief Executive until 31 December 2019	105-110	11,000		120-125	130-135	8,700		135-140
Dr Rod Harpin, Executive Medical Director, Lead for North Cumbria University Hospitals NHS Trust until 31 May 2019	5-10	100	0-2.5	5-10	50-55		17.5-20	70-75
Mr Brian Hetherington, Non-Executive Director until 30 September 2019	5-10	200		5-10	15-20			15-20
Ms Heike Horsburgh, Non-Executive Director until 30 September 2019	5-10	200		5-10	10-15			10-15
Prof John Howarth, Joint Deputy Chief Executive	120-125	2,800		125-130	80-85	1,500		85-90
Ms Esther Kirby, Executive Director of Nursing wef 18 April 2018 - 31 July 2018					15-20			15-20
Mr George Liston, Non-Executive Director wef 1 August 2018	5-10	200		5-10	0-5			0-5
Mrs Susan McKenna, Non-Executive Director wef 2 January 2020	0-5			0-5				
Mr Alan Moore, Non-Executive Director until 30 September 2019	5-10	100		5-10	10-15			10-15

Name and Title	2019/20				2018/19			
	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
Mrs Mandy Nagra, Interim Chief Operating Officer wef 1 July 2018	65-70	300		65-70	35-40			35-40
Dr Louise Nelson, Non-Executive Director	5-10	100		5-10	5-10			5-10
Mr Gary O'Hare, Interim Executive Director of Mental Health & Learning Disabilities wef July 2018 until 30 September 2019	25-30	200	17.5-20	45-50	30-35		95-97.5	125-130
Mr Jeffrey O'Neill, Non-Executive Director wef 1 October 2019	5-10			5-10				
Mrs Clare Parker, Executive Director of Quality & Nursing until 20 May 2018					15-20	300	207.5-210	225-230
Mrs Helen Ray, Executive Managing Director of Operations until 15 July 2018					15-20		27.5-30	45-50
Mr Peter Rooney, Interim Executive Director of Service Improvement wef 27 August 2019 and Executive Lead for Digital wef 16 October 2019	n/a	n/a	n/a	n/a				
Mr Daniel Scheffer, Joint Company Secretary	95-100	900	32.5-35	130-135	90-95	200	17.5-20	110-115
Mrs Lyn Simpson, Chief Executive wef 1 January 2020	45-50		17.5-20	65-70				
Mr Michael Smillie, Executive Director of Finance & Estates wef 1 May 2018; and Executive Lead for Workforce and Organisational Development 1 February 2018 - 4 November 2018 and from 16 October 2019	95-100		0-2.5	95-100	65-70		152.5-155	220-225
Mrs Alison Smith, Executive Director of Nursing wef 9 July 2018 until 5 January 2020	65-70	100	82.5-85	150-155	35-40		142.5-145	175-180
Mrs Anna Stabler, Interim System Executive Chief Nurse wef 1 January 2020	0-5	100	2.5-5	5-10				
Mr Robin Talbot, Chair	35-40	400		35-40	45-50			45-50
Mrs Judith Toland, Executive Director of Workforce & Organisational Development (wef 5 November 2018) and Digital (wef from 1 April 2019) until 16 October 2019	35-40	200		40-45	25-30		5-7.5	30-35

Remuneration Notes:
The salary range quoted is pro rata to the annual salary and relates to the period that the individual was employed by the Trust. In addition, it reflects the joint Board arrangements that were in place and excludes remuneration relating to roles for North Cumbria University Hospitals NHS Trust between 1 April 2019 and 30 September 2019.

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 does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include, but are not limited to, a change in role with a resulting change in pay and impact on pensions and/or changes in the wider remuneration package of an individual.

Up until 30 September 2019 the Trust had a joint Board arrangement with North Cumbria University Hospitals NHS Trust and there were recharges between the 2 Trusts for all posts excluding the Chair, Non-Executive Directors, the Interim Director of Service Improvement and the Joint Company Secretary.

The total remuneration for 2019/20 for individuals where there were recharges between Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust is shown in the table below:

	Salary (bands of £5,000)	**Expense payments (taxable) total (to nearest £100)**	**All pension related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
	£000	**£**	**£000**	**£000**
Dr Vincent Connolly wef 1 June 2019	190-195	200	457.5-460	650-655
Mrs Ramona Duguid	130-135	200	57.5-60	190-195
Mr Rod Harpin until 31 May 2019	30-35	200	5-7.5	35-40
Mr John Howarth	160-165	3,700		165-170
Mrs Mandy Nagra until 31 December 2019	95-100	400		95-100
Mr Michael Smillie	130-135		0-2.5	130-135
Mrs Alison Smith	100-105	100	122.5-125	220-225
Mrs Judith Toland	70-75	200		70-75

Mrs Duguid, Mr Rooney and Mrs Toland did not have a voting right on the Trust's Board of Directors.

Mr Cook, Mr Liston and Dr Nelson were Joint Non-Executive Directors for Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust and Mr Talbot was the Joint Chair. They were paid a salary by each of the Trusts directly.

Mr Eames was on secondment from The Mid Yorkshire Hospitals NHS Trust and the Trust was invoiced for his salary costs. Since 1 September 2017 Mr Eames worked as Joint Chief Executive for both North Cumbria University Hospitals NHS Trust and Cumbria Partnership NHS Foundation Trust and the Trust has been invoiced for 50% of his costs since that date. From 3 June 2019 Mr Eames had been seconded 1 day per week to Humber Coast and Vale Health & Care Partnership and the Trust has invoiced this organisation for 0.5 days per week of its share of Mr Eames' salary. Mr Eames' total remuneration for the period 1 April 2019 – 31 December 2019 was £215k-£220k inclusive of benefits in kind.

For the period to 31 May 2019 Dr Harpin's salary was split between his role as a director for the Trust (£5k-£10k) and his clinical duties as a Consultant Anaesthetist (£15k - £20k).

Mrs Nagra was on secondment from NHSE/I until 30 April 2019 and North Cumbria University Hospitals NHS Trust was invoiced for her salary costs until then.

Mr O'Hare was on secondment from Northumberland, Tyne & Wear NHS Foundation Trust one day per week from July 2018 up until 30 September 2019. Mr O'Hare's total remuneration for the period 1 April 2019 - 30 September 2019 is shown below:

	Salary (bands of £5,000) £000	Expense payments (taxable) total (to nearest £100) £	All pension related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Mr Gary O'Hare until 30 September 2019	95-100	700	132.5-135	230-235

Mr Rooney was on secondment from North Cumbria Clinical Commissioning Group who met all his salary and pension costs.

Mr Scheffer is the Joint Company Secretary, however, all his salary and pension costs were met by the Trust and there were no recharges to North Cumbria University Hospitals NHS Trust.

In addition to the roles noted above, Mr Smillie was Director of Strategy & Support Services 1 February 2018 - 30 April 2018 and between 1 May 2018 and 31 March 2019 he was Executive Lead for Digital.

Mrs Smith was on secondment from NHS Improvement until 1 November 2018 and the North Cumbria University Hospitals NHS Trust was invoiced for her salary costs up until that date.

Mrs Stabler is on secondment from North Cumbria Clinical Commissioning Group who recharged the Trust for the incremental increase in her salary only. Pension benefits reflected in the table above relate only to this incremental charge.

Mrs Toland's remuneration included pay in lieu of annual leave in the range £0k - £5k.

Taxable expenses include benefits in kind arising from lease cars.

Fair pay multiple (**The information below is subject to audit)**
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

Median remuneration of staff

	Year ended 31 March 2020	Year ended 31 March 2019
Median Total Remuneration £	29,535	28,098
Band of Highest Paid Director's Total Remuneration (£000)	230-235	275-280
Ratio	7.9	10.0

The banded remuneration of the highest paid director in North Cumbria Integrated Care NHS Foundation Trust in the period to 31 March 2020 was £230,000 - £235,000 (2018/19: £275,000 - £280,000). This was 7.9 times (2018/19: 10.0) the median remuneration of the workforce which was £29,535 (2018/19: £28,098). The ratio has decreased as a result of the decrease in the band of the highest paid director's remuneration. There was also a small increase in the median remuneration which has contributed to the reduction in the ratio.

During the period to 31 March 2020 4 Trust-employed members of staff (2018/19: nil) received remuneration in excess of the highest paid director. The equivalent of 20 agency medical staff earned more than the highest paid director (2018/19: nil). Remuneration ranged from £17,652 to £300,363 (2018/19: £6,277 to £279,799).

Total remuneration includes salary and benefits in kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Total Pension Entitlement (**The information below is subject to audit)**

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
	£000	£000	£000	£000	£000	£000	£000
Dr Vincent Connolly, Executive Medical Director wef 1 June 2019	15-17.5	42.5-45	90-95	240-245	1,356	362	1,966

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
Mrs Ramona Duguid, Director of System Integration wef 24 May 2018 and Executive Director of Strategy wef 1 April 2019	2.5-5	7.5-10	30-35	60-65	357	33	427
Dr Rod Harpin, Executive Medical Director until 31 May 2019	0-2.5	n/a	10-15	n/a	193	3	255
Mr Gary O'Hare, Interim Executive Director of Mental Health & Learning Disabilities wef July 2018 until 30 September 2019	0-2.5	5-7.5	95-100	285-290	1,805	50	2,192
Mr Daniel Scheffer, Company Secretary	0-2.5	0-2.5	20-25	40-45	347	41	396
Mrs Lyn Simpson, Chief Executive wef 1 January 2020	0-2.5	2.5-5	80-85	245-250	n/a	n/a	n/a
Mr Michael Smillie, Executive Director of Finance & Estates wef 1 May 2018; and Executive Lead for Workforce and Organisational Development 1 February 2018 - 4 November 2018 and from 16 October 2019	0-2.5	0-2.5	45-50	105-110	759	0	789
Mrs Alison Smith, Executive Director of Nursing wef 9 July 2018 until 5 January 2020	2.5-5	10-12.5	45-50	145-150	858	85	1,062
Mrs Anna Stabler, Interim System Executive Chief Nurse wef 1 January 2020	0-2.5	0-2.5	40-45	120-125	773	4	883
Mrs Judith Toland, Executive Director of Workforce & Organisational Development (wef 5 November 2018) and Digital (wef from 1 April 2019) until 16 October 2019	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Notes:
As Non-Executive members are not eligible to be members of the NHS Pension scheme there are no entries in respect of pensions for Non-Executive members. Only those Executive Directors who are members of the NHS Pension Scheme are included in the table above.

The real increases noted above only reflect the increase for the proportion of the year that the member of staff has been in the stated post and the proportion of their pensionable pay that has been paid for by North Cumbria Integrated Care NHS Foundation Trust.

As Mrs Simpson is beyond the normal retirement age there are no Cash Equivalent Transfer Value (CETV) values.

As Mrs Toland had been a member of the NHS Pension scheme for less than 2 years there are no benefits payable.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Cash Equivalent Transfer Factors (CETVs) are calculated by the Government Actuary Department (GAD) based on the assumption that benefits are indexed in line with CPI.

Signed L. Simpson Date: 23rd June 2020

Lyn Simpson
Chief Executive

2.3 Staff Report

The information in the tables below is subject to audit.

Analysis of staff costs

	2019/20			2018/19
Staff Costs - Gross	**Permanently Employed £000s**	**Other £000s**	**Total £000s**	Total £000s
Salaries and wages	151,128	7,859	158,987	100,385
Social Security costs	13,282	691	13,973	9,361
Apprenticeship Levy	687	49	736	481
Employer's contributions to NHS Pensions	26,468	1,372	27,840	12,733
Pension cost - other	85	0	85	0
Termination Benefits	40	0	40	193
Temporary staff	0	12,453	12,453	5,237
Total staff costs	**191,690**	**22,424**	**214,114**	128,390
Of which:				
Costs capitalised as part of assets	281	0	281	732

Analysis of average staff numbers

Average whole time equivalents (WTE) by staff groups

	2019/20			2018/19
	Total	**Permanently employed**	**Other**	**Total**
Average Staff Numbers				
Medical and dental	365	332	33	107
Administration and estates	1,347	1,321	26	722
Healthcare assistants and other support staff	795	677	118	869
Nursing, midwifery and health visiting staff	1,399	1,340	59	876
Scientific, therapeutic and technical staff	763	745	18	510
Healthcare Science Staff	214	214	0	0
Other	29	27	2	0
Total	**4,912**	**4,656**	**256**	3,084
Of which:				
Number of employees (WTE) engaged on capital projects	12	12	0	15

Male/female staff numbers as at 31/03/19 (Information below is not subject to audit)

	Female	Male
Directors (Executive & Non Executive)	6	9
Other Senior Managers	0	1
All other employees	5,502	1,007
Grand Total	**5,508**	**1,017**

Sickness absence data

The Trust's sickness absence data is published by NHS Digital and is available at this link: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff policies and actions applied during the financial year

Policies relating to our staff continued to be reviewed and updated throughout 2019/20. The joint consultation process with NCUH continued to develop and agree workforce related policies across both Trusts to ensure consistency in how staff are treated across both organisations until the move to a single Trust from 1st October.

The Trust was the first in the UK to have a Menopause Policy, which was developed with the Staff Representative Chair, who has a particular interest in championing this important subject.

All revised policies went through local Equality Impact Assessment processes, and the HR team work in conjunction with the occupational health service and line managers to ensure any reasonable adjustments which are required to either sustain a staff member in post, or assist a return to work are put in place where appropriate as quickly as possible.

Trade Union facility time

The Trust continues to work closely with staff representatives on the Partnership Forum and Local Negotiating Committee to collate the data required under the regulations. Both are now joint forums with one nominated staff side chair on each.

Staff engagement

Our core objective is to embed the right culture and make the organisation a great place to work. Staff engagement is essential because we know that when staff are happy and fully engaged they provide the best possible care for our patients. 'This is Us' has been our approach to staff engagement. Staff had the opportunity to meet with the CEO each quarter, in a variety of locations, to hear about our plans, raise any concerns and ask questions. The annual business plan and priorities are shared at the start of the financial year and cascaded to individuals through Quarterly TALKs, our values based approach to appraisal. Staff have also been kept informed through a weekly CEO Blog, the staff intranet portal, weekly news emails and 'Trust Talk' printed magazine.

NHS Staff Survey

The NHS Staff Survey is the largest survey of staff opinion in the UK; it is carried out annually to gather the views on staff experience at work in eleven key indicators. The survey is administered electronically and completely anonymous. Indicators are measured on a scale of 10 and we are benchmarked against the average score of other similar trusts.

As the survey was released on the cusp of the merger the results are reported separately for CPFT and NCUH and include mental health staff. Information is available at care group and service level.

Cumbria Partnership NHS Foundation Trust (CPFT):

The CPFT response rate for the 2019 NHS staff survey was 40% compared to a national median of 48%. The scores for each indicator, together with comparison against the average for Combined Mental Health / Learning Disability and Community Trusts are presented in the table below:

Indicators	2019		2018		2017	
	Trust	Average	Trust	Average	Trust	Average
Equality, diversity and inclusion	9.3	9.1	9.2	9.2	9.4	9.2
Health and wellbeing	5.9	6.1	5.9	6.1	6.1	6.1
Immediate managers	7.0	7.2	7.1	7.2	7.2	7.1
Morale	6.0	6.3	6.2	6.2	x	x
Quality of appraisals	5.5	5.7	5.5	5.5	5.7	5.4
Quality of care	7.4	7.4	7.2	7.4	7.5	7.4
Safe environment – bullying and harassment	8.0	8.2	8.2	8.2	8.3	8.3
Safe environment – violence	9.6	9.5	9.6	9.5	9.5	9.5
Safety culture	6.6	6.8	6.7	6.8	6.7	6.7
Staff engagement	6.8	7.1	7.0	7.0	7.1	7.0
Team Work	6.8	6.9	6.9	6.9	7.0	6.9

One theme, ‘Morale’, has the lowest score nationally. The results show that staff engagement has dropped to 6.8; Staff recommendation of the Trust as a place to receive treatment is lower than average at 60.8% (average is 67.5%) and recommendation as a place to work is lower than average at 54.4%, (average is 62.4%). The theme for Equality, Diversity and Inclusion remains above the national average.

North Cumbria University Hospitals NHS Trust (NCUH):

The NCUH response rate for the 2019 NHS staff survey was 34% compared to a national median of 47%. The scores for each indicator, together with comparison against the average for Acute Trusts are presented in the table below:

Indicators	2019		2018		2017	
	Trust	Average	Trust	Average	Trust	Average
Equality, diversity and inclusion	9.0	9.0	9.1	9.1	9.2	9.1

Health and wellbeing	5.3	5.9	5.6	5.9	5.8	6.0
Immediate managers	6.0	6.8	6.2	6.7	6.3	6.7
Morale	5.5	6.1	5.7	6.0	*	*
Quality of appraisals	4.8	5.6	4.8	5.4	4.8	5.3
Quality of care	6.7	7.5	7.1	7.4	7.2	7.4
Safe environment – bullying and harassment	7.5	7.9	7.8	7.9	8.0	8.0
Safe environment – violence	9.4	9.4	9.4	9.4	9.3	9.4
Safety culture	5.7	6.7	6.1	6.7	6.2	6.6
Staff engagement	6.1	7.0	6.5	7.0	6.6	7.0
Team work	5.9	6.6	6.2	6.5	6.3	6.5

Eight of the 11 themes have the lowest score nationally. The results show that staff engagement has dropped to 6.1; staff recommendation of the Trust as a place to receive treatment is 39.7%, which is the worst score nationally (average is 70.5%) and recommendation as a place to work is 36%, which is the worst score nationally (average is 62.5%).

Staff are telling us that

- Quality of Care needs to be the organisations top priority.
- Senior managers are not always visible or demonstrate behaviours in line with our values. As staff they say they would like to be more involved and see how their feedback has been acted upon.
- They do not feel valued or have opportunities to develop. The scores tell us that conversations with managers and the quality of their appraisal is poor.

Future Priorities and Targets

The Trust is committed to making improvements by working together closely with staff so that it becomes a great place to work. The survey was undertaken at a time when we experienced high levels of organisational change and pressures and we have since renewed our focus on quality and safety, improving patient experience and living by our values.

With a new Chief Executive in post the Trust is prioritising getting the basics right and putting clinicians at the forefront of decision making in the organisation.

Get the basics right and be **driven by quality** and patient experience. We will focus on staffing and quality improvement, strengthening workforce planning. We have commissioned a staffing review and have an increased focus and plan for international recruitment. We will promote and enable staff to make improvements in their day to day work through training and embedding the application of our Cumbria Production System, seeing value from our patient's perspective and reducing waste so there is more time to care.

Be more visible and **live our values –** bullying behaviours are not acceptable and we need to build self-awareness and capability in our managers and leaders so they take responsibility for their actions, 'care' for their staff and support and enable their teams. There is a new leadership programme designed to give leaders the skills in good management practice planned to commence in April. This aligns with the new national Leadership Compact. Our Freedom To Speak Up Guardians are working with unions and staff to create the environment where people feel they can speak up and challenge; values cards will give permission and inform staff of how to speak up.

Create a **Better Place to Work –** this is also one of the national People Plan priorities and we are working with colleagues in the NE and NC system to support more flexible working and learning passports. We need to work with our staff to understand what will make the difference to them. We are currently working with union representative to review our staff networks to understand how staff can have a stronger voice to influence change. Conversations between managers and individual staff are critical in supporting staff in their current role and also help plan for their next role we will review our approach to appraisal and management supervision and provide training available to managers to embed the process.

Expenditure on consultancy

The total consultancy fees for 2019/20 were £308k (2018/19: £938k).

Off-payroll engagements

Off-Payroll Engagements longer than 6 months

The Trust is required to publish information about any off-payroll engagements that cost more than £245 per day and that last longer than six months.

Number of existing arrangements as of 30 March 2020	**Number 11**
Of which, the number that have existed:	
for less than one year at the time of reporting	
for between one year and two years at the time of reporting	3
for between 2 years and 3 years at the time of reporting	6
for between 3 years and 4 years at the time of reporting	
for 4 or more years at the time of reporting	2

New Off-Payroll Engagements

The Government reformed the Intermediaries legislation, often known as IR35. This updated legislation for the off-payroll working rules within the public sector applied to

payments made on or after 6 April 2017. Under the reformed rules the Trust must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC). The Trust is required to provide information on how new engagements have been assessed for tax purposes.

For all new off-payroll engagements between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months duration, between 1 April 2019 and 30 September 2020	**Number 2**
Of which:	
Number assessed as caught by IR35	
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll	
No of engagements reassessed for consistency / assurance purposes during the year	
No of engagements that saw a change to IR35 status following the consistency review	

Board Member/Senior Management engagements

The Trust had no Board Members or senior managers with significant financial responsibility who were off-payroll engagements between 1 April 2019 and 31 March 2020.

No of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
"board members, and/or, senior officials with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements.	22

Reporting of compensation schemes - exit packages 2019/20:

The table below details all exit packages, analysed between compulsory redundancies and other, non-compulsory, departures. The value of these exist packages are analysed by cost band.

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
<£10,000	-	15	**15**
£10,000 - £25,000	2	3	**5**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	2	-	**2**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**5**	**18**	**23**
Total cost (£)	**£201,000**	**£89,000**	**£290,000**

Reporting of compensation schemes - exit packages 2019/20:

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
<£10,000	1	7	8
£10,000 - £25,000	2	1	3
£25,001 - 50,000	2	-	2
£50,001 - £100,000	-	-	-
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	6	8	14
Total resource cost (£)	£218,000	£44,000	£262,000

Exit packages: other (non-compulsory) departure payments:

	2019/20		2018/19	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	17	71	8	44
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	18	-	-
Total	**18**	**89**	**8**	**44**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

2.4 NHS Foundation Trust Code of Governance – disclosures

North Cumbria Integrated Care 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 (CoG), most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Governors' Council Report Directors Report
Board Nomination Committee Audit Committee Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration Committees. It should also set out the number of meetings of the board and those Committees and individual attendance by directors.	Directors Report Nominations Committee Report Audit & Risk Committee Report Remuneration Report
Governors' Council	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Governors' Council Report
Governors' Council	FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Governors' Council Report Directors Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Directors Report
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Directors Report
Board	FT ARM	The annual report should include a brief description of the length of appointments of the NEDs, and how they may be terminated.	Remuneration Report Governors' Council Report Directors Report
Nominations Committee	B.2.10	A separate section of the annual report should describe the work of the nominations Committee(s), including the process it has used in relation to board appointments.	Nominations Report
Nominations Committee	FT ARM	The disclosure in the annual report on the work of the nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Nominations Report
Chair / Governors' Council	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Directors Report
Governors' Council	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governors' Council Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Governors' Council	FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Governors' Council Report
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its Committees, and its directors, including the chairperson, has been conducted.	Directors Report Performance Report
Board	B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Directors Report
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they 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 the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors Report AGS
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	AGS

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Audit & Risk Committee
Audit Committee Governors' Council	C.3.5	If the council of governors does not accept the audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit Committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Audit & Risk Committee
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit Committee in discharging its responsibilities. The report should include: the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Audit & Risk Committee
Board Rem Com	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of	Remuneration Report

Relating to	CoG ref.	Summary of requirement	Location in Annual Report
		whether or not the director will retain such earnings.	
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the NEDs, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Directors Report Governors' Council Report
Board Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership Report
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Governors' Council Report
Membership	FT ARM	The annual report should include: a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; information on the number of members and the number of members in each constituency; and a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Membership Report
Board Governors' Council	FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Directors Report and Governors' Council Report signpost to Register of Interests

2.4.1 Audit and Risk Committee Report

Composition
The Audit and Risk Committee consists of Non-Executive Directors and as the CPFT Committee was chaired by Mr Brian Hetherington and once by Ms Heike Horsburgh; from 1st October 2020 the NCIC Committee was chaired by Mr Jeff O'Neill. Other members of the committee during the year for CPFT were Heike Horsburgh and Alan Moore; from 1st October for NCIC with Mr George Liston and Mr Malcolm Cook.

Meetings
The CPFT committee met on four occasions and the NCIC Committee met on four occasions during 2019/20. The following table gives details of attendance by individual committee members at the meetings and includes details of attendance by Executive Directors.

Although not members of this committee, Executive Directors (or their nominated deputy) are invited to attend, particularly where specific risk discussions fall under the remit of that Director. For this the appropriate Executive Director attends for some or all of the meeting and this is shown in the table below. Furthermore, papers relating to Audit and Risk Committee meetings are issued to all Executive Directors and where they are not in attendance, they are able to provide input where appropriate. The Terms of Reference for this committee includes a requirement for the Chief Executive to attend at least one meeting during each reporting year. The Chief Executive was unable to attend the Audit and Risk Committee in 2019/20.

Table: Meetings of the Audit and Risk Committee 1 April 2019 – 31 March 2020

Name	**Position**	**Attendance - (total of 4 meetings held during 2019/20)**
Committee members – CPFT		
Brian Hetherington	Non-Executive Director	3/4
Heike Horsburgh	Non-Executive Director	2/4
Alan Moore	Non-Executive Director	3/4
Committee members – NCIC		
Mr Jeff O'Neill	Non-Executive Director	4/4
Mr George Liston	Non-Executive Director	4/4
Name	**Position**	**Attendance - (total of 4 meetings held during 2019/20)**
In attendance (Executive		**Audit and Risk Committee Attendance (partial or full attendance based on requirement)**

Directors) - CPFT		
Michael Smillie	Director of Finance, Digital, Estates and Support Services	4/4
In attendance (Executive Directors) - NCIC		**Audit and Risk Committee Attendance (partial or full attendance based on requirement)**
Michael Smillie	Director of Finance, Digital, Estates and Support Services	2/4
Anna Stabler	Interim Executive Chief Nurse	1/4
Peter Rooney	Executive Director of Improvement	1/4

Role and responsibilities

The work of the Audit and Risk Committee is to:

Seek assurances as to the adequacy and effectiveness of internal control, corporate governance, and financial and non-financial reporting arrangements, to support the delivery of safe and quality services for patients. This includes oversight of external and internal audit; and functions relating to the annual statutory accounts, standing orders, standing financial instructions and standards of business conduct.

The key activities undertaken by the committee in fulfilling its responsibilities for the year are set out below.

Risk management and internal control
Key items considered were as follows:

Internal Audit
The committee approved the Internal Audit Plan and monitored its delivery throughout the year. The committee ensured that Executive Directors were held to account for implementation of recommendations.

The role and structure of the internal audit function are detailed later in this report.

Counter Fraud
The committee received the Local Counter Fraud Specialist Annual Report 2018/19 and approved the Local Counter Fraud Specialist Plan 2019/20

Raising Concerns

The committee received the annual report on Raising Concerns.

CQC registration

The committee received assurance on the arrangements for ensuring compliance with CQC requirements and preparations for the inspection of core services.

Governance statements and declarations process

The committee received assurance on the Trust's governance statements and declarations process.

Litigation and claims management

The committee received assurance on the management of litigation and claims.

Trust Annual Report

The committee reviewed the 2018/19 annual report and accounts and agreed to recommend to the Board that they be adopted.

Financial Reporting

During 2019/20, the committee considered key accounting issues and judgements relating to the accounts. The significant areas of judgement considered, in relation to the financial statements for the year ended 31 March2020, were as follows:

- **Valuation of land and buildings** – During 2019/20, the Trust revalued its land and buildings based on professional advice from its valuers, Cushman & Wakefield. and noted that as a result of the COVID-19 crisis the valuers have had to use their judgement in a set of unprecedented circumstances. Consequently, the valuation has a higher degree of uncertainty attached than would normally be expected although this does not mean that the valuation cannot be relied upon. We considered and agreed the basis of the revaluation and its enhanced disclosure in the financial statements.
- **Plant, equipment & intangible assets –** We agreed that, as these assets are not valued, depreciated replacement cost was a reasonable approximation to fair value.
- **Contingent assets and liabilities** – As disclosed in note 27 to the financial statements, the Trust has contingencies in respect of a dispute with its PFI provider and employers' liability claims. We considered the available expert and legal advice and approved the accounting treatment of these matters.
- **Provisions** – The Trust has a number of provisions as set out in note 26 to the financial statements. We reviewed and accepted the judgements made by management in assessing provisions.
- **Receivables** – The £1.5m receivable in respect of the insurance claim for the fire in the WCH Energy Centre. We considered the basis for continuing to include this in receivables and accepted the judgements made by management.

- **PFI** – The Trust is in dispute with its PFI for Workington Hospital in respect of fire defects and other issues. The Trust has recognised an asset in its financial statements that may require adjustment once the dispute process has ended. We reviewed and accepted the judgements made by management in respect of this asset.
- **PFI** – The Trust includes estimates for future RPI in order to populate its PFI Models and provide analysis of future costs. We accepted the estimation approach used by management.
- **Going Concern** – We considered the financial position of the Trust at our meeting in Marchand agreed that the accounts should be prepared on a going concern basis.

Quality accounts

The committee considered the integrity and accuracy of the 2018/19 quality accounts and agreed to recommend to the Board that they be adopted. We received updates throughout the year on the implementation of improvement actions.

Standing Orders and Standing Financial Instructions (SFIs)

The committee reviewed activity and were satisfied that these were appropriately managed.

Data quality

The committee monitored progress against the Data Quality Strategy to improve the quality of data underpinning key performance indicators, particularly those subject to external audit. For further details see the Quality Report (published separately).

Board Assurance Framework

The committee monitored the review and subsequent development of the Board Assurance Framework towards an outcomes-based approach and noted work to improve the connectivity between the BAF and the corporate risk register.

Risk management

The committee reviewed the Trust's arrangements for monitoring and managing risk. The Risk Management Strategy and policy were considered and the committee noted ongoing work and embed the risk appetite statement.

Charitable Trust Fund

The committee reviewed the annual accounts of the Charitable Trust Fund and agreed to recommend to the Corporate Trustee that they be approved. The committee considered the management of the Charitable Trust Fund and approved changes to the Charitable Funds Policy. The Committee agreed that the Charitable Trust Funds should not be consolidated into the accounts of North Cumbria Integrated Care NHS Foundation Trust on the grounds that they are not material.

External audit

The audit of the 2018/19 financial statements was the end of Mazars' 2 year contract. Following a tendering exercise Grant Thornton were awarded a contract for 3 years commencing with the 2019/20 audit. The value of the contract for 2019/20 is £78,000 including VAT.

At least one representative from the external auditor in contract was in attendance at all meetings through the year.

The Committee approved the External Audit Strategy Memorandum.

The committee considered if non-audit work undertaken by the Trust's External Auditor represented any conflict of interest. The Trust has a policy for appointment of External Auditors to undertake non-audit work approved by the Trust governors. The Trust sought confirmation that where External Audit staff were undertaking non-audit services, these staff were not involved in the external audit service. Due to the COVID-19 crisis a Quality Report was not required to be produced at the same time as the Annual Report for 2019/20. Therefore, there were no non-audit services provided by the External Auditors in respect of the Quality Report for 2019/20.

Internal Audit – role and structure

Internal audit provides an independent, objective assurance and consulting activity designed to add value and improve the Trust's operations. It assists the Trust to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

The Trust continues to obtain internal audit and counter fraud services from Audit One. Audit One is a not-for-profit provider of internal audit, information systems assurance and counter fraud services, to the public sector in the North of England. Their work is based on a risk based plan; agreed and overseen by the Trust's Audit and Risk Committee. The committee receive summaries of all internal audit reports, including regular progress information on the status of agreed management actions arising from internal audit recommendations. All internal audit reports are provided to the Chair of the Audit and Risk Committee.

The Audit One Managing Director of Audit, as part of his requirements, provides the Trust's Chief Executive with an annual Head of Audit opinion. This supports the Annual Governance Statement and is based upon all internal audit work undertaken during the year, and the arrangements for gaining assurance via the Board Assurance Framework. All internal audit work is undertaken in accordance with the requirements of the Public Sector Internal Audit Standards.

2.4.2 Governors Council Report

As a NHS Foundation Trust, we are required to comply with the arrangements set out by our independent regulators, NHS England and NHS Improvement, in the NHS Foundation Trust Code of Governance (2014). The Code of Governance requires us to have a comprehensive framework in place to ensure the Trust is managed and governed properly. We comply with the provisions of the code and will continue to observe the spirit of the code in everything we do.

Our business is managed by the Board of Directors which exercises all the powers of the Trust subject to any contrary provisions of the NHS Act 2006 and the Health and Social Care Act 2012. The Board of Directors is responsible for approving the Annual Report and accounts. In preparing the Annual Report they take into account the views of the Governors' Council which contain information about our forward planning.

This section describes the composition of the Governors' Council during the year, their roles and responsibilities, how they work together and the types of decisions taken during the year to develop the organisation and describes how disagreements between the Board of Directors and the Governors' Council will be resolved.

Roles and responsibilities

The roles and responsibilities of the Governors' Council, which are to be carried out in accordance with the Trust's Constitution and NHS Provider Licence, are as follows:

- To hold the NEDs individually and collectively to account for the performance of the Board of Directors
- To represent the interests of the Members of the Foundation Trust as a whole and the interests of the public
- To appoint or remove the Chair and the other NEDs
- To approve an appointment (by the NEDs) of the Chief Executive
- To decide the remuneration, allowances and other terms and conditions of office of the NEDs
- To appoint or remove the Foundation Trust's auditor
- To be presented with the annual accounts, any report of the auditor on them and the annual report
- To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning
- To undertake such functions as the Board of Directors may from time to time request
- To review at least annually the Foundation Trust's membership strategy
- To make recommendations to the Board of Directors for any amendments in this Constitution to the composition of the Governors' Council
- To respond as appropriate when consulted by the Board of Directors on any proposed revision of this Constitution or any other matter.

On 31 March 2020 the Governors' Council, chaired by the Trust Chair, Professor Robin Talbot, consisted of up to 38 governors representing the Public and Staff constituencies and representatives from the Local Authority and Partner Organisations as identified by the Trust's Constitution: 22 Public Governors; 7 Staff Governors and up to 9 Appointed Governors. There are currently 2 vacancies on the Governors' Council.

Information on governors who held office during 2019/20 is shown in Table 3.3 (CPFT) and 3.4 (NCIC) which includes details of their constituencies or organisations represented; whether they are elected or appointed; their term of office and attendance at meetings. In accordance with the Trust's Constitution and NHS Provider Licence, all governors are required to meet the 'Fit and Proper Persons Test' on appointment and on reappointment.

Lead Governor and Deputy Lead Governor

The Lead and Deputy Lead Governors are elected by their peers for a term of 3 years or until their term ends, whichever is the sooner.

- Lead Governor - Jane Smith, Staff Governor Allerdale and Copeland (Jan 2017 – Dec 2020) (current Staff Governor term ends 30 Sept 2020)
- Deputy Lead Governor – Keith Amey, Public Governor Copeland (July 2017 – June 2020) (current Public Governor term ends 30 Sept 2023)

Table 3.3: CPFT Governors' Council – composition and meeting attendance record from 1 April 2019 – 30 September 2019

Constituency	* No. of Governor positions	Name	Appointment	** No. of meetings
Public constituency (elected)				
Allerdale	5	2 vacancies	n/a	n/a
		Rachael H Davies	Oct 2016 - Dec 2019	2/4
		Linda Radcliffe	Oct 2016 - Dec 2019	4/4
		Alinson McCourt	Oct 2017 - Sep 2020	2/4
Carlisle	5	2 vacancies	n/a	n/a
		Elizabeth Freeman	Oct 2016 - Dec 2019	4/4
		Jack Smith	Oct 2017 - Sep 2019	0/4
		Garry English	Oct 2013 - Sep 2019	0/4
Copeland	5	2 vacancies	n/a	n/a
		Kerry-Ann Lister	Oct 2013 – Dec 2019	4/4
		Keith Amey	Oct 2012 – Dec 2019	4/4
		Carole Woodman	Jan 2019 – Dec 2019	4/4
Eden	5	Vacant	n/a	n/a
		Mike Taylor	Oct 2017 - Dec 2019	1/4
		Jacqueline Nicol	Oct 2017 - Sep 2020	4/4

Constituency	* No. of Governor positions	Name	Appointment	** No. of meetings
		David Pollitt	Oct 2014 - Sep 2020	3/4
		Hilary Carrick	Oct 2014 - Sep 2020	2/4
Furness	5	3 vacancies	n/a	n/a
		Stephen Newton	Jun 2013 - Dec 2019	4/4
		Shahnaz Asghar	Jan 2019 - Dec 2019	4/4
Lancashire	1	Derek Seber (Rev)	Oct 2017 - Sep 2020	2/4
North East England	1	Vacant	n/a	n/a
South Lakeland	5	2 vacancies	n/a	n/a
		Patricia Turton	Oct 2016 - Dec 2019	0/4
		George Butler	Jan 2019 - Dec 2019	3/4
		Jim Ring	Oct 2017 - Sep 2020	4/4
Staff constituency (elected)				
Allerdale and Copeland	3	Leslie Blacklock	Oct 2017 - July 2019	2/2
		Tricia Goldwater	Oct 2013 - Dec 2019	3/4
		Jane Smith	Oct 2011 - Sep 2020	3/4
Carlisle and Eden	3	Vacant	n/a	n/a
		Peter Farrell	Oct 2016 - Sep 2019	1/4
		Robert Donlevy	Oct 2017 - Sep 2020	1/4
Furness and South Lakeland	3	2 vacancies	n/a	n/a
		Kevin McVeigh	Oct 2015 – Sep 2019	2/4
Appointed Governors				
Cumbria County Council	2	Vacant	n/a	n/a
		Vacant	n/a	n/a
University of Cumbria	1	Alison Hampson	Apr 2017 - Apr 2020	3/4
Cumbria CVS	2	2 vacancies	n/a	n/a
Leagues of Friends	1	James Porter	May 2018 - Apr 2021	3/4
	47			

***** Number of governor positions per constituency. Elections are held annually so the table shows governors that held a position at some point during 2019/20.

****** Number of Governors' Council meetings that each governor attended, out of the total number they were eligible to attend, based on their Term of Office.

Table 3.4: NCIC Governors' Council – composition and meeting attendance record from 1 October 2019 – 31 March 2020

Constituency	* No. of Governor positions	Name	Appointment	** No. of meetings
Public constituency (elected)				
Allerdale	4	Alinson McCourt	Oct 2017 - Sep 2020	
		Linda Radcliffe	Oct 2016 - Sep 2023	2/2
		Leslie Blacklock	Jan 2020 - Sep 2022	0/1
		Martin Whitmill	Jan 2020 - Feb 2020	0/1
		William Miskelly	Mar 2020 - Sep 2021	0/0
Carlisle	4	Elizabeth Freeman	Oct 2016 - Sep 2021	2/2
		Derrick Bates	Jan 2020 - Sep 2023	1/1
		Janet Blair	Jan 2020 - Sep 2022	1/1
		Annette Oxley	Jan 2020 - Feb 2020	0/1
		Rebecca Mullins	Mar 2020 - Sep 2023	0/0
Copeland	4	Keith Amey	Oct 2012 - Sep 2023	2/2
		Les Hanley	Jan 2020 - Sep 2023	1/1
		Carole Woodman	Jan 2019 - Sep 2021	2/2
		Kerry-Ann Lister	Oct 2013 - Sep 2021	1/2
Eden	4	Mike Taylor	Oct 2017 - Sep 2023	2/2
		Jacqueline Nicol	Oct 2017 - Sep 2020	1/2
		David Pollitt	Oct 2014 - Sep 2020	2/2
		Hilary Carrick	Oct 2014 - Sep 2020	1/2
Furness	2	Stephen Newton	Jun 2013 - Sep 2022	1/2
		Shahnaz Asghar	Jan 2019 - Sep 2023	2/2
Lancashire	1	Derek Seber (Rev)	Oct 2017 - Sep 2020	1/2
North East England	1	Christopher Mason	Jan 2020 - Sep 2023	1/1
South Lakeland	2	Jim Ring	Oct 2017 - Feb 2020	1/2
		George Butler	Jan 2019 - Sep 2022	1/2
Staff constituency (elected)				
Allerdale and Copeland	3	Jane Smith	Oct 2011 - Sep 2020	2/2
		Christopher Fleming	Jan 2020 - Sep 2023	1/1
		Clare France	Jan 2020 - Sep 2022	0/1
Carlisle and Eden	3	Robert Donlevy	Oct 2017 - Sep 2020	1/2
		Deborah Berg	Jan 2020 - Sep 2023	1/1
		Neil Racher	Jan 2020 - Sep 2022	1/1
Furness and South Lakeland	1	Vacant	n/a	n/a
Appointed Governors				

Constituency	* No. of Governor positions	Name	Appointment	** No. of meetings
Cumbria County Council	2	2 vacancies	n/a	n/a
University of Cumbria	1	Alison Hampson	Apr 2017 - Apr 2023	0/2
Cumbria CVS	2	2 vacancies	n/a	n/a
Leagues of Friends	1	James Porter	May 2018 - Apr 2021	1/2
Unidentified	3	Vacant	n/a	n/a
	38			

***** Number of governor positions per constituency. Elections are held annually so the table shows governors that held a position at some point during 2019/20.
****** Number of Governors' Council meetings that each governor attended, out of the total number they were eligible to attend, based on their Term of Office.

Details of company directorships of Governors
The register of interests for members of the Governors' Council is available on the Trust's website https://www.cumbriapartnership.nhs.uk/the-trust/governors or from the Corporate Governance Team on **01228 603761**.

Supporting the role of governor
The Health and Social Care Act s151(5) places a duty on Foundation Trusts to take steps to secure that governors are equipped with the skills and knowledge they require in their capacity as such. This duty is also included within the Trust Constitution at section 6.4.

In order to ensure governors are equipped with the skills and knowledge they require to fulfil their role, governors are provided with training and development opportunities throughout their tenure. The training and development programme continues to be adapted to meet the needs of the governors.

Communications between the Board of Directors, Governors' Council and members
The Board of Directors (the Board) and Governors' Council (GC) work closely together. All members of the Board have an open invitation to attend the GC meetings. Executive and Non-Executive Directors (NEDs) are invited to make formal presentations at these meetings (6 meetings in year) for the purpose of obtaining information on the Trust's performance of its functions and the Directors' performance of their duties and to hear the views of the governors, members and the public. There are also ad-hoc meetings and discussions between individual Board members and governors on specific subjects of interest.

The Senior Independent Director (SID) attends the GC meeting to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors. The SID also attends/chairs the Nominations Committee when considering the Chair appraisal or Chair appointment.

The Chair ensures that the views of governors and members are communicated to the Board as a whole through the Lead Governor sitting at the Board table and the Executive and Non-Executive Directors attending the GC meetings.

At Board meetings the Lead Governor has a seat at the Board to ask questions and seek assurances/share best practice on behalf of the GC. The Board meetings include a quarterly standing item on the activities and views of the GC presented by the Lead Governor. Governors and members can attend Board meetings and ask questions on notice or about the agenda items.

The GC meeting is held in public and advertised on our website. The public has an opportunity at the meeting to give their views or ask questions on the agenda. NEDs attend GC meetings to feedback on progress of issues from the Board Committees to help governors fulfil their role in 'holding Non-Executive Directors to account'.

The following information details the steps taken during the year by the GC to engage with members and the public on our forward planning, our objectives, priorities and strategy, and their views are shared with the GC and included in their activity report presented to the Board. However, due to the impact of coronavirus all visits and face to face meetings ceased in March 2020 and will not resume until we receive national guidance to the contrary. The Board continued to engage with the GC electronically and via teleconference.

Trust Talk was the quarterly magazine for members and the public during 2019, available on our website and sent to staff and public members by email, with limited paper copies available in Trust premises. This magazine is being revamped and will be relaunched in 2020.

Engagement Partnerships - North and South groups maintain communications with members, third sector organisations, local ICCs and neighbouring Foundation Trust governors providing services in our area. Governors are involved with the development of their local ICCs and other service developments within their local area.

Joint Non-Executive Director (NED) and Governor Visiting programme - The purpose of visiting services is to provide staff the opportunity to openly discuss service developments and improvements, and to highlight any key issues/risks in their service that may prevent patients from receiving high quality, safe care, and having the best experience whilst using our services. These monthly visits aim to promote transparency and to ensure that staff feel supported and are confident in fulfilling their day to day roles. The engagement team

feeds back issues and good practice to senior managers at the end of the visit. Reports are provided to the relevant care group governance group for consideration and shared with the Quality Improvement and Safety Committee and the GC.

Governors Special Interest Groups (SIGs) – These groups focus on engaging with members and the public supporting the development of the integrated health and care system (IHCS).

- The Governance SIG is a task and finish group. During 2019 the group acted as the forum that engaged with, and lead on the process about the merger transaction between CPFT and NCUH. The group finished on the successful merger.
- The Mental Health SIG had a similar role in relation to the mental health, learning disability and CAMHS service transactions proposed by the Clinical Commissioning Groups and finished on the transfer of services to neighbouring providers.
- The Engagement SIG focuses on engaging with members and the public in line with the approved Member Engagement Strategy. This group is working closely with the Communications Team to promote health and wellbeing through a number of campaigns throughout 2020.

These groups report to the GC through the Governors Advisory Committee.

Organisational Form transaction

The GC were engaged in the process and received updates and discussed the proposals at all meetings of the GC. As part of this transaction the GC reviewed and approved the revised structure of the membership and GC for the new Trust, which was implemented post-merger.

Mental Health/Learning Disability and CAMHS service transaction

The GC attended meetings with staff to hear their views and met with both Northumberland Tyne and Wear NHS Foundation Trust and Lancashire Care NHS Foundation Trust to hear their proposals. Four governors were involved in the MH Stakeholder Advisory Group. The SIG fed back their views to the GC and the Board during this time.

Annual Members meeting – the second joint meeting with North Cumbria University Hospitals NHS Trust was held on 19 September 2019. Fifty-six people attended, including governors, members, staff and the public to hear about our achievements and challenges over the past year and our future plans as part of the developing the North Cumbria integrated health and care system (IHCS). Jane Smith, Lead Governor and Keith Amey, Deputy Lead Governor presented on how the Governors' Council was fulfilling its role in holding the Non-Executive Directors to account for the performance of the Board; how they were engaging with members and the wider public and representing their views to the Board; and how they plan to continue to engage across the health system, encouraging co-production and joint engagement activities for members and the public.

Patient Led Assessment of the Care Environment – This is a national annual programme of assessment of all inpatient areas and seven governors took part in 2019.

Peer Review Assessments – Peer reviews form part of the Trust's quality governance arrangements and involve staff from across the Trust's services. As of January 2020 governor involvement in these assessments is welcomed.

Governors' Council meeting governance - All formal meetings involving governors have Terms of Reference, minutes and action plans that include a section on issues to be escalated to the Governors' Council and/or Board. The agenda and papers for the meetings of the Governors' Council are published on our website. This provides a clear audit trail of engagement and communication between members, governors and the Board.

Chief Executive Appointment - Following an external recruitment exercise during Q3 of 2019/20 Lyn Simpson was appointed as Chief Executive. Constitutional requirements relating to Governors' Council approval of the Chief Executive appointment were met, although the process around governor involvement and engagement was not as robust as it should have been. Concerns raised by the GC about the process were addressed quickly to the satisfaction of all parties and the Board has enhanced its processes for governor engagement as a result of this experience.

Dispute between the Governors' Council and the Board of Directors
There were no disputes during 2019/20. In the event of any unresolved dispute between the Governors' Council and the Board of Directors, the Chair will:

- Take such steps as the Chair considers appropriate to try to reach a common and clear understanding of the issues in dispute
- Consider whether independent advice will help to resolve the dispute and if appropriate arrange for independent advice to be made available to the Foundation Trust
- If the dispute continues to be unresolved, ensure that an appropriate record of it is made in the minutes of a meeting of the Governors' Council and in the minutes of a meeting of the Board of Directors.
- Ensures that an appropriate record of any unresolved dispute is made in our annual report for the relevant period including a summary of the issues in dispute and the action taken by the Board and the GC to attempt to resolve the dispute.

2.4.3 Nominations Committee Report

The Nominations Committee is a sub-committee of the Governors' Council and its primary function is to ensure that the Board includes an appropriate number of independent, skilled, experienced and effective NEDs and a Chair. The Committee must also ensure that the levels of remuneration for the Chair and other NEDs reflect the time commitment and responsibilities of their roles.

The Committee must work to ensure that appointments to the Board:

- Are made on merit, against objective criteria
- Meet the fit and proper persons test described in the NHS Provider Licence issued by NHS England and NHS Improvement
- Have due regard for the benefits of diversity on the Board and the requirements of the Trust, and that appointees have enough time available to discharge their responsibilities effectively.

The Committee should satisfy itself that plans are in place for orderly succession for Non-Executive appointments, including the Chair, to the Board and that the Board maintains an appropriate balance of skills and experience.

The Trust Chair is the Chair of the Committee which was undertaken by Prof. Robin Talbot until his resignation on 31 March 2020. The current Interim Trust Chair is Peter Scott. The Vice Chair is the Senior Independent Director (SID) and this role was undertaken by Heike Horsburgh, Non-Executive Director until 30 September 2019; George Liston, Non-Executive Director was appointed to this role on 7 November 2019. The SID is invited to attend when considering the Chair's appraisal and chairs the meeting when considering the Chair's appointment.

The Committee membership includes three governors: Jane Smith (Staff Governor Allerdale and Copeland/Lead Governor), Keith Amey (Public Governor Copeland/Deputy Lead Governor) and Linda Radcliffe (Public Governor Allerdale). To ensure continuity, we have two reserves; Jacqueline Nicol (Public Governor Eden) and Elizabeth Freeman (Public Governor Carlisle) who take part in the business of the Committee.

The Committee, met thirteen times during the year to consider the following areas:

- Board succession planning
- NED appointments
- Chair appointment
- Remuneration review

No Directors were invited to attend the Committee in the year.

Non-Executive Directors (NEDs) Appointments and Re-appointments

As part of the Organisational Form transaction to take effect from the date of the merged organisation, the Committee considered Non-Executive Director appointments and re-appointments in line with the approved process for appointment/reappointment of the Chair and NEDs.

The Committee undertook the re-appointment process in line with the agreed procedure and recommended the following NEDs, who held a post in either CPFT or NCUH, for re-

appointment: Louise Nelson, George Liston, Jeff O'Neill and Malcolm Cook. The GC approved the recommendations.

The Committee undertook an external recruitment process in line with the agreed procedure and identified preferred candidates for the two remaining NED vacancies. The Committee recommended David Allen to the GC meeting on 5 September 2019 and Susan Mckenna to the GC meeting on 19 September 2019. The GC approved both recommendations.

Chair Appointment

Professor Robin Talbot offered his resignation to the Board in January 2020 to take effect in March 2020; one year earlier than the end of his term of office.

In January 2020 the Committee undertook a further review of the Chair remuneration following the publication by NHS England and NHS Improvement in September 2019 on the recommended standardised framework of remuneration for Chairs and NEDs across NHS Trusts and Foundation Trusts. The Committee recommended a slight decrease in the remuneration for the new Chair from £50,901 to £50,000 in line with the published framework, along with the recruitment information pack and timetable to the GC meeting on 6 February 2020 which was unanimously approved.

The Committee undertook the Chair appointment process in line with the agreed procedure. However, in line with national guidance on the need cancel non-essential meetings due to the coronavirus pandemic, the stakeholder event and interviews were postponed. An Interim Chair was identified and approved by the Trust, with the agreement of the Committee; Peter Scott was appointed Interim Chair on 1 April 2020 for a period of up to 6 months. Once national guidance allows face to face meetings, the Chair Recruitment process will restart to ensure continuity of provision.

Non-Executive Director Remuneration Review

The Committee undertook a review of NED remuneration in April 2019 taking into consideration the national benchmarking exercise carried out by NHS Providers in February 2019. The Committee made recommendations to the GC meeting on 4 July 2019, all of which would take effect from the date of the merged organisation; on increased remuneration from £12,000 to £13,491, recognising an increased commitment from 3 to 5 days per month; and to cease the historic uplift allowance made to two NEDs for their duties as chair of the Audit & Risk Committee and Vice Chair, as it was recognised all NEDs contribute in different and important ways. The GC approved the recommendations.

Following the publication by NHS England and NHS Improvement in September 2019 on the recommended standardised framework of remuneration for Chairs and NEDs across NHS Trusts and Foundation Trusts, the Committee considered these recommendations in October 2019 and shared this information with the GC meeting on 7 November 2019 with a view to considering remuneration at a future meeting of the Committee in 2020.

2.4.4 Membership Report

What is membership?
All Foundation Trusts have a duty to engage with their local communities and encourage local people to become Members and to take steps to ensure that their membership is representative of the communities they serve. We are committed to an engaged and vibrant membership community.

Anyone who lives in the area or who works for us, and is 14 years or older, can apply to become a member (exclusions apply as detailed in our Constitution).
They will be eligible to join one of two membership groups:
Public membership – divided into eight constituencies
Staff membership – divided into three joint constituencies

An individual cannot be a member of more than one group. You can find out more about the eligibility criteria and the process for membership application in our Constitution which can be accessed via our website
https://www.ncic.nhs.uk/trust/how-we-are-run/meet-board
or request a copy from the Corporate Governance Team on 01228 603761
or email AskYourGovernor@ncic.nhs.uk

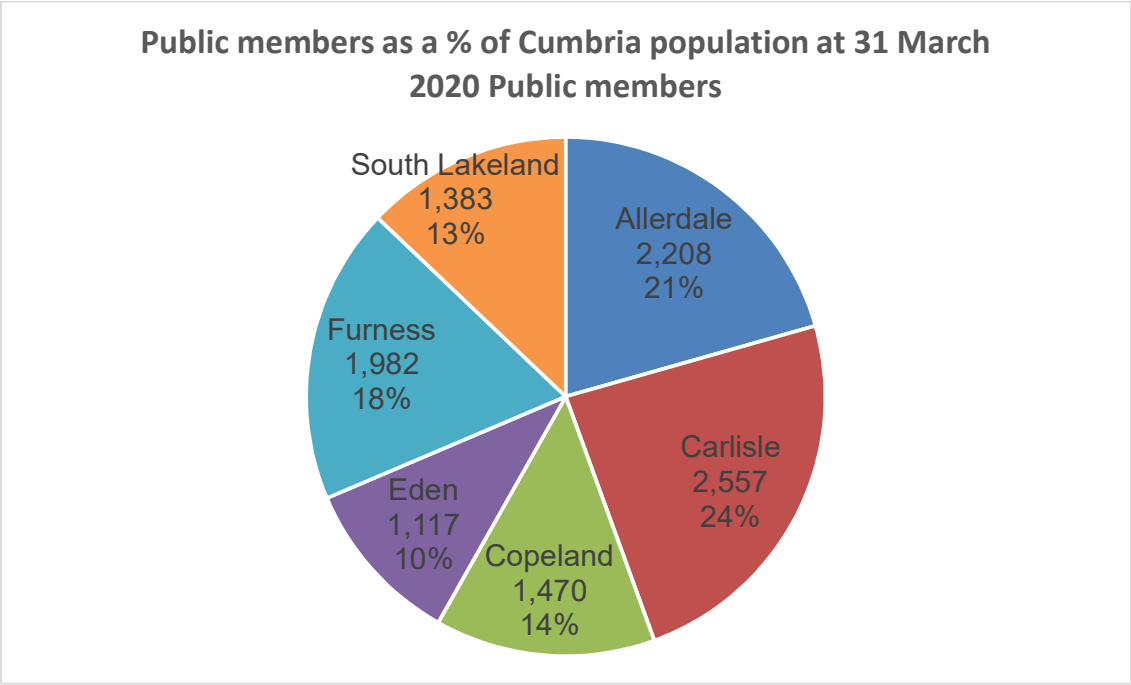
Public membership
We have eight public constituencies which are open to all residents of Cumbria, Lancashire and North East England over the age of 14 years. The eight public constituencies correspond to the six district council areas within Cumbria County Council, Lancashire County Council and the North East of England (Cleveland, Durham, Northumbria and Tyne & Wear).

Staff membership
The staff constituency is divided into three classes that are geographically based according to where the member of staff works:

- West Cumbria (Allerdale and Copeland)
- North/East Cumbria (Carlisle and Eden)
- South Cumbria (Furness and South Lakeland)

We have adopted an opt-out scheme and all staff who are employed (including indirectly employed) by us for 12 months or more are included as Members. New employees who meet the criteria above are automatically included as Members.

Membership profile
Information on the total number of Members and the number of Members in each constituency at 31 March 2020 is shown in the chart below.



There are 9 Public members in North East England which have been attracted through links with North Cumbria University Hospitals NHS Trust and our general communications channels. There are 49 members in Lancashire which have been attracted through our general communications channels, primarily our website. The total public membership figure at 31 March 2020 is 10,775, a reduction of 131 from the previous year following the annual data cleanse exercise, plus 88 new public members, 29 of which joined following the launch of the 'be involved' membership campaign.

Membership Engagement Strategy 2019 - 2022

Our ambition is to have a membership base which is engaged and actively involved in co-producing future service design and delivery, reflective of the needs of patients and the local community.

Our vision is to build a new integrated health and care system together, using our collective capabilities for a healthier and happier population. The merged organisation is the platform for the development of the North Cumbria Health & Care System and therefore our plans closely align with the strategic aims that are set out in our system strategy for the next five years.

This signals a clear opportunity for real engagement with our members in communities, our patients and staff. The Governors' Council has a duty to represent the interests of the members of the Trust as a whole and the interests of the public and feed back to their communities. Our engagement strategy set out the ways in which the Governors' Council and the Trust should engage with our membership which was refreshed in 2019 to support

governors engaging with members and the public to contribute to coproduction in our developing integration health and care system.

Our objectives for 2019 - 2022 are:-

- Objective 1: Recruit and retain members who are representative of the community in Cumbria
- Objective 2: Communication and engagement with public and staff members
- Objective 3: The Trust will actively engage with its members on co-production opportunities to deliver our strategic aims

The Governors' Council will agree how we will deliver these objectives and monitor progress against their delivery.

We have over 10,000 public Members, of which currently one third is active. We aim to have as many actively participating members as possible and with this in mind there is a drive to improve engagement. Details of engagement this year can be found in the Governors' Council Report.

Membership monitoring
The Board monitors the level and effectiveness of membership engagement through the presentation of the GC activity report on a quarterly basis by the Lead Governor.

Contact a Director or Governor
If you wish to make contact with a Director please contact:
Communications Team
Address: The Pillars, Cumberland Infirmary, Carlisle, CA2 7HY
Telephone: 01228 603890
Email: communications.helpdesk@ncic.nhs.uk

If you wish to make contact with a governor please contact:
Email: AskYourGovernor@ncic.nhs.uk
Telephone: 01228 603761

You are welcome to attend our Annual Members meeting or Governors' Council meetings which are held throughout the year – find out more at
https://www.ncic.nhs.uk/trust/how-we-are-run/board-meetings
https://www.ncic.nhs.uk/trust/how-we-are-run/governors-council-meetings

2.5 NHS England and NHS Improvement's Oversight Framework

NHS England and NHS Improvement's (NHSE/I) NHS Oversight Framework 2019/20 provides the framework for overseeing providers and identifying potential support needs. The framework looks at the following themes:

- New service models
- Preventing ill health and reducing inequalities
- Quality of care and outcomes
- Leadership and workforce
- Finance and use of resources

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.

Segmentation

This segmentation information is the Trust's position at 31 March 2020. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England and NHS Improvement website. North Cumbria Integrated Care NHS Foundation Trust has been placed in segment 2, which is defined as 'providers offered targeted support'.

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 NHS England and NHS Improvement's Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 Q1 score	2019/20 Q2 score	2019/20 Q3 score	2019/20 Q4 score
Financial sustainability	Capital service capacity	1	4	4	4
	Liquidity	4	4	4	4
Financial Efficiency	I&E margin	4	4	4	4
Financial Controls	Distance from financial plan	1	4	4	4
	Agency spend	3	3	2	3
Overall scoring		**3**	**4**	**4**	**4**

2.6 Statement of Chief Executive's responsibilities as the Accounting Officer of North Cumbria Integrated Care NHS Foundation Trust

The NHS 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 NHSE/I.

NHSE/I, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require North Cumbria Integrated Care 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 North Cumbria Integrated Care 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 NHSE/I, 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 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 Foundation Trust and to

enable them 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 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 no 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.*

Signed L. Simpson..... Date: 23rd June 2020

Lyn Simpson
Chief Executive

2.7 Annual Governance Statement

On 1st October 2019 Cumbria Partnership NHS Foundation Trust (CPFT) merged through 'statutory acquisition' under Section 56A, of the National Health Service Act 2006 with North Cumbria University Hospitals Trust (NCUH) to form North Cumbria Integrated Care NHS Foundation Trust (NCIC). This Annual Governance Statement covers the period 1st April 2019 to 30th September 2019 for CPFT and the remainder of 2019/20 for NCIC.

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 NCIC, 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 NCIC for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk and risk management arrangements

The Chief Executive has overall accountability for risk management and discharges that duty through the Executive Team who have collective responsibility for maintaining a system of sound internal control.

Following agreements from NHS England and NHS Improvement (NHSE/I) and CPFT Governors Council during 2018 and 2019, the formal merger between NCUH and CPFT took effect on 1st October 2019. This transaction was technically an acquisition of NCUH by CPFT. During the first six months of 2019/20, the Trust worked increasingly collaboratively with NCUH to further align, develop and improve our quality governance arrangements ahead of the merger.

In quarter 2 of 2019/20 we introduced integrated Care Group governance and leadership structures spanning all of both trusts' services. We now have two Care Groups; Integrated Pathways Care Group and the Specialist Care Group, which includes governance structures for our Integrated Care Communities. Care Groups are supported by staff within Corporate and Support Service teams who are specialists in various aspects of risk management, and who are a central resource for training, advice and guidance.

A 'best of both' principle was adopted in the work to refresh, align and integrate our quality governance, clinical risk management and leadership frameworks to ensure good practice in both trusts formed the basis of NCIC's arrangements to identify, manage, escalate and report risks, as appropriate to the scale and nature of the risk. Senior clinical leaders have responsibility for driving improvements to quality and safety, and to actively support our staff in the identification and management of identified risks. Staff are supported to attend mandatory training and additional subject-specific and core skills training including risk management, which make up the overall training programme. The Board of Directors (the Board) has line of sight to the management of significant operational and strategic risks through the Board Assurance Framework and through the functioning of its Committee and governance frameworks.

We benefit from good practice through a range of learning and improvement mechanisms, including:

- Robust investigation processes
- Peer review
- Clinical audits
- Professional and personal development
- The application of evidence-based practice
- Quality improvement tools, such as the Cumbria Production System

Investigation of complaints, incidents and near misses is overseen by our Executive Chief Nurse. Quality, safety and performance matters are cascaded and escalated through governance frameworks. Improving the quality of care and safety are the driving principles of our quality governance arrangements.

The Risk and Control Framework

Board Membership

During the period 1st April 2019 to 30 September 2019 (pre-merger), there were no changes to the Executive Director team. All Executive Directors had remit across NCUH and CPFT as part of the aligned governance arrangements across both trusts. Following Non-Executive Director recruitment by CPFT in quarter 1 of 2019/20, in July 2019 two NCUH Non-Executive Directors were appointed as Non-Executive Directors for CPFT, bringing the number of Non-Executive Directors holding positions in both trusts to four. All Executive Directors continued in post in NCIC upon merger on 1st October. Appointments

to NCIC's Non-Executive Director positions were made in accordance with NHSE/I merger transaction guidance.

Stephen Eames, Chief Executive, left the Trust in December 2019 although continues as System Lead of the Integrated Care Partnership for North Cumbria. Following an external recruitment exercise during quarter 3 of 2019/20 which involved our governors, our Regulators, and other key stakeholders, Lyn Simpson was appointed as Chief Executive. Lyn commenced in post in January 2020. Constitutional requirements relating to Governors' Council approval of the Chief Executive appointment were met following initial concerns on governor involvement and engagement. Concerns raised by the Governors' Council about the process were addressed to the satisfaction of all parties and the Trust Board has since enhanced its processes for governor engagement as a result of this experience.

In January 2020, Robin Talbot, the Trust's Chair, gave notice he would be leaving the Trust. Activity to recruit his successor began in January 2020 but was paused in March 2020 due to COVID-19 disruption. Peter Scott took up post as interim Chair on 1st April 2020 and will continue in post until a substantive Chair appointment is made during 2020/21.

Since the establishment of NCIC in October 2019, the following changes have occurred within the Executive Director team: -

- Alison Smith, Executive Chief Nurse, left the Trust in January 2020 to take up a secondment with NHS England and NHS Improvement which continued until end March 2020. Anna Stabler commenced in post in January 2020 as interim Executive Chief Nurse.
- Mandy Nagra, Chief Operating Officer in January 2020 took up a secondment elsewhere within the NHS. The post is currently being covered by interim arrangements.
- Peter Rooney joined the Trust Board as Executive Director of Service Improvement on secondment from North Cumbria Clinical Commissioning Group until 31st March 2020.
- Judith Toland, Executive Director of People & Digital left the Trust in October 2019. The post was covered by interim arrangements which recruitment to the substantive post holder was completed. Her successor, Justine Steel commenced in post on 4th May 2020.
- Gary O'Hare, Executive Director of Mental Health and Learning Disabilities left CPFT on 30th September 2019 as part of the transfer of mental health, learning disabilities and children and mental health services from CPFT to alternative providers on 1st October 2019. That post did not continue in NCIC.

- Vince Connolly, Executive Medical Director left the Trust on 31 March 2020 to South Tees Hospitals NHS Foundation Trust. This post is being filled on an interim basis by Dr Rod Harpin.
- The Chief Executive established a transitional leadership team from 1st April 2020 whilst substantive appointments are made to executive positions currently covered by interim arrangements.

As at 27th May 2020, the Trust has:

- Seven Non-Executive Directors (the Chair plus six other Non-Executive Directors. Three Non-Executive Directors held positions in both CPFT and NCUH, one held a position in NCUH, and three who did not hold positions in either CPFT or NCUH)
- Eight Executive Directors, six of whom have voting rights,
- Three Executive Director positions are covered by interim secondment arrangements (Executive Chief Nurse, Executive Director of Operations, Executive Medical Director).
- No Non-Executive Director vacancies

The balance between Executive and Non-Executive Directors on the Board remains in line with the Code of Governance for NHS Foundation Trusts and our Constitution and Standing Orders. Further details about Board members and changes to Board membership during the year can be found in the Directors Report and the Remuneration Report.

Board and Board level Committee

Feedback received from NHSE/I in March 2019 as part of their supportive 'Moving to Good' programme, was considered in reviewing and implementing changes to our governance structures in July 2019.

Meetings that have been in place during 2019/20, and any changes or adjustments to their arrangements within the year, are set out below.

The Board was supported by a governance structure as follows, which dealt with various components of corporate governance and risk. With the exception of the Audit & Risk Committee and Charitable Funds Committee all meetings described below happened as aligned meetings between CPFT and NCUH (meeting at the same place, at the same time) until end September 2019. These then became part of the governance framework for NCIC from 1st October 2019.

- Audit & Risk Committee (A&R) – an independent committee and senior Board subcommittee, with all members NEDs. The A&R Committee has responsibility for overseeing risk management and internal control. The A&R Committee agreed audit plans with our internal and external auditors and received progress updates and audit opinions throughout the year.

- Quality Improvement & Safety Committee (QIS) (name changed from Quality and Safety Committee (Q&S) in September 2019) – the designated Board subcommittee which oversees quality and safety issues. It is chaired by a Non-Executive Director (NED) and had Executive and NED membership. The QIS Committee monitors clinical risk management performance throughout the year and made recommendations to the Board as appropriate.
- Finance Investment and Performance Committee (FIP) - the designated Board subcommittee which oversees financial, corporate performance and investment issues. It is chaired by a NED and has Executive and NED membership. The FIP Committee monitored risks to operational and financial performance throughout the year and made recommendations to the Board as appropriate.
- Charitable Funds Committee – this designated Board subcommittee which oversees the management of Charitable Funds held by the Trust.
- Remuneration Committee – wholly NED membership.

High level governance meetings that support Board Committee effectiveness

- Executive Leadership Group – membership is Executive Directors, led by the Chief Executive.
- Clinical Management Group (CMG) - the senior operational management group led by the Medical Director and attended by Executive Directors, senior operational and clinical leaders within care groups and Heads of Support Services. CMG monitors risks to operational, clinical and financial performance and escalates issues and risks to Board level Committees as appropriate.
- Quality Improvement & Safety Group (formerly Compliance Board) - led by the Executive Director of Operations and including Executive Directors and senior managerial and clinical leaders, with a specific focus on CQC compliance. This Group superseded the Trust Wide Clinical Governance Group which was disbanded in April 2019 as its membership and function required review. Revised governance arrangements were agreed in June 2019 and were implemented from July 2019 although this group did not become embedded in the governance framework until quarter 4 of 2019/20.

The effectiveness of our Board and committees was evaluated in quarter 1 of 2019/20 as part of merger preparations when it was determined that Committees were functioning effectively in line with their Terms of Reference and would continue into NCIC. The annual review of Board and Committee effectiveness was undertaken in quarter 4 of 2019/20. These reviews have traditionally been via a survey of Board members and members of each Board Committee, and also through consideration of the Committees' performance against their work plans. In response to feedback during the 2018/19 board effectiveness review, alternative approaches were explored and a combined approach of surveys and interviews with Committee chairs was adopted for 2019/20. This evaluation indicated each Committee had met and fulfilled their functions in accordance with their Terms of Reference

Trust Governance Framework and Priorities
The Board agreed the Trust's Integrated Governance Framework document on 26 September 2019. This brought together the documents which described governance and risk management processes within NCUH and CPFT and the Trust's Risk Management Strategy into a single integrated document ahead of the merger. It also sets out our arrangements for priority setting, business planning and Board Assurance Framework. Governance priorities for 2019/20 were included in the Trust's annual plan for 2019/20.

The executive team have collective accountability for the implementation of the Trust's governance framework and delivery of priorities. The Executive Chief Nurse is accountable for delivery of effective clinical governance. Our Governance Framework is implemented through the Risk Management Policy which sets out the framework for how risks are identified, evaluated and controlled. Risks can be identified through a variety of means, including investigations into incidents through to changes in the way services are designed or delivered. Risks, once identified, are assessed using the risk assessment methodology set out within our risk management policy and recorded within our Ulysses risk management system. Operational risks are managed on a day-to-day basis by staff throughout the organisation through the Trust's governance structures. Risks which are complex in nature that require senior management attention are escalated through our governance frameworks (ultimately to the Board of Directors) for decisions on how the risk will be managed. Risks which have strategic impacts are recorded in our Board Assurance Framework (BAF).

Risk Management Strategy
Our Risk Management Strategy is contained within our Integrated Governance Framework document, more commonly referred to as the 'governance manual'.

We have an integrated approach to risk governance, which incorporates:

- Strategic planning activities
- Business planning activities
- Quality Governance Framework
- Assurance Framework
- Governance Assurance and Accountability Framework

Central to our integrated approach to risk governance is risk appetite. Our risk appetite statement was last reviewed in May 2020. In setting out our appetite for risk, we use a risk appetite framework based upon that promoted by the Good Governance Institute but which has been expanded to include wider range of risk domains that reflect complex sustainability challenges currently facing the NHS. Board members' individual risk appetites inform a collective debate on the organisational risk appetite which is then agreed by the Board. Board members' individual risk appetites inform a collective debate

on the organisational risk appetite which is then agreed by the Board of Directors. Our risk appetite is articulated in our Integrated Governance Framework document.

The Executive Chief Nurse is accountable for ensuring appropriate systems and processes are in place to enable the implementation of our Risk Management Strategy.

Our Risk Management Strategy is implemented through the Risk Management Policy which sets out the framework for how risks are identified, evaluated and controlled. Operational risks are managed on a day-to-day basis by staff through our governance structures.

The Risk Management Strategy is also delivered through other policies and procedures that support the activities mentioned above, including:

- Policies on specific risk areas, including policies and procedures with respect to countering fraud and corruption
- Policies for the reporting and investigation of incidents, complaints, concerns, and claims
- A risk-based training programme based on an annual analysis of skills and competencies required to support the delivery of safe and effective services
- Induction programmes for our staff and governors
- Training delivered by a combination of in-house experts and external partners, that gives the flexibility to provide tailored training to meet the needs of individuals with additional risk management responsibilities
- Reporting to the Board and its Committee on quality governance matters, including patient safety, patient experience, performance against key performance indicators and other regulatory and compliance requirements.

Risk Management Policy

The Risk Management Policy, last reviewed during October 2019, sets out our approach to the identification, evaluation, assessment, management, reporting and monitoring of risks. In addition, it also sets out how risks are to be escalated through our governance frameworks.

Risk management is part of our training programme. In addition to subject-specific training and core skills training, which make up the overall training programme, we deliver risk management training for team leaders, which covers the essentials of risk management. This includes learning from incidents and complaints through appropriate level investigations, and duties as a manager under health and safety law. Policies and procedures to support and enable risk management are available to all staff on our intranet site.

The Board Development programme incorporated risk management training for board members through activity to review and update of strategic risks that underpin the BAF, due diligence around merger and significant transactions, externally facilitated sessions around the Care Quality Commission's (CQC) well led framework and Getting It Right First Time (GiRFT), and activity to deliver the County's suicide prevention strategy.

We are continually seeking ways in which to enhance the quality of information available to frontline services to support their decision making around risk management. Quality and Safety dashboards which have been developed over recent years in liaison with our clinical leads, enable our leaders to actively identify and respond to quality and safety risks within their services. Dashboards were unavailable during quarter 3 whilst systems, such as Ulysses and ESR, were reconfigured following merger, but were reinstated in January 2020. The use of dashboards will become embedded within our governance arrangements during 2020/21. A continual improvement approach is taken to enhance the capabilities of our dashboards and risk management information system to ensure the system enables us to meet our statutory obligations with accuracy.

Quality governance

Quality governance is a key activity of the Board to ensure essential levels of quality and safety are met. External sources of assurance include:

- Internal and external auditors
- CQC
- NHS Resolution
- Other visits and inspections from regulatory agencies

The role of internal audit is to provide independent, objective assurance on the robustness and effectiveness of the Trust's systems and processes and to add value by identifying opportunities for improvement. The role of external audit is to perform an audit, in accordance with specific laws or rules, of the Trust's financial statements and is independent of the Trust.

Internal sources of assurance include:

- Activities undertaken by Care Groups, Quality & Nursing teams and the Corporate Governance Department
- Performance metrics
- Non-Executive Director and Governor visiting programme
- Incident reporting
- Patient and carer feedback and staff surveys

We undertake an annual self-assessment against NHSE/I's Well Led Framework which informs our evaluation of our quality governance arrangements. Our 2019/20 'Well-Led' self-assessment commenced in Quarter 3 and was scheduled for approval by the Board of

Directors in April 2020. Due to disruption associated with COVID-19 finalisation of the self-assessment has been delayed and is anticipated will conclude in quarter 2 of 2020/21.

This year, in addition to the Trust-level self-assessment, each care group undertook a self-assessment which helped to inform their organisational and learning and development plans for 2020/21.

CPFT's last formal Well Led external review was undertaken by Deloitte in 2015. Following merger, NCIC was to arrange for formal well led external review to be undertaken around six months post-transaction and the scope agreed with NHSE/I regional team. We have agreed with NHSE/I that this will be done during 2020/21.

CPFT's last formal Well Led inspection by the CQC was in June 2019. The CQC inspection report, published in September 2019, assessed the Trust as 'requires improvement' overall with 27 'must do' actions requiring immediate attention. This assessment rating carried over into NCIC upon merger. Details of how we have responded to their recommendations can be found in the Quality Report which is published separately. At the time of writing, we are awaiting confirmation when NCIC's formal Well Led inspection by the CQC will take place following their provider information request received in February 2020.

Risks logged within our risk registers continue to be managed and regularly monitored through our governance frameworks. Scrutiny of the corporate risk register is undertaken monthly by the Clinical Management Group (CMG). Monthly monitoring is also undertaken to ensure risks within risk registers are reviewed and updated in a timely manner.

Substantial work was needed on improving the quality and content of the Trust's risk register during quarters 3 and 4 of 2019/20 as a result of the creation of new care groups prior to merger, transfer of mental health, learning disabilities and children and mental health services from CPFT to alternative providers on 1st October 2019, and the integration of CPFT and NCUH's risk management system into a single version of Ulysses.

Due to competing priorities and high demands on Executive Directors' capacity, Executive Directors' engagement with the BAF review process gradually reduced during the first half of 2019/20, impacting on quality of content and its effectiveness in driving the Board's agenda on the management and mitigation of strategic risks. In recognition of this, the Board agreed to reinvigorate the BAF process through a significant refresh and reframing of the strategic risks to give greater focus to risks impacting the Trust (as opposed to the wider system). The Board agreed the Trust's revised BAF risks in December 2019, with reporting on these taking effect in January 2020 for quarter 3. The BAF continues to be reviewed quarterly, but is more closely overseen by the Audit & Risk Committee. Risk assessment records within Ulysses have also been updated to note the relationship between the risk and the BAF enabling a better understanding of our risk profile. The BAF is shared with our care group and support service leadership teams after each quarterly

update to enable cascading throughout the Trust of how the most significant risks to our objectives are being managed. We continue to focus on quality improvement of our risk register content and risk management processes.

The Board receives performance reports on agreed safety and quality key performance indicators in accordance with the integrated performance management framework.

To comply with the governance conditions of the Provider Licence, the Trust is required to provide a Corporate Governance Statement to NHSE/I. The Corporate Governance Statement relating to 2018/19 was presented to the Board of Directors for formal acceptance in May 2019 with the Statement for 2019/20 expected to be presented in June 2020. The Corporate Governance Statement sets out any risks to our compliance with the governance conditions, along with the actions taken or being taken to maintain future compliance. The statement sets out a number of key questions essential for quality governance, with evidence gathered through self-assessment or review. The Chief Executive has overall responsibility for ensuring compliance with the Trust's Provider Licence conditions, which he discharges through the Executive Team.

The Trust complied with all of the Provider Licence conditions during 2019/20. No exception reports have been required during 2019/20. We expect to comply with all of the Provider Licence conditions in 2020/21. Should there be any indications to the contrary we will ensure NHSE/I are notified as soon as they become apparent. NHSE/I is regularly appraised of our financial position. Further information on our quality governance arrangements can be found in the Quality Report (published separately).

Incident reporting

A positive approach to incident reporting is communicated through our policies and procedures. Every six months NHSE/I publishes reports on reported patient safety incidents that help trusts understand how they benchmark with trusts who provide similar services.

The most recently published reports were for the period 1 April 2019 to 30 September 2019 and related to CPFT and NCUH prior to the merger. CPFT was benchmarked with mental health trusts, NCUH was benchmarked with non-specialist acute trusts. Whilst not yet confirmed, it is expected that NCIC will be benchmarked with non-specialist acute trusts for reports relating to October 2019 onwards. CPFT has consistently benchmarked within the top third of its benchmark trusts. NCUH was placed around the median number of incidents reported by its benchmark trusts. An indicator of a positive reporting culture is for there to be high levels of reported incidents with the majority relating to low or no harm incidents. In both trusts most reported incidents fell within the no/low harm categories.

We encourage the reporting of incidents or concerns and use as a tool to learn and improve. We have a clear focus on open and honest reporting of incidents, with

investigation into an incident proportional to the level of harm or potential harm, as detailed in the Trust's Being Open/Duty of Candour and Serious Incident policies.

Our approved Raising Concerns policy is published on our website. The Audit & Risk Committee oversees our Raising Concerns process and our Freedom to Speak Up Guardian provides regular updates to the Board.

Serious incidents which occur within the Trust are reported to the Trust's Commissioners. After reporting the incidents, a root cause analysis (RCA) is undertaken for each incident report. An investigation report, including an action plan, is produced following the RCA investigation with the report initially reviewed by the Care Group governance meeting and then by the Trust Patient Safety Panel, chaired by the Medical Director. Once approved, the report is submitted to the Commissioners. Actions arising for the investigation are monitored within the Divisions and by the Patient safety Panel until they are completed.

CPFT and NCIC declared a total of 57 serious incidents between 1 April 2019 and 31 March 2020. An annual analysis of themes from serious incidents during the year is undertaken to ensure that the wider contributory factors are informing the themes of learning across the organisation.

The Trust has continued with the sharing of Trust-wide safety information through specific patient safety alerts, Trust-wide safety newsletter and where appropriate patient safety summits. Further details of our arrangements for incident reporting and learning from reported incidents and other events can be found in the Quality Report, published separately.

Risk reporting

Evaluated using a 5 x 5 risk grading matrix, and recorded and reported in accordance with the Risk Management Policy.

Top strategic risks are managed through the Board Assurance Framework (BAF). Work activities of the Board and Board level committee are aligned to the BAF in order to enable line of sight to the management of strategic risks.

All operational risks are recorded in the Trust's risk management information system (Ulysses). Those risks recorded within Ulysses collectively form the Trust's risk register. Risks recorded on the Trust's risk register which are scored 15-25 i.e. high risks, are also identified on the corporate risk register. An Executive Director or other senior manager is formally accountable for each recorded risk on the Trust's risk register. Individual responsibilities include ensuring appropriate arrangements are in place for effective risk management and mitigation.

The BAF is subject to formal review quarterly by the Board, QIS Committee and FIP Committee. The A&R Committee considers the BAF at each of its meetings, The CMG has responsibilities for risk management performance and receives monthly updates on the management of risks on the corporate risk register. The BAF review process incorporates a quarterly review of risks on the corporate risk register. The management of risks is a routine item for discussion at each of the care groups' clinical governance forums.

The QIS Committee receive update reports from each care group about their clinical governance arrangements and Care Quality Commission (CQC) compliance. Any significant risks identified from these reviews are managed as per the agreed accountabilities and responsibilities framework. The Clinical Governance team within the Quality and Nursing Directorate coordinate arrangements for monitoring and overseeing CQC registration and compliance requirements.

Public stakeholders are involved in identifying and managing risks through membership of the Governors' Council and by attending specific service users' and carers' groups in the Trust. The Governors' Council is provided with performance information and is involved in the annual planning process. All service users, carers and visitors are encouraged to provide feedback on the service received and offer suggestions for improvement.

Data quality

Good data quality underpins most things that we do. The A&R Committee received updates on progress against the strategy throughout 2019/20 and the internal audit programme included audits on data quality which demonstrated positive improvements. Data quality reviews undertaken by our internal auditors in quarter 3 of 2019/20 at the request of the Trust, on waiting times in A&E and referral to treatment (RTT) waiting times, identified some improvements were needed. Actions to improve data quality have been taken in response to these audits. Details of the steps we have taken to address data quality are provided in the Quality Report.

Top strategic risks

We take assurance that our quality governance arrangements are effective from a range of sources including audits by our Internal Auditors, and reviews by external bodies such as the CQC. We recognise that balancing high quality care with long term financial sustainability and delivering integrated care are significant and challenging strategic risks. These are integral to our BAF. We are working collaboratively with our system partners and our communities to find workable solutions to these very challenging strategic risks and to deliver the ambitions of the NHS long term plan.

On at least an annual basis, usually during Quarter 3 we reflect on whether the top strategic risks upon which our BAF is structured require refresh. In December 2019 we refreshed our BAF to reflect the most significant risks impacting the trust following the merger. These are listed below.

A. Our leaders are not enabled or empowered to deliver high quality care in a safe and supportive organisational culture
B. Our workforce model is not suitable or sustainable to meet the needs of the trust and its patients.
C. The quality of our services, as experienced by our patients and staff, does not improve
D. We are unable to make the necessary changes and improvements to our services at the pace needed due to dependencies on system partners who are not sufficiently ready or able to support our plans
E. We are unable to reach and maintain a position of financial sustainability
F. Our property and digital infrastructure is unable to effectively meet current operational requirements or enable improvements to service quality
G. We are unable to deliver all of our services and/or meet the needs of our patients during period of prolonged significant disruption such as COVID-19 (Added April 2020)

Significant operational and clinical risks

Risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and the aligned performance framework. Risk reporting and measurement are actioned through our Outcomes Framework, quality and safety dashboards, and via the risk management information system (Ulysses) - all of which enable line of sight to risk management performance at all levels throughout the Trust. The greatest risks facing the trust, both operationally and strategically, are in relation to workforce, quality, and estates / IMT infrastructure. These are reflected with the corporate risk register and the BAF.

Policy Management

A risk-based approach to policy reviews was adopted prior to and following merger which led to some adjustments to timeframes for scheduled policy reviews. Policy review activity continued throughout 2019/20 and continued during disruption from COVID-19, however the overall pace for policy reviews was slower than we would have hoped. Our revised target for all policies to be made fit for purpose for NCIC is mid-July 2020 (from 31st March 2020). Policy management continues to be a governance priority for 2020/21.

Policy management performance is monitored by the CMG with oversight provided by A&R Committee. Information on how we have responded to the CQC inspection relating to the management and implementation of some policies is provided within the Quality Report (published separately).

Quality Impact Assessments

The Trust's approach to undertaking quality impact assessments, agreed by the QIS Committee in April 2018, was applied throughout 2019/20. We take a holistic approach to assessing the impacts of major change schemes, including those proposed within our

efficiency programme. The impact assessment approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The process is jointly led by the Executive Chief Nurse and Executive Medical Director and overseen by the QIS Committee. It is also integrated into the Trust's business planning process.

Board level assurance on the timely undertaking of impact assessments is provided through the QIS Committee who also have a role in the EQIA approvals process. During 2019/20 the EQIA process has been strengthened further through undertaking evaluations of post-change impacts compared with anticipated impacts.

Workforce strategies

The QIS Committee receive routine 'hard truths' nurse staffing reports throughout the year, including fill rates and care hours per patient day (CHPPD). A monthly workforce dashboard also provides the Board and sub committees with regular oversight of workforce performance.

The People Plan for the North Cumbria Integrated Health and Care System, approved by the Board in March 2019, sets out the strategic delivery approach to ensure a sustainable workforce. A number of the delivery plan priorities for 2019/20 have been implemented including implementing a new induction process and a values based appraisal, rapid improvements of recruitment processes and a review of the volunteer service and mandatory training. Quarterly reports on progress are presented to the Trust's QIS Committee.

There is a continued focus on reducing the cost of temporary staffing in line with national targets through good rota management and monitoring. On a weekly basis the Executive Director team receives reports on agency spend, this includes any individuals whose hours have exceeded 48 hours worked and/or (un)paid breaks not taken as well - this is to ensure safe working and manage spend. In addition the Executive Directors team is updated on agency spend for the previous week and a forecast for the following week. Strict processes are in place to ensure substantive/NHS recruitment is prioritised where agency workers are being deployed.

Care Quality Commission

North Cumbria Integrated Care NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. During 2019/20 the Trust underwent a formal inspection by the CQC against the CQC and NHSE/I's joint 'Well Led' framework. The Trust was rated as 'requires improvement' however a number of notable improvements were identified since their last inspection of the Trust in 2018/19. Progress on addressing CQC must and should do recommendations is overseen by the QIS Committee and Board of Directors. Improvement actions to address CQC must and should do recommendations from previous CQC inspections form part of NCIC's quality

improvement plan. Details of how we have responded to CQC recommendations and progress against the quality improvement plan can be found in the Quality Report (published separately).

Business conduct / conflicts of interest

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/.

The Trust's Standards of Business Conduct policy reflects statutory requirements. A plan to implement the requirements of our policy on a phased basis was agreed in 2018/19. Oversight of its implementation is through the A&R Committee. The position reported to the A&R Committee in January 2020 was that the majority of policy requirements were being met and had become business as usual activity. The implementation plan continues into 2020/21 when it is expected the Trust will be fully compliant with national and local policy requirements.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Environmental Issues

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. Further details can be found in the Performance Report.

Emergency preparedness

All NHS-funded organisations must demonstrate that they have plans in place and can deal for a wide range of incidents and emergencies that could impact on health or patient care.

Very high and high risks in the current version of the Cumbria Community Risk Register are covered by either the Trust's contingency planning, or wider health or multi-agency planning to which we contribute.

We seek to comply with the Civil Contingencies Act 2004 regime and align with the international standard for business continuity, BS ISO 22301:2012 and its guidance, BS ISO 22313:2012.

Under NHS England's Emergency Preparedness Resilience and Response (EPRR) guidance, we must:

- have a suitable and up-to-date incident response plan which sets out how the organisation would respond to and recover from a major incident/emergency affecting local communities or the delivery of its services; and
- adopt business continuity plans to enable the organisation to maintain or recover the delivery of its critical services in the event of significant disruption.

We comply with NHS England's requirements by providing an EPRR structure and implementing a business continuity management system through which we will endeavour to respond to critical incidents and emergencies as well as maintaining the organisation's critical functions, its ordinary functions and contractual obligations as far as reasonably practicable.

COVID-19

We kept a watching brief on the development of COVID-19 from early in quarter 4 of 2019/20. In March 2020 we invoked our Major Incident, Pandemic Flu plan and business continuity plans and established strategic and tactical command and decision making structure into our governance framework. Some adjustments to our governance framework were made as part of our COVID-19 response, such as streamlining board-level and other governance meetings whilst ensuring essential business continued.

The objectives of our COVID-19 response were to reduce direct and indirect excess mortality linked to COVID-19 and to protect our staff. In delivering our objectives we adapted our control environment in line with, and at times ahead of, national guidance to ensure patients, staff and visitors were as safe as possible and cared appropriately.

In March and April 2020 some elective activity was paused or reduced to divert capacity and resource to the COVID-response, however, with support of system partners, urgent cancer and trauma care continued to be provided. We experienced our peak of COVID-related admissions and deaths early to mid-April 2020. At this time a substantial proportion (around 20%) of the workforce were also absent due to covid- or non-covid related absence. Redeployment of some of our workforce enabled essential services to continue at this exceptionally challenging time. Further details on how COVID impacted our performance can be found in the Performance Section of this annual report.

Lessons learned from redesign of pathways during the COVID response will inform a review of the trust-level and service/team level business continuity plans and emergency preparedness arrangements during quarter 1 of 2020/21.

The Head of Internal Audit opinion has not been impacted by COVID-19. The Head of Internal Audit was satisfied he had sufficient evidence, largely based on completion of the Core Internal Audit plan and carefully considered professional judgement, to provide the Trust with a robust Head of Internal Audit Opinion.

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

CQC last undertook Well Led and Use of Resources inspection of NCUH during 2018/19 and published their report in November 2018. NCUH was rated as 'Requires Improvement' for quality and use of resources. Actions to address the CQC's inspection recommendations which were not completed at the time of merger have been incorporated into NCIC's quality improvement and efficiency programmes.

We closely monitor budgetary control and expenditure through the Financial Delivery Group, CMG and, at Board level, through the FIP Committee. A dedicated programme management team support the identification and delivery of schemes which improve efficiency and positively impact our overall financial efficiency efforts.

The Executive Director of Finance, Estates & People presents finance reports to both the FIP Committee and the Board. Through our Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation the Board has created clarity regarding delegated authority levels across the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each area of our operations.

The Board receives both performance and financial reports at each of its public meetings in addition to reports from the Chairs of its Committees, to which it has delegated powers and responsibilities. When required, the Board receives further assurance provided by its internal and external auditors.

The financial plan for 2019/20 was developed in conjunction with NCUH and North Cumbria Clinical Commissioning Group and was agreed by both Boards in March 2019. NHSE/I have been kept abreast of risks to the delivery of the plan throughout the period of this report and the financial position at the time of merger.

Following severe in-year pressures and the impact of COVID-19 in March, the Trust worked with ICS partners and NHSE/I to absorb the Trust's control total slippage for the year of £30m (£29m plus additional COVID-19 annual leave accrual of £1m). The Trust therefore earned £16.9m of Financial Recovery Fund (FRF) incentive monies which replaced the Provider Sustainability Fund (PSF) and FRF monies lost as a result of not

achieving its original financial plan. Although this incentive funding does not score against the control total it supports the Trust's cash position.

During 2019/20 the Trust acted within an agreed risk sharing arrangement. This arrangement allowed the North Cumbria University Hospitals NHS Trust to achieve its mid-year control total and secure PSF and FRF monies of £8.2m for the local health economy.

The 2020/21 financial planning process has been suspended and a temporary financial regime put in place whilst the NHS responds to the COVID-19 incident. The Trust's financial performance is much improved from the underlying normalised position despite a much reduced level of service. To maintain financial governance, budgets for the year have been set in line with the Board approach prior to the COVID-19 incident. These budgets include a significant level of savings and will need to be revised as the temporary national financial regime ceases and the Trust resets a formal plan for the year. This is expected to take place at end of June 2020 (subject to national decisions yet to be announced).

NCIC was rated as being placed in Segment 2 under NHSE/I's SOF at 26th May 2020. You can find further details about ratings in the NHSE/I Single Oversight Framework Report.

During the year we continued to reduce reliance on agency staff where possible and controls were in place to control expenditure on agency workers. Board-level oversight of expenditure on agency workers was undertaken by the FIP Committee as part of the Board level performance reports. Information is also readily available to front line managers through quality and safety dashboards.

Information governance (IG) and data security

As NCIC (from 1 October 2019), we have reported five incidents via the Data Security and Protection Toolkit to the Regulator during 2019-20. For the period 1 April 2019 to 31 September 2019 two incidents were reported for CPFT and NCUH; one incident per organisation (see table below).

Date of Incident	Reference Number	Summary of Incident	Outcome	Status
11 July 2019 (CPFT incident before integration)	14080	A patient approached the Trust to advise she believed her confidentiality had been breached in a public house by a receptionist member of staff. This led the Trust to	Serious Incident	Complete

Date of Incident	Reference Number	Summary of Incident	Outcome	Status
		accessing the Trust's privacy audit software to ascertain the position.		
23 July 2019 (NCUH incident before integration)	14235	Obstetric and gynaecology on call handover sheets found in public area in hospital	Reported via Data Security and Protection Toolkit but fell below threshold for Information Commissioner Office's attention	Clear instruction to staff included in the IG Handbook
16 October 2019	17354	From a clinic on 2 October 2019 a clinician dictated prognoses and discharge records for his patients from clinic. The tape is unaccounted for with clinician needing to re dictate the outcome of clinic letters.	Reported via Data Security and Protection Toolkit but fell below threshold for Information Commissioner Office's attention	Reprioritisation of project to put in place electronic dictation methods to avoid this occurring in future.
16 October 2019	17351	An email was received by the Information Team from a contractor helpdesk team highlighting that they are receiving patient level detail	Reported via Data Security and Protection Toolkit but fell below threshold for Information Commissioner Office's attention	Changes to the data warehouse reporting system to cease this from occurring in the future.
21 November 2019	17818	Member of staff within the complaints department sent an escalation email to a senior staff member within the Trust for an investigation officer to be appointed. The complaints member of staff mistakenly copied to a member of the public who submitted a separate complaint	Serious incident	Complete.
22 January 2020	18558	Five patient case notes gone missing from the Research and Development department	Reported via Data Security and Protection Toolkit but fell below	Investigation and audit completed with

Date of Incident	Reference Number	Summary of Incident	Outcome	Status
			threshold for Information Commissioner Office's attention.	recommendation for improvement
14 February 2020	18897	Telephone call received from a member of staff who had viewed agenda for Network Governance meeting which included embedded documents holding personal identifiable information	Reported via Data Security and Protection Toolkit but fell below threshold for Information Commissioner Office's attention	Revised approach for meeting paperwork agreed.

All incidents are investigated and reports sent to the Information Commissioners Office with recommendations completed for improvement. We are committed to learning from all incidents with a view to preventing recurrence in the future. You can find further details about our Information Governance and data security arrangements in the Quality Report (published separately).

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHSE/I (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

We have arrangements in place to assure the Board that the Quality Report presents a balanced view and that there are controls in place to ensure the accuracy of data. Overseeing the Quality Report preparation and content was the responsibility of the Interim Executive Chief Nurse during 2019/20.

We recognise that good quality data is essential for the delivery of safe and effective care to our patients as well as enabling us to manage services and performance. To support this, we have in place a strategy with supporting policies and procedures which govern the accuracy, completeness and timeliness of data at the point of capture and when reporting either for internal or external purposes.

A governance framework is in place which oversees data quality performance from operational services through to Board level. Data quality performance is overseen by the Information Governance department. Key performance indicators (KPI) are subject to data

quality and data validation processes. Performance is routinely reported and regularly reviewed at all levels within the governance structure in accordance with our performance and governance frameworks. This includes care groups' monthly performance review meetings, oversight through the Clinical Management Group and review of monthly performance assurance reports by the Finance Investment & Performance Committee and Board. Performance reports are also provided to each meeting of the Governors' Council.

A balanced view of our data quality is obtained through comparing and analysing data accuracy from checks undertaken by front line staff and service managers, and through independent audits undertaken by our internal and external auditors.

We currently use a number of separate electronic and paper patient record systems to record clinical information and produce reports. This includes EMIS and RiO electronic patient record systems which are used in our Care Groups. Checks are in place to provide assurance that the data from these systems is accurate. Assurances have been provided during the year through the internal audit programme and our data validation checks and monitoring processes that our data quality has improved through implementation of our Data Quality Strategy.

Our suite of policies and procedural documents are reviewed as part of an ongoing review programme to reflect changes to legislation and best practice. Ensuring policies are fit for purpose for NCIC has been a priority given focussed attention leading up to and in the first six months following merger. Policy Management Group (PMG) met on fortnightly throughout most of 2019/20 to enable timely ratification and publication of updated policies. A&R Committee oversee policy management arrangements and seek assurance on behalf of the Board of Directors that policies are reviewed in a timely manner.

Our governance framework sets out responsibilities and accountabilities for performance and governance at all levels within the Trust. This is underpinned by the Outcomes and Performance Framework, which comprises performance indicators and metrics by which we measure and monitor our performance with local, regional and national standards and targets.

The Outcomes and Performance Framework populates a set of dashboards which enable our staff and managers to identify, monitor and improve the quality of data derived from patient information systems. The dashboards, which continue to evolve, also provide the basis for assuring the Board on the quality, accuracy and completeness of data and enable triangulation of safety data.

Our organisational development, service improvement and programme management functions, which have been brought together as the CLIC Delivery Support Unit, support our leadership teams with implementing quality improvements and delivering programmes to support business plan objectives. A suite of tools and training on quality improvement methodologies is also available to all staff.

We achieved a number of quality improvements during the year, including launch of the Hyper Acute Stroke Unit (HASU) in Carlisle in December 2019. Work also commenced on building the new cancer centre on the Cumberland Infirmary site. Further details about these and other quality highlights, and also details about our performance and achievement of key performance indicators can be found in the Quality Report (published separately).

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 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 & Risk Committee (A&R), Quality Improvement and Safety Committee (QIS), and Finance Investment and Performance Committee (FIP) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Executive Chief Nurse is responsible for developing and delivering the clinical audit programme and for ensuring the audit programme supports a process of continual improvement. Oversight of the clinical audit programme was through Quality Improvement & Safety Committee who also receive monthly updates on significant or escalating risks to quality and safety.

The QIS Committee, FIP Committee, Charitable Funds Committee and A&R Committee each have activity schedules framed around enabling the Board of Directors to have line of sight to any significant risks to internal control. An annual evaluation of committee effectiveness is undertaken for each of these Board committees. This is via a self-assessment by committee members and regular attendees, the outcome of which is considered by the A&R Committee

We also has an active programme of internal and external audit. The audit programme, including recommendations from audits, is overseen by the A&R Committee. The focus of the internal and external audit programme is set to both support and complement our objectives and provide an assessment for the Board on areas of specific risk. The internal audit programme is developed having due regard to the risks and risk controls set out in the BAF and corporate risk register. Audit recommendations are framed around improving internal control and also identifying opportunities for creating added value from our current systems and processes. Any significant risks to internal control identified through the internal audit programme are assigned to a nominated Executive Director to resolve, and are monitored through CMG.

Internal audit plans for CPFT and NCUH were adopted by NCIC upon merger on 1st October 2019. Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of audits into our fire safety, health and safety and business continuity arrangements, duty of candour, physical and environmental controls of our data centres, administration of the waiting list for our elective endoscopy services, arrangements for non-medical prescribing, and general controls for our pharmacy IT system, which were all awarded limited assurance. We are actively working to strengthen and improve arrangements in all of these areas. Progress is being managed and monitored through our governance frameworks, with oversight by the A&R Committee.

At the time of merger, a number of audits on the NCUH internal audit plan had commenced but none had concluded. In giving their opinion on the effectiveness of internal controls within NCIC, the Head of Internal Audit has given consideration to arrangements within NCUH and CPFT before merger, and within NCIC after merger. The Head of Internal Audit has given an overall opinion of reasonable assurance that there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Conclusion

As Accounting Officer and based on the review process outlined above, I conclude that no significant internal control issues have been identified during the year with the exception of our arrangements for fire safety management, health and safety management, business continuity management, duty of candour, administration of elective endoscopy services waiting list, physical and environmental controls of our data centres, administration of the waiting list for our elective endoscopy services, arrangements for non-medical prescribing, and general controls for our pharmacy IT system, all of which have been responded to through the implementation of remedial actions and an improvement plan that will be delivered in conjunction with our system partners during 2020/21.

Signed L. Simpson Date: 23rd June 2020

Lyn Simpson
Chief Executive

2.8 Voluntary Disclosure

2.8.1 Equality Reporting

Equal Opportunities, Equality & Diversity and Disability
The Trust's Equality, Diversity and Human Rights annual report, which is available on the Trust website at this link - https://www.ncic.nhs.uk/trust/freedom-information/equality-diversity-and-inclusion, provides information on how the Trusts is meeting its legal duties set out in the Equality Act 2010, the Public Sector Equality Duty 2011 and the Human Rights Act 1998 which aim to:

- Eliminate unlawful discrimination, harassment and victimisation and other unlawful conduct
- Advance equality of opportunity between people of different groups; and
- Foster good relationships between people who share a protected characteristic and those who do not.

Gender Pay Gap Analysis
Following government consultation, it became mandatory from 31 March 2017 for public sectors organisations with over 250 employees to report annually on their gender pay gap. The Trust meets the mandatory requirements of the gender pay gap analysis by publishing the report on our website and submitting data on to the government website along with action plan.
https://www.ncic.nhs.uk/trust/freedom-information/equality-diversity-and-inclusion

The gender pay gap describes the difference between the average earning of all the women in an organisation compared to the average earnings of all the men in that organisation. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same. Our Clinical Excellence Awards apply to consultant level medical and dental staff, these are defined as a bonus within the gender pay definitions. As a healthcare provider a high proportion of the workforce is female, this is reflected in the national NHS workforce with 77% being female.

2.8.2 Modern Slavery Act

As of October 2015 all commercial organisations carrying on business in the UK with a turnover of £36m or more have to complete a slavery and human trafficking statement for each financial year. The Modern Slavery Act consolidates offences relating to trafficking and slavery (both in the UK and overseas). As a large business we need to publicly state each year the actions we are taking to ensure our suppliers are slavery free. We continue to work within the Act.

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31ST MARCH 2020

Independent auditor's report to the Governors Council of North Cumbria Integrated Care NHS Foundation Trust

Report on the Audit of the Financial Statements

Qualified opinion

Our opinion on the financial statements is modified

We have audited the financial statements of North Cumbria Integrated Care NHS Foundation Trust (the 'Trust') for the year ended 31 March 2020 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 notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic we did not observe the counting of physical inventories at the end of the year. We were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities held at 31 March 2020, which have a carrying amount in the Statement of Financial Position of £6,852,000, by performing other audit procedures. Related balances such as drug costs and supplies and services may be materially misstated for the same reason.

Consequently, we were unable to determine whether any adjustment to these amounts were necessary. In addition, were any adjustments to these amounts to be required, the Annual Report would also need to be amended.

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 Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accounting Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All

of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which indicates that the Trust submitted a draft financial plan for 2020/21 to NHS Improvement to deliver a deficit of £50.1 million, which included the delivery of a £24.7million Cost Improvement Programme (CIP) . The plan also included revenue and capital support loans of £17.4 million.

As disclosed in note 1.2 in the financial statements, due to the need for the NHS to focus on responding to the Covid-19 pandemic, the 2020/21 contracting and financial planning processes were suspended in March and a Covid-19 financial framework put in place to cover the period to 31 July 2020 in the first instance. However, the Trust does not have final signed contracts with its commissioners for 2020/21 and it is unclear what the contracting arrangements will be for 2020/21 and beyond. In the event that current arrangements are discontinued, the Trust has an expectation that any shortfall in earned income over expenditure for the remainder of the year will be met in the form of revenue support from the Department of Health and Social Care, but this additional support has not been confirmed.

These events or conditions, along with the other matters as set forth in note 1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Grant Thornton

Overview of our audit approach

Financial statements audit

- Overall materiality: £4,506,000 which represents 1.35% of the Trust's gross operating costs (consisting of operating expenses and finance expenses);
- Key audit matters were identified as:
  - Revenue recognition
  - Valuation of land and buildings
  - Accuracy of PFI related balances
  - Fraud in expenditure recognition

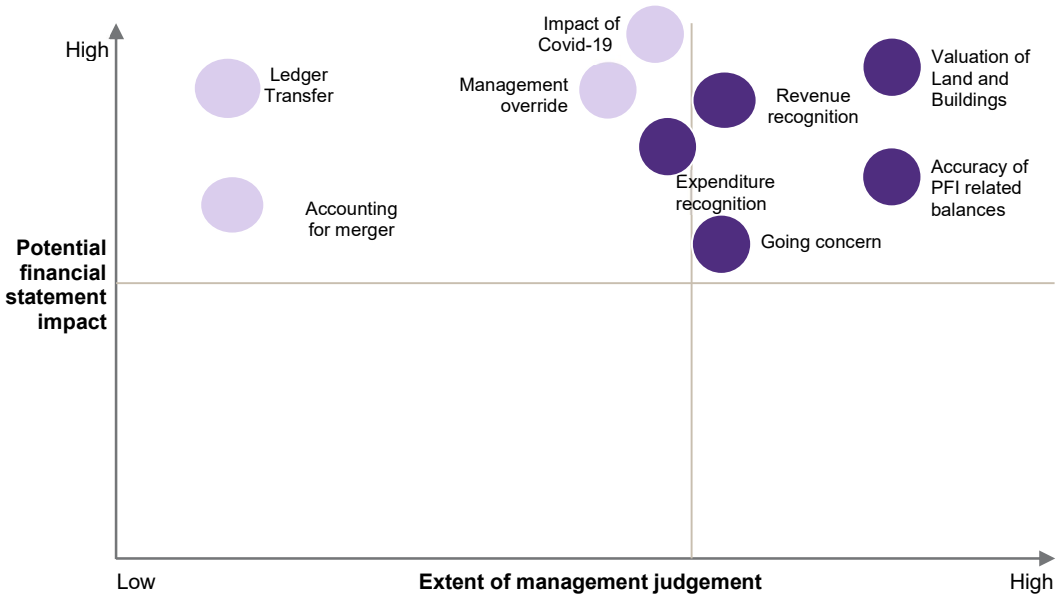
  During the year, the Trust acquired North Cumbria University Hospitals University Hospitals NHS Trust. This significantly increased the income, expenditure assets and liabilities of the Trust. There was a corresponding increase in the scope of our audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that 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, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to the matters described in the basis for qualified opinion section and the material uncertainty related to going concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 - Valuation of land and buildings The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. The valuation represents a significant accounting estimate by management in the financial statements, which is sensitive to changes in assumptions and market conditions. Management engage the services of a qualified valuer, who is a Regulated Member of the Royal Institute of Chartered Surveyors (RICS), to estimate the current value of its	Our audit work included, but was not restricted to; • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work; • evaluating the competence, capabilities, and objectivity of the valuation expert; • considering the basis on which the valuations were carried out; • challenging the information and assumptions used by the valuer to

Key Audit Matter	How the matter was addressed in the audit
land and buildings. The last full valuation was as at 31 March 2020. The effects of the COVID-19 virus will affect the work carried out by the Trust's valuer in a variety of ways. Inspecting properties could prove difficult and access to evidential data, such as values of comparable assets may be less freely available. RICS Regulated Members have therefore been considering whether a material uncertainty declaration is now appropriate in their reports. Its purpose is to ensure that any client relying upon the valuation report understands that it has been prepared under extraordinary circumstances. In their 2019/20 valuation report the Trust's valuer Cushman and Wakefield included a material uncertainty and this was disclosed in note 1.24 to the financial statements. We therefore identified the valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement.	assess completeness and consistency with our understanding; • testing the completeness and accuracy of data held by the Trust and provided to the valuer; • testing key assumptions and inputs which impact the valuation, including build rates, floor space, obsolescence, and professional fees; • agreeing the reasonableness of movements in asset values from the 31 March 2019 valuation through discussions with the valuer and analysis of RICS BCIS All in TPI Indices; • evaluating and challenging the judgements made by the Trust and its valuation expert; and • testing, on a sample basis, revaluations made during the year to ensure they have been input correctly into the Trust's asset register. The Trust's accounting policy on Property Plant and Equipment is shown in note 1.8 to the financial statements and related disclosures are included in note 14. As, disclosed in note 1.24 to the financial statements, the outbreak of Covid-19 has caused uncertainties in markets. As a result, the Trust's valuer has declared a 'material valuation uncertainty' in their valuation report. The values in the valuation report have been used to inform the measurement of property assets at valuation in the financial statements. The Trust has disclosed the estimation uncertainty related to the year-end valuations of land and buildings in 1.24 to the financial statements. The Trust's valuer prepared their valuations in accordance with the RICS Valuation – Global Standards using the information that was available to them at the valuation date in deriving their estimates. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the valuation of land and buildings was appropriate, • the assumptions and processes used by management in determining the estimate

Key Audit Matter	How the matter was addressed in the audit
	of valuation of property were reasonable; and • the valuation of land and buildings disclosed in the financial statements is reasonable.
Risk 2 - Revenue recognition Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand, and cost pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • Block contract income element of patient care revenues • Education & training income We have not deemed it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. We have therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of revenue from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2019/20; • updating our understanding of the Trust's system for accounting for revenue from patient care and other operating revenue, and evaluating the design of the associated controls; • agreeing on a sample basis, revenue from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners; • agreeing, on a sample basis, revenue and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence; and • agreeing provider support funding and financial recovery funding to NHS Improvement notifications and obtaining supporting evidence that confirms the Trust has met NHS Improvement requirements for recognising this income. The Trust's accounting policy on revenue is shown in note 1.5 to the financial statements and related disclosures are included in note 3 and note 4. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policies for recognition of contract income and other operating revenue comply with the DHSC group accounting manual 2019-20 and have been applied appropriately; and • income from patient care activities and other operating income and the

Key Audit Matter	How the matter was addressed in the audit
	associated receivable balances are not materially misstated.
Risk 3 - Accuracy of PFI related balances The Trusts uses a PFI accounting model to allocate the annual unitary charge payable to the PFI Provider. The model allocates the unitary charge between interest charge, repayment of finance lease liability, service element and other charges to operating expenditure, capital lifecycle maintenance, contingent rent and additions to lifecycle prepayment. The allocation of the PFI annual unitary charge is a key accounting estimate which is sensitive to changes in assumptions and market conditions The Trust has a significant PFI lifecycle prepayment. The movement in the PFI lifecycle prepayment is derived by calculating the difference between the capital lifecycle additions as per the Trust's PFI model and actual works carried out by the PFI operator. At each year end, the Trust obtains confirmation from the PFI operator of the actual capital works carried out. Over a number of years, the actual works carried out have been less than the lifecycle works per the model, which has meant that the prepayment has gradually increased. We have therefore identified the accuracy of PFI accounting entries as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • reviewing and agreeing key assumptions input into the Trust's PFI model as reasonable; • using specialist software to gain assurance that the PFI model has been appropriately updated for the period ended 31 March 2020; • reviewing the recoverability and valuation of the Trust's PFI Lifecycle Prepayment; and The Trust's accounting policy on PFI is shown in note 1.8 to the financial statements and related disclosures are included in note 30. **Key observations** We obtained sufficient audit assurance to conclude that: • the basis of the PFI liability and allocation of unitary charge was appropriate, • the assumptions and processes used by management in determining the estimate of the PFI liability were reasonable; and • the Trust's PFI lifecycle prepayment was valued correctly and is recoverable.
Risk 4 - Fraud in expenditure recognition Practice Note 10 suggests that the risk of material misstatement due to fraudulent financial reporting that may arise from the manipulation of expenditure recognition needs to be considered, especially where the body is required to meet targets. The Trust is facing significant external pressure to restrain budget overspends. We have therefore determined that there is a completeness and accuracy risk which applies to all non-pay expenditure excluding depreciation, amortisation, clinical negligence, audit fees, impairments and PFI costs, and including agency costs	Our audit work included, but was not restricted to: • documenting the goods received not invoiced accrual process, challenging any key assumptions, the appropriateness of the source data used and the basis for calculations; • testing substantively a sample of expenditure to supporting documentation to confirm correct accounting treatment; • obtaining a listing from the cash book of non-pay payments made in April to ensure they have been charged to the appropriate year; and

Key Audit Matter	How the matter was addressed in the audit
We have therefore identified fraud in expenditure recognition a significant risk, which was one of the most significant assessed risks of material misstatement	• testing substantively a sample of year end creditor and accrual balances. The Trust's accounting policy on expenditure recognition is shown in note 1.7 to the financial statements and related disclosures are included in note 6. **Key observations** We obtained sufficient audit assurance to conclude that: • the good received not invoiced process was appropriate, and • operating expenses and the associated payable balances are not materially misstated.

Our application of materiality

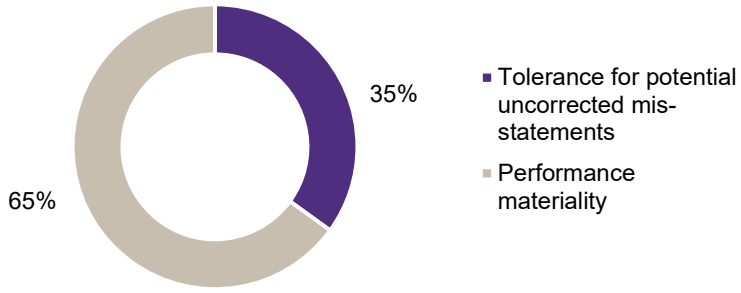
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating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

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£4,506,000 which is 1.35% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is lower than the level determined by the Trust's predecessor auditor for the year ended 31 March 2019 to reflect the higher profile of local audit following external reviews such as those led by Sir John Kingman and Sir Tony Redman and increased risks profiles associated with a hospital with significant transactions and financial challenges.
Performance materiality used to drive the extent of our testing	65% of financial statement materiality
Communication of misstatements to the Audit and Risk Committee	£225,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and included:

- undertaking an interim audit visit in March 2020 where we:
  - completed walk through tests of the Trust's controls operating in key financial systems where we consider that there is a risk of material misstatement to the financial statements; and
  - performed testing, on a sample basis, of operating expenses and income for the months up to February 2020.
- undertaking a final visit during May to June 2020 which included:
  - obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams of the Trust's revenues;
  - obtaining supporting evidence, on a sample basis, of the Trust's operating costs;
  - obtaining evidence to demonstrate that the Trust had accounted for its merger and transfer of mental health services appropriately;
  - obtaining evidence to demonstrate the completeness of the transfer of data to the Trust's new general ledger in month 12;
  - obtaining supporting evidence, on a sample basis, for property plant and equipment and the Trust's other material assets and liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report and Accounts**,** 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 the other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities, which have a carrying amount in the Statement of Financial Position of £6,852,000 at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

In this context, we have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable as set out on page 95 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit and Risk Committee reporting set out on page 67 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance- the section describing the work of the Audit and Risk Committee does not appropriately address matters communicated by us to the Audit and Risk Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2019/20 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider 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 this regard.

Our opinion on other matters required by the Code of Audit Practice is modified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2019/20 and the requirements of the National Health Service Act 2006; and
- except for the possible effects of the matter described in the basis for qualified opinion section of our report, based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2019/20, 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 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 has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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 Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2020, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that, in all significant respects, North Cumbria Integrated Care NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

In considering the Trust's arrangements for securing efficiency, economy and effectiveness in its use of resources, we identified the following matters:

- On 1 October 2019 Cumbria Partnership NHS Foundation Trust (CPFT) acquired North Cumbria University Hospital NHS Trust (NCUHT) and was renamed North Cumbria Integrated Care NHS Foundation Trust (NCIC). The combined financial plan for NCUHT and CPFT was a deficit of £46.5 million for the year ended 31 March 2020 (before PSF/FRF funding). The combined position ended up at £76.5 million deficit – slippage of £30 million and a 64% variance from plan.

- The 2019/20 combined CIP target for 2019/20 was £25.4 million including an agency reduction target of £2.1 million. The actual CIP delivered in the year was £14.1 million – a shortfall of £11.3 million.
- In line with national guidance, a draft operational plan was submitted to NHS Improvement for 2020/21, which forecast a deficit of £61.4 million. Due to the Covid-19 national pandemic, planning has been suspended and therefore the Trust has not yet agreed a formal plan for 2020/21. The forecast deficit of £61.4 million represents a shortfall of £14.3 million against the Trust's financial improvement target.
- The draft operational plan sets a target of making cost and efficiency savings of £14.2 million, transformation savings of £9 million and additional savings of £7.9 million in 2020/21. This is a challenging target given the savings delivered in 2019/20.

These matters highlight pervasive weaknesses in the Trust's arrangements for setting and delivering a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services and levels of demand on services.

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

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 1 - Financial Sustainability The Trust has been reporting an adverse variance from its financial plan throughout the 2019/20 year. The Trust's variance from plan at month 8 was approximately £15 million, with a forecast outturn of a £25 million variance from the planned control total of a deficit of £46.5 million. In view of this, the Trust agreed an updated 'stretch' reforecast with NHSI/E of a deficit of £66.7 million, a £20.2 million overspend against control total. The Trust's plan had been to improve its underlying financial position from a monthly deficit of approximately £6 million to approximately £3 million. However, despite achieving a 3% level of planned cost improvements, further reduced costs from service reforms and cost pressures from increased service demands have not delivered the reduced monthly deficit. The Trust continues to have a challenging cash position and is heavily reliant on borrowing from the Department of Health and Social Care. There is a risk that the Trust does not have proper arrangements for setting and	Our audit work included, but was not restricted to: • review of the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; • review of the Trust's arrangements for monitoring and managing delivery of its budget and savings plans for 2019/20; and • review of the Trust's arrangements for updating, agreeing and monitoring its sustainability and operational plans, and how it communicates key findings to the Board and Finance, Investment and Performance Committee. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis for adverse conclusion section of the report.

delivering a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services and levels of demand on services.

Significant risks not forming part of our qualified conclusion	How the matter was addressed in the audit
Risk 2 Arrangements to support the merger and transfer out of mental health services The Trust has delivered two major transactions in 2019/20. The merger took place on 1 October 2019 via a technical acquisition of NCUHT by CPFT which was renamed to North Cumbria Integrated Care NHS Foundation Trust. The transfer out of mental health services also occurred on 1 October 2019. In North Cumbria the services transferred to Northumberland, Tyne and Wear NHS Foundation Trust and in South Cumbria they transferred to Lancashire Care NHS Foundation Trust. There is a risk that the Trust does not have proper arrangements in place to work effectively with partners and other third parties in order to deliver these transactions.	Our audit work included, but was not restricted to: • review of the Trust's arrangements to support both transactions; • review of the due diligence, risk management and integration processes put in place to deliver a successful merger and transfer of services; and • review of arrangements put in place to ensure risks have been monitored and resolved post-transfer to ensure there is no impact on service quality or continuity. **Key findings** • The Trust successfully delivered two major transaction, a merger with North Cumbria University Hospitals Trust and the transfer out of Mental Health services. • There was regular reporting to board on progress towards the merger via the Trust's organisational form transaction update reports • NHSI issued a Risk Rating for the transaction which was accepted by the board. The Risk Rating of amber set out a set of requirements which would be monitored by NHSI post transaction. The Trust has made progress on each of these requirements. • The Trust, together with partners, formed a programme board to oversee the transfer of Mental Health services. A transformation / transition plan was agreed and implemented.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of North Cumbria Integrated Care NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Governors Council of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Governors Council 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 Trust and the Trust's Governors Council, as a body, for our audit work, for this report, or for the opinions we have formed.

Andrew Smith

Andrew Smith, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor
Manchester

25 June 2020

North Cumbria Integrated Care NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

North Cumbria Integrated Care NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by North Cumbria Integrated Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed L. Simpson

Name **Lyn Simpson**
Job title **Chief Executive**
Date **23 June 2020**

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	240,031	147,620
Other operating income	4	34,614	12,829
Operating expenses	6, 7	(328,782)	(165,686)
Operating surplus/(deficit) from continuing operations		**(54,137)**	(5,237)
Finance income	10	192	266
Finance expenses	11	(4,714)	(565)
PDC dividends payable		0	(1,507)
Net finance costs		**(4,522)**	(1,806)
Other gains / (losses)	12	(95)	(4)
Gains / (losses) arising from transfers by absorption	34	(89,040)	(585)
Surplus / (deficit) for the year		**(147,794)**	(7,632)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	15	(6,304)	137
Revaluations	16	6,349	0
Total comprehensive income / (expense) for the period		**(147,749)**	(7,495)
Adjusted financial performance			
Surplus / (deficit) for the period		(147,794)	(7,632)
Remove net impairments not scoring to the Departmental expenditure limit	15	20,946	2,530
Remove (gains) / losses on transfers by absorption	34	89,040	585
Remove I&E impact of capital grants and donations		50	(462)
Adjusted financial performance surplus / (deficit)		**(37,758)**	(4,979)

Note a: An impairment charge is not considered part of the Trust's operating position.
Note b: DHSC group bodies must account for transfers of functions to and from another DHSC group body as a 'transfer by absorption'.
Note c: Where grants and donations are received in year they are accounted for as income receipts. Any difference between this income and the government grant and donated expenditure charged in the year is excluded from the Trust's operating position.

On 1 October 2019 Cumbria Partnership NHS Foundation Trust (CPFT) transferred its mental health services to Lancashire Care NHS Foundation Trust and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. On the same date Cumbria Partnership NHS Foundation Trust acquired North Cumbria University Hospital NHS Trust and was renamed North Cumbria Integrated Care NHS Foundation Trust.

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	4,219	2,817
Property, plant and equipment	14	230,027	67,611
Investments in associates and joint ventures	18	35	35
Receivables	20	15,709	0
Total non-current assets		**249,990**	70,463
Current assets			
Inventories	19	6,852	0
Receivables	20	47,837	11,864
Non-current assets for sale and assets in disposal groups	21	617	0
Cash and cash equivalents	22	24,585	7,239
Total current assets		**79,891**	19,103
Current liabilities			
Trade and other payables	23	(48,548)	(25,244)
Borrowings	25	(303,174)	(1,687)
Provisions	26	(1,163)	(851)
Other liabilities	24	(3,895)	(1,005)
Total current liabilities		**(356,780)**	(28,787)
Total assets less current liabilities		**(26,899)**	60,779
Non-current liabilities			
Borrowings	25	(49,878)	(7,916)
Provisions	26	(4,186)	(1,444)
Total non-current liabilities		**(54,064)**	(9,360)
Total assets employed		**(80,963)**	51,419
Financed by			
Public dividend capital		52,390	37,023
Revaluation reserve		16,068	9,400
Income and expenditure reserve		(149,421)	4,996
Total taxpayers' equity		**(80,963)**	51,419

The financial statements on pages 1 to 36 were approved by the Board on 23 June 2020 and signed on its behalf by:

Chief Executive: L. Simpson **Date: 23 June 2020**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**37,023**	**9,400**	**4,996**	**51,419**
Surplus/(deficit) for the year	0	0	(147,794)	**(147,794)**
Transfers by absorption: transfers between reserves	0	6,670	(6,670)	**0**
Impairments	0	(6,304)	0	**(6,304)**
Revaluations	0	6,349	0	**6,349**
Public dividend capital received	15,367	0	0	**15,367**
Other reserve movements	0	(47)	47	**0**
Taxpayers' and others' equity at 31 March 2020	**52,390**	**16,068**	**(149,421)**	**(80,963)**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	34,758	9,295	12,596	56,649
Surplus/(deficit) for the year	0	0	(7,632)	(7,632)
Transfers by absorption: transfers between reserves	0	(32)	32	0
Impairments	0	137	0	137
Public dividend capital received	2,265	0	0	2,265
Taxpayers' and others' equity at 31 March 2019	37,023	9,400	4,996	51,419

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(54,137)	(5,237)
Non-cash income and expense:			
Depreciation and amortisation	6.1	8,430	3,542
Net impairments	15	20,946	2,530
Income recognised in respect of capital donations	4	(65)	(473)
(Increase) / decrease in receivables and other assets		12,753	(4,801)
(Increase) / decrease in inventories		(753)	0
Increase / (decrease) in payables and other liabilities		(7,013)	7,421
Increase / (decrease) in provisions		652	(16)
Other movements in operating cash flows		21	0
Net cash flows from / (used in) operating activities		**(19,166)**	2,966
Cash flows from investing activities			
Interest received		183	266
Purchase of intangible assets		(808)	(270)
Purchase of PPE and investment property		(16,193)	(6,476)
Sales of PPE and investment property		0	1
Receipt of cash donations to purchase assets		32	473
Net cash flows from / (used in) investing activities		**(16,786)**	(6,006)
Cash flows from financing activities			
Public dividend capital received		15,367	2,265
Movement on loans from DHSC		41,205	2,383
Capital element of finance lease rental payments		(77)	(79)
payments		(476)	(274)
Interest on loans		(2,079)	(26)
Other interest		(8)	0
Interest paid on finance lease liabilities		(14)	(14)
Interest paid on PFI, LIFT and other service concession obligations		(2,544)	(523)
PDC dividend (paid) / refunded		72	(1,572)
Net cash flows from / (used in) financing activities		**51,446**	2,160
Increase / (decrease) in cash and cash equivalents		**15,494**	(880)
Cash and cash equivalents at 1 April - brought forward		**7,239**	8,119
Cash and cash equivalents transferred under absorption accounting	34	1,852	0
Cash and cash equivalents at 31 March	22	**24,585**	7,239

During 2019/20 the Trust accessed loans totalling £41,855k to support its revenue position and £1,723k to support capital projects. It repaid a total of £2,373k (including £1,945k capital loan repayment) giving a net movement of £41,205k.

During 2019/20 the Trust also accessed Public Dividend Capital (PDC) of £15,367k for a number of capital schemes including £8,472k for the new cancer centre and £1,611k for CT & MRI scanners.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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 and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

IAS1 Presentation of Financial Statements requires management to assess, as part of the accounts preparation process, whether the financial accounts should be prepared on a going concern basis. In preparing the financial statements the Directors have considered the Trust's overall financial position and expectation of future financial support. On 1 October 2019 NHS Improvement approved the acquisition of North Cumbria University Hospital NHS Trust by Cumbria Partnership NHS Foundation Trust which was renamed on the same date to North Cumbria Integrated Care NHS Foundation Trust. During 2019/20 the merged Trust delivered a deficit of £37.8m and increased borrowing from the Department of Health & Social Care by £41.2m to £301.9m. (Borrowing of £256.5m transferred from the North Cumbria University Hospitals NHS Trust at the point of its acquisition.)

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loan principal totalling £299.3m is classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Trust submitted a draft financial plan for 2020/21 to NHS Improvement to deliver a deficit of £50.1m which included the delivery of a £24.7m CIP programme. The plan also included revenue and capital support loans of £17.4m. Due to the need for the NHS to focus on responding to the COVID-19 pandemic the 2020/21 contracting and financial planning processes were suspended in March and a COVID-19 financial framework put in place to cover the period to 31 July 2020 in the first instance. This framework ensures that providers receive block payments in advance to reduce the need for invoicing between NHS bodies and to support cashflow. In addition, providers are receiving "top up" income to achieve financial breakeven for this period. However, the Trust does not have final signed contracts with its commissioners for 2020/21 and it is unclear what the contracting arrangements will be for 2020/21 and beyond. In the event that current arrangements are discontinued, the Trust has an expectation that any shortfall in earned income over expenditure for the remainder of the year will be met in the form of revenue support from the Department of Health and Social Care, but this additional support has not been confirmed. This represents a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern.

The Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and Clinical Commissioning Group (CCG) allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers can therefore continue to expect NHS funding to flow at similar levels to that previously provided where services are still expected to be commissioned. DHSC has also confirmed that temporary revenue support arrangements will continue in order to support providers who are demonstrating cash needs.

Taking these factors into account therefore, and in accordance with the GAM 2019/20 and the Treasury FReM, the Trust's accounts have been prepared by the directors on a going concern basis. The Trust has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.3 Charitable Funds

Following Treasury's agreement to apply IFRS10 to NHS Charities from 1 April 2013, the Trust established that as the Trust is the corporate Trustee of its charities it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context of the whole group and transactions have not been consolidated. Details of the transactions with its Charities are included in the related parties' note (Note 33).

Note 1.3 Charitable Funds (cont'd)

On 30 September 2019 the Trust transferred Cumbria Partnership NHS Charitable Fund to Cumbria Community Foundation.

The North Cumbria University Hospitals NHS Trust Charitable Fund formed part of the formal acquisition process on 1 October 2019. The Charity has been renamed the North Cumbria University Hospitals Charitable Fund.

Note 1.4 Joint Ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The Trust entered into a joint venture with the partners of Waterloo House Surgery and University Hospital of Morecambe Bay NHS Foundation Trust with each organisation having one third control over the GP Practice. Joint ventures are accounted for using the equity method.

Limited Company

On 26 January 2018 the Trust established a company called North Cumbria Primary Care Ltd (NCPC). The company has been used as a vehicle to support primary care throughout the north of Cumbria. The Trust has no control in terms of decision making within the organisation but has exercised its right to appoint a director to NCPC's board.

Note 1.5 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.

The majority of the Trust's income is from contracts with other NHS bodies. Under the terms of these contracts the Trust receives income in fixed monthly amounts with adjusting invoices or credit notes issued at quarterly intervals to reflect actual performance where appropriate.

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.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

1) As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;

2) The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

3) The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Note 1.5 cont'd

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

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets including A&E 4 hour waiting targets. Income earned from the funds is accounted for as variable consideration.

Other forms of income

Education & Training (>95% from contracts with Health Education England for the delivery of training to junior medical staff, medical students and a range of other staff)

Non patient services to other bodies (eg provision of Pathology and Radiology services to non-Trust patients)

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The Trust is also one of a small number that receives central PFI support annually. In this situation the Trust is not transferring any goods or services to the customers in exchange for the amount paid. However, under paragraph 15 of IFRS when an entity has no remaining obligations to transfer goods or services to the customer and all, or substantially all, of the consideration promised by the customer has been received by the entity and is non-refundable the entity can recognise the revenue. As PFI funding is received in full each year before 31 March it is included as revenue in the Trust's accounts.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. An estimate for the cost of annual leave entitlement relating to employees on sick and maternity leave which has not been taken by employees at the end of the period is recognised in the financial statements.

Pension costs

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

The Trust has identified component parts of the estate as individual buildings which are separately identifiable and depreciated over their own useful economic lives.

Note 1.8 Property, plant and equipment (cont'd)
Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

The Trust has valued its buildings on net of recoverable VAT on the basis. This is based on the Trust being a part of the Cumbria ELift scheme since 2016/17 and, that if the buildings required replacement they are currently likely to be replaced by the LIFT arrangement and under current VAT legislation where input tax is recoverable.

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

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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.
Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.
Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

Note 1.8 Property, plant and equipment (cont'd)

De-recognition

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

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

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

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

payment for the fair value of services received
repayment of the finance lease liability, including finance costs, and
payment for the replacement of components of the asset during the contract 'lifecycle replacement'.
The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.
The Trust can recover VAT on payments for certain contracted-out services, including the provision of a fully managed and serviced building under a PFI. The Trust has taken the view that when revaluing the assets arising from the PFI project this should be based on a value excluding recoverable VAT, reflecting the cost at which the service potential would be replaced by the PFI operator.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.
The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.
The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.8 Property, plant and equipment (cont'd)

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	0	0
Buildings, excluding dwellings	1	74
Dwellings	0	35
Plant & machinery	5	17
Transport equipment	0	7
Information technology	5	7
Furniture & fittings	5	15

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

Note 1.9 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 where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Software

The Trust only holds one type of intangible asset which is purchased software. Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset. All purchased software is held at depreciated historic cost as an approximation of fair value and is amortised over a maximum of 7 years.

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.

Amortisation

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

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method.

A small number of the Trust's inventory counts were unable to proceed due to COVID-19 priorities. The Trust reviewed previous inventory counts and used this information to estimate inventory values for 31 March 2020 for the affected areas.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 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, ie, when receipt or delivery of the goods or services is made.

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 and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for invoiced contract receivables and for Injury Cost Recovery receivables at an amount equal to lifetime expected credit losses.

HM Treasury has ruled that central government bodies may not recognise impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust, therefore, does not recognise loss allowances for impairments against these bodies. Additionally, the DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for impairments against these bodies.

The Trust determines the credit loss allowance for its remaining invoiced contract receivables and Injury Cost Recovery receivables by grouping these into categories and using its experience of credit losses on these groups of receivables over a number of recent years to calculate a percentage credit loss allowance to apply.

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.

Derecognition

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

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

Note 1.13 Leases

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

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

Note 1.13 cont'd

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Leases of Land and Buildings

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

The Trust as a 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.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% (2018/19 positive 0.29%) in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 26.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Clinician Pension Tax

Clinicians (and other senior clinical staff) who are members of the NHS Pension Scheme and who, as a result of work undertaken in 2019/20 tax year, face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid for by the NHS Pension Scheme.

The Trust created a provision broadly equal to the tax charge owed by clinicians who will want to take advantage of the 2019/20 Commitment. This is offset by the commitment from NHS England and the Government to fund the payments to the clinicians as and when they arise. The provision and offsetting asset will initially increase year on year in line with the pension scheme growth and be released as commitments are met, i.e. as eligible members retire under the rules of the NHS Pension Scheme.

Trusts are required to include a provision in their accounts in 2019/20 where clinicians are likely to have a tax liability and take advantage of this policy. A separate reimbursement asset will be recognised in the Trust's SoFP with the I&E effects netted off.

Due to the timescale for pension tax annual allowance charges and nominations to the scheme there is no data for actual nominations for the 2019/20 tax year available. The deadline for the initial nomination is 31 July 2021 with the ability to make changes up to 31 July 2024.

Note 1.14 cont'd
Using information from the Government's Actuary Department (GAD) and NHS Business Services Authority (NHS BSA) a national average discounted value per nomination of £3,345 has been calculated which can be used to calculate a Trust provision. Where the number of staff likely to take up the offer is unknown it is recommended that the Trust's consultant headcount from NHS Digital's NHS Workforce Statistics - November 2019 is used in order to ensure that the national position is not understated. This figure was 216 for the Trust giving a total provision of £723k for 2019/20 (See Note 26.1 and also Note 20.1 for the offsetting asset).

Note 1.15 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.17 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 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 FReM.

Note 1.19 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.20 Transfers of functions
For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets or liabilities transferred is recognised within income or expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets or liabilities transferred is recognised within expenses or income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.21 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate (1.27%). The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 1.23 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The Cumberland Infirmary and Workington Hospital were constructed under the Private Finance Initiative (PFI) and it is the Trust's judgement that they fall within the scope of IFRIC 12 Service Concession Arrangement. It reaches this judgement for the following reasons:
- the private sector providers provide services to the NHS body;
- the contracts involve the use of assets that are dedicated to the arrangement in providing those services;
- the assets concerned are hospitals which are on the list of infrastructure assets within IFRIC 12;
- the Trust controls/regulates the services being provided by the assets, to whom the services are provided and the price charged for the services;
- the Trust controls the residual interest in the assets at the end of the concessions.

The Trust's judgement that it has controls/regulates the services being provided, to whom the services are provided and the price charged for the services is based on the following:
- the Trust's PFI contract specifies the asset to be used (the Cumberland Infirmary/Workington Hospital) and what services are to be provided to the Trust using the assets;
- the contract specifies the site to be used to build the assets as well as when and to whom the assets should be available and there is very limited/no scope for the private company to make the assets and services available to users of its own choice;
- there is a payment formula in the contract (the unitary payment increases by the movement in RPI) which prevents the private companies charging a different price in the event that their cost base suffers unpredictable changes or additional unplanned lifecycle replacement costs. For the purposes of IFRIC this gives the Trust control over the price.

Where a PFI scheme meets the criteria of IFRIC 12 the grantor must recognise an asset and a corresponding finance lease liability in accordance with IAS 17 Leases. See Note 26 for additional information.

Note 1.23 Critical judgements in applying accounting policies (cont'd)

HM Treasury adapts IAS 16 Property, Plant & Equipment to state that assets held for their service potential and which are in use must be measured at current value in existing use. For specialised assets current value in existing use should be interpreted as the present value of the asset's remaining service potential, which can be assumed to be at least equal to the cost of replacing that service potential. The Trust's judgement is that the cost of replacing the service potential of its operational buildings would exclude VAT. The Trust is a signatory of the Strategic Partnering Agreement with the local eLIFT scheme. The Trust's buildings have been valued on a modern equivalent asset basis and net of recoverable VAT based on the Trust's assessment that if its buildings required replacement the only viable route to facilitate this would be through the eLIFT arrangement. The Trust's judgement is based on the reduced availability of public funding for major capital projects in the NHS currently. There are tax advantages to using the eLIFT route, particularly around construction costs of buildings and their respective lifecycle replacements. Under current VAT regulations input tax would be recoverable and, therefore, the asset value should be stated net of recoverable VAT. See Note 14 Property, Plant and Equipment.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Uncertainty	**Consequences if actual results differ from assumption**
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows: • Land and non-specialised buildings – market value for existing use • Specialised buildings – depreciated replacement cost on a modern equivalent asset basis. The Trust seeks professional advice from its valuers annually in determining the value of its land and buildings. Due to the market uncertainties caused by COVID-19 the valuers report in March declared a material valuation uncertainty. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercised his professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation.	The net book value at 31 March 2020 of the Trust's Property Plant & Equipment valued by professional valuers and reflected in these financial statements is £186.7m. A reduction in the estimated values would result in reductions to the Revaluation Reserve and / or a loss recorded as appropriate in the Statement of Comprehensive Income. If the value of land and buildings were to reduce by 10% this would result in a charge to the Statement of Comprehensive Income of approximately £36.9m and a reduction in the Revaluation Reserve of £2.7m. An increase in estimated valuations would result in a reduction to the Revaluation Reserve of approximately £4.0m and reversals of previous negative revaluations to the Statement of Comprehensive Income of approximately £1.8m.
The Trust is in dispute with its Private Finance Initiative (PFI) provider for Workington Hospital and has claimed penalties and deductions relating to fire defects and other issues. The Trust has recognised an asset but this may require adjustment following the conclusion of the dispute process. The above disclosure has been reduced due to its commercially sensitive nature	Any settlement lower than the value included in the Trust's accounts would result in an equivalent charge to the Statement of Comprehensive Income. There is also potential that the impact of a lower settlement may have resulted in the loss of some, or all, of the Financial Recovery Fund (FRF) incentive income earned by the Trust (16.9m). Any settlement higher than the value included in the Trust's accounts would result in an equivalent reduction in charges to the Statement of Comprehensive Income and may have resulted in the Trust earning a higher level of FRF incentive income.

Note 2 Operating Segments

The Trust has one operating segment which is the provision of Healthcare.

The Trust's "Chief Decision Maker" is the Trust Board. Information presented to the Board is not split into segments.

The Trust received income from external organisations for patient care activities amounting to £240,031k (2018/19: £147,620k) as shown in notes 3.1 and 3.2.

£228,346k of the income comes from Clinical Commissioning Groups in England and NHS England which is 95% of the total patient care income (2018/19: £135,805k which was 92% of the total).

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 3.1 Income from patient care activities (by nature)	**2019/20**	2018/19
	£000	£000
Acute services		
Elective income	16,554	0
Non elective income	46,729	0
First outpatient income	7,343	0
Follow up outpatient income	9,339	0
A & E income	6,263	0
High cost drugs income from commissioners (excluding pass-through costs)	12,732	3,446
Other NHS clinical income	21,725	0
Mental health services		
Cost and volume contract income	391	880
Block contract income	35,501	65,715
Clinical income for the secondary commissioning of mandatory services	23	19
Other clinical income from mandatory services	474	1,928
Community services		
Community services income from CCGs and NHS England	62,910	64,083
Income from other sources (e.g. local authorities)	8,937	9,794
All services		
Private patient income	396	0
Agenda for Change pay award central funding (a)	0	1,755
Additional pension contribution central funding (b)	8,679	0
Other clinical income (c)	2,035	0
Total income from activities	**240,031**	147,620

Note a: Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into the Trust's baseline tariff.

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

Note c: Other income includes £1,215k relating to COVID-19 costs the Trust had incurred up to 31 March 2020.

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	**£000**	£000
NHS England	40,557	11,273
Clinical commissioning groups	187,789	124,532
Department of Health and Social Care	0	1,755
Other NHS providers	973	2,089
NHS other	0	5
Local authorities	7,602	7,283
Non-NHS: private patients	340	0
Non-NHS: overseas patients (chargeable to patient)	56	0
Injury cost recovery scheme	357	0
Non NHS: other	2,357	683
Total income from activities	**240,031**	147,620
Of which:		
Related to continuing operations	240,031	147,620

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

	2019/20	2018/19
	£000	£000
Income recognised this year	56	0
Cash payments received in-year	7	0
Amounts added to provision for impairment of receivables	6	0
Amounts written off in-year	1	0

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	**Non-contract income**	**Total**	Contract income	Non-contract income	Total
	£000	**£000**	**£000**	£000	£000	£000
Research and development	511	0	**511**	348	0	348
Education and training	4,017	578	**4,595**	2,767	0	2,767
Non-patient care services to other bodies	5,045		**5,045**	5,097	0	5,097
Provider sustainability fund (PSF) (a)	340		**340**	1,804	0	1,804
Financial recovery fund (FRF) (a)	17,147		**17,147**	0	0	0
Marginal rate emergency tariff funding (MRET)	994		**994**	0	0	0
Receipt of capital grants and donations		65	**65**	0	473	473
Charitable and other contributions to expenditure		89	**89**	0	0	0
Rental revenue from operating leases		568	**568**	0	1,007	1,007
Other income (b)	5,260	0	**5,260**	1,333	0	1,333
Total other operating income	**33,314**	**1,300**	**34,614**	11,349	1,480	12,829

Note a: The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) were established in 2016/17 and 2019/20 respectively to support recovery across the NHS. In 2019/20 the Trust accessed £603k (2018/2019: £1,804k) of its share of allocated funds (£340k PSF and £263k FRF) and received £16,884k of FRF incentive funding.

Note b: Other income includes £3,150k in support for the PFI scheme at the Cumberland Infirmary, Carlisle. This funding was agreed by the Department of Health during 2012/13 and is received on an on-going basis. Other income also includes £1,177k for car parking, catering and accommodation income.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	**£000**
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	525	474

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20	2018/19
	£000	**£000**

Income from services designated as commissioner requested services	228,921	147,620
Income from services not designated as commissioner requested services	11,110	0
Total	**240,031**	**147,620**

Note 6.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	2,420	588
Staff and executive directors costs	213,793	126,147
Remuneration of non-executive directors	113	109
Supplies and services - clinical (excluding drugs costs)	19,442	5,074
Supplies and services - general	3,137	3,757
drugs)	22,797	5,634
Inventories written down	67	0
Consultancy costs	308	938
Establishment	3,206	1,634
Premises	12,496	7,321
Transport (including patient travel)	3,840	2,767
Depreciation on property, plant and equipment	7,430	2,911
Amortisation on intangible assets	1,000	631
Net impairments	20,946	2,530
Movement in credit loss allowance: contract receivables / contract assets	(385)	(211)
Increase/(decrease) in other provisions	20	0
Change in provisions discount rate (a)	304	(4)
Audit fees payable to the external auditor (b)		
audit services- statutory audit	78	40
other auditor remuneration (external auditor only)	0	8
Internal audit costs	202	126
Clinical negligence	5,483	462
Legal fees	521	522
Insurance	234	20
Education and training (c)	1,319	736
Rentals under operating leases	2,442	3,219
Redundancy	40	193
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	6,072	(1,588)
Car parking & security	54	8
Hospitality	11	0
Losses, ex gratia & special payments	45	29
Other services, eg external payroll	584	0
Other	763	2,085
Total	**328,782**	165,686

Note a: The 2019/20 HM Treasury discount rates were used to calculate the present value of the cashflows associated with provisions see note 26

Note b: Audit fees are inclusive of VAT. The Trust's auditors for 2019/20 were Grant Thornton UK LLP (2018/19: Mazars).

Note c: Education & Training includes notional expenditure to match the notional income from the apprenticeship fund (see Note 4).

Operating expenditure includes £2,232k of costs relating to COVID-19, including a provision of £1,017k for annual leave owing due to the pandemic.

Note 6.2 Other auditor remuneration

Other auditor remuneration for 2019/20 was £nil (2018/19: £8k for the provision of audit-related assurance services in respect of the Trust's Quality Accounts).

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: no specified limitation stated in the Auditors engagement letter).

Note 7 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	158,987	100,385
Social security costs	13,973	9,361
Apprenticeship levy	736	481
Employer's contributions to NHS pensions (a)	27,840	12,733
Pension cost - other	85	0
Termination benefits	40	193
Temporary staff (including agency)	12,453	5,237
Total gross staff costs	**214,114**	128,390
Recoveries in respect of seconded staff	0	(1,318)
Total staff costs	**214,114**	127,072
Of which		
Costs capitalised as part of assets	281	732

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

Note 7.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the Trust agreed on the grounds of ill-health (2018/19: 8). The estimated additional pension liabilities of these ill-health retirements is £228k (2018/19: £293k).

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

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

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

The Pensions Act 2008 introduced new duties on employers to provide access to a workplace pension that meets certain legal requirements. As from 1 April 2013 the Trust choose the National Employment Savings Trust (NEST) to fulfil this role for employees who are unable to join the NHS Pension Scheme due to its restrictions. It is a defined contribution pension scheme where the retirement income a member gets depends on how much has been contributed, investment returns and the amount of charges over time. Current combined employee and employer contributions were £198k to the 31 March 2020.

Note 9 Operating leases

North Cumbria Integrated Care NHS FT as a Lessor

The Trust has a number of small operating leases including lease arrangements for the use of clinic rooms at several of its Community Hospitals and also the hospital shop at West Cumberland Hospital. The acquisition of North Cumbria University Hospital NHS Trust has contributed to the decrease in operating lease revenue.

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	568	1,007
Total	**568**	1,007

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	6	1,007
- later than one year and not later than five years;	22	0
- later than five years.	5	0
Total	**33**	1,007

North Cumbria Integrated Care NHS FT as a Lessee

The Trust has a number of lease arrangements for both clinical and non clinical spaces, with the higher value leases having lease terms of over 15 years.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	2,442	3,219
Total	**2,442**	3,219

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,571	2,970
- later than one year and not later than five years;	5,664	2,614
- later than five years.	15,100	7,734
Total	**23,335**	13,318

Note 10 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	100	54
Other finance income	92	212
Total finance income	**192**	266

Note 11.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,137	28
Finance leases	14	14
Interest on late payment of commercial debt	8	0
Main finance costs on PFI and LIFT schemes obligations	1,523	523
Contingent finance costs on PFI and LIFT scheme obligations	1,021	0
Total interest expense	**4,703**	565
Unwinding of discount on provisions	11	0
Total finance costs	**4,714**	565

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	0

Note 12 Other gains / (losses)

The Trust made losses of £95k 2019/20 (2018/19: £4k) on the disposal of Property, Plant and Equipment.

Note 13 Intangible assets

	Software licences		Software licences
	£000		
Valuation / gross cost at 1 April 2019 - brought forward	**4,510**	Valuation / gross cost at 1 April 2018 - as previously stated	4,240
Transfers by absorption (a)	4,614	Transfers by absorption	0
Additions	808	Additions	270
Reclassifications	(69)	Reclassifications	0
Valuation / gross cost at 31 March 2020	**9,863**	Valuation / gross cost at 31 March 2019	4,510
Amortisation at 1 April 2019 - brought forward	**1,693**	Amortisation at 1 April 2018 - as previously stated	1,062
Transfers by absorption (a)	3,020	Transfers by absorption	0
Provided during the year	1,000	Provided during the year	631
Reclassifications	(69)	Reclassifications	0
Amortisation at 31 March 2020	**5,644**	Amortisation at 31 March 2019	1,693
Net book value at 31 March 2020	**4,219**	Net book value at 1 April 2019	2,817

Note a: Relates to the incoming assets of North Cumbria University Hospitals NHS Trust and also the transfer out of assets relating to mental health services.

Note 14.1 Property, plant and equipment - 2019/20

	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	**5,669**	**53,317**	**248**	**0**	**6,545**	**253**	**13,832**	**1,955**	**81,819**
Transfers by absorption (a)	4,022	146,448	735	7,796	44,220	0	4,804	746	**208,771**
Additions	0	4,911	0	7,318	5,232	0	2,512	336	**20,309**
Impairments	(3,379)	(28,768)	(549)	0	0	0	0	0	**(32,696)**
Reversals of impairments	0	2,111	0	0	0	0	0	0	**2,111**
Revaluations	17	6,426	0	0	0	0	0	0	**6,443**
Reclassifications	0	1,777	(1)	(1,777)	(623)	(47)	(3,260)	(241)	**(4,172)**
Transfers to / from assets held for sale	(170)	(401)	0	0	0	0	0	0	**(571)**
Disposals / derecognition	0	(21)	0	0	(484)	0	(53)	(110)	**(668)**
Valuation/gross cost at 31 March 2020	**6,159**	**185,800**	**433**	**13,337**	**54,890**	**206**	**17,835**	**2,686**	**281,346**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**1,330**	**0**	**0**	**3,572**	**159**	**7,676**	**1,471**	**14,208**
Transfers by absorption (a)	0	717	(3)	0	30,756	0	5,606	570	**37,646**
Provided during the year	0	3,157	24	0	2,564	21	1,447	217	**7,430**
Impairments	0	(2,669)	(20)	0	0	0	0	0	**(2,689)**
Reversals of impairments	0	(646)	0	0	0	0	0	0	**(646)**
Revaluations	0	94	0	0	0	0	0	0	**94**
Reclassifications	0	(2)	(1)	0	(621)	(47)	(3,260)	(241)	**(4,172)**
Disposals / derecognition	0	0	0	0	(392)	0	(53)	(107)	**(552)**
Accumulated depreciation at 31 March 2020	**0**	**1,981**	**0**	**0**	**35,879**	**133**	**11,416**	**1,910**	**51,319**
Net book value at 31 March 2020	**6,159**	**183,819**	**433**	**13,337**	**19,011**	**73**	**6,419**	**776**	**230,027**
Net book value at 1 April 2019	**5,669**	**51,987**	**248**	**0**	**2,973**	**94**	**6,156**	**484**	**67,611**

Note a: Relates to the incoming assets of North Cumbria University Hospitals NHS Trust and also the transfer out of assets relating to mental health services and Millom Community Hospital. The assets of North Cumbria University Hospitals NHS Trust included two general hospitals, one in Carlisle and one in Whitehaven, as well as substantial medical equipment. The transfer of mental health services included the Carleton Clinic Site at Carlisle. Assets under Construction includes redevelopment of West Cumberland Hospital and the construction of a new cancer centre at the Cumberland Infirmary.

Note 14.2 Property, plant and equipment financing - 2019/20

	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
Net book value at 31 March 2020									
Owned - purchased	6,159	116,568	433	13,337	18,427	73	6,336	768	**162,101**
Finance leased	0	0	0	0	0	0	78	0	**78**
On-SoFP PFI contracts and other service concession arrangements	0	66,755	0	0	0	0	0	0	**66,755**
Owned - donated	0	496	0	0	584	0	5	8	**1,093**
NBV total at 31 March 2020	**6,159**	**183,819**	**433**	**13,337**	**19,011**	**73**	**6,419**	**776**	**230,027**

Note 14.3 Property, plant and equipment - 2018/19

	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 - as previously stated	6,009	52,484	253	821	6,399	254	11,410	1,894	79,524
Prior period adjustments	0	0	0	0	0	0	0	0	0
Valuation / gross cost at 1 April 2018 - restated	6,009	52,484	253	821	6,399	254	11,410	1,894	79,524
Transfers by absorption (a)	(60)	(412)	0	0	(106)	0	(194)	0	(772)
Additions	0	1,826	0	1,662	269	21	2,658	298	6,734
Impairments	(103)	(449)	0	0	0	0	0	0	(552)
Reversals of impairments	680	8	1	0	0	0	0	0	689
Revaluations	(857)	(2,623)	(6)	0	0	0	0	0	(3,486)
Reclassifications	0	2,483	0	(2,483)	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(17)	(22)	(42)	(237)	(318)
Valuation/gross cost at 31 March 2019	5,669	53,317	248	0	6,545	253	13,832	1,955	81,819
Accumulated depreciation at 1 April 2018 - as previously stated	0	1,236	0	0	3,103	164	6,649	1,601	12,753
Prior period adjustments	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 1 April 2018 - restated	0	1,236	0	0	3,103	164	6,649	1,601	12,753
Transfers by absorption (a)	0	(30)	0	0	(55)	0	(102)	0	(187)
Provided during the year	0	1,074	6	0	536	17	1,171	107	2,911
Impairments	857	1,796	0	0	0	0	0	0	2,653
Reversals of impairments	0	(123)	0	0	0	0	0	0	(123)
Revaluations	(857)	(2,623)	(6)	0	0	0	0	0	(3,486)
Disposals / derecognition	0	0	0	0	(12)	(22)	(42)	(237)	(313)
Accumulated depreciation at 31 March 2019	0	1,330	0	0	3,572	159	7,676	1,471	14,208
Net book value at 31 March 2019	5,669	51,987	248	0	2,973	94	6,156	484	67,611
Net book value at 1 April 2018	6,009	51,248	253	821	3,296	90	4,761	293	66,771

Note a: Relates to the transfer of South Community Services to University Hospitals of Morecambe Bay NHS Foundation Trust.

Note 14.4 Property, plant and equipment financing - 2018/19

	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
Net book value at 31 March 2019									
Owned - purchased	5,669	35,792	248	0	2,973	94	5,999	484	51,259
Finance leased	0	6,749	0	0	0	0	157	0	6,906
On-SoFP PFI contracts and other service concession arrangements	0	8,882	0	0	0	0	0	0	8,882
Owned - donated	0	564	0	0	0	0	0	0	564
NBV total at 31 March 2019	5,669	51,987	248	0	2,973	94	6,156	484	67,611

Note 15 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price (a)	22,072	2,530
Other (b)	(1,126)	0
Total net impairments charged to operating surplus / deficit	**20,946**	2,530
Impairments charged to the revaluation reserve (c)	6,304	(137)
Total net impairments (c)	**27,250**	2,393

Note 16 Revaluations of property, plant and equipment

The Trust revalued its Land, Buildings and Dwellings on 31 March 2020. The revaluation was carried out by RICS Registered Valuer at Cushman & Wakefield, and is consistent with the requirements of IAS 16. As the Trust has specialised assets for which there is no active market, the valuer has used Modern Equivalent Asset (MEA) valuations as a substitute for fair value. MEA is based on the value of an asset with the same service potential, not a like for like replacement.

COVID-19

The valuation exercise was carried out in March and April 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 valuer's report states:

'*Marketing activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence and published build cost information for comparison purposes, to inform opinions of value. Indeed the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.*

Our valuation is therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuations than would normally be the case.

For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. It is used in order to be clear and transparent with all parties, in a professional manner that - in the current extraordinary circumstances - less certainty can be attached to the valuation than would otherwise be the case.'

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 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. A 10% change in the valuation of land and buildings would have £18.7m impact on the Statement of Financial Position.

Notes

Note a: Following the acquisition of North Cumbria University Hospitals NHS Trust there has been alignment of accounting policies and valuation methods. The Trust (previously known as Cumbria Partnership NHS FT) joined the Cumbria E-lift programme on the 31 March 2017 and all the Trust land, buildings and dwellings were valued net of recoverable VAT on the 31 March 2020. This is based on the Trust's current assessment that if its buildings required replacement the only viable route to facilitate this would be through the eLIFT arrangement.

Note b: Following acquisition the Trust recognised rectification costs of £1,126k relating to fire safety compliance issues at the Cumberland Infirmary in Carlisle. As at 31 March 2020 it was deemed that the building had become fully compliant with fire regulation and the remaining rectification cost was reduced to £nil.

Note c: Of the total net impairments, £3.2m relates to the land values at the Cumberland Infirmary and West Cumberland Hospital (WCH). In valuing the land component of the specialist assets, the area of the sites required to accommodate the modern equivalent assets with the same service potential as the existing would be smaller than the existing land area (Asset MEA Site Area: CIC 18.1 acres; WCH 10.6 acres), causing a reduction in the valuation.

Following on from note (a) above, the largest impact of the VAT change is on West Cumberland Hospital. This has been estimated at a reduction in value of £18m, mitigated by other factors which resulted in an overall reduction in value at West Cumberland Hospital of £16.8m. The other significant downward valuation is £4.9m across 7 community hospitals due to normal fluctuations in the building valuation indices.

Note 17 Donations of property, plant and equipment

The Trust received donations of assets in the year valued at £32k from the North Cumbria University Hospitals Charitable Fund and £33k from the League of Friends for the purchase of assets.

Note 18 Investments in associates and joint ventures

The Trust maintained its £35k investment in the joint venture with the partners of Waterloo House Surgery and University Hospitals of Morecambe Bay NHS Foundation Trust with each organisation having one third control over the GP Practice.

Note 19 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	2,536	0
Work In progress	0	0
Consumables	4,101	0
Energy	61	0
Other	154	0
Total inventories	**6,852**	0

Inventories recognised in expenses for the year were £31,321k (2018/19: £0k). Write-down of inventories recognised as expenses for the year were £67k (2018/19: £0k).

A small number of the Trust's inventory counts, including Theatres at the West Cumberland Hospital and Cumberland Infirmary, were unable to proceed due to COVID-19 priorities. The Trust reviewed previous inventory counts and used this information to estimate inventory values for 31 March 2020 for the affected areas. The total value of inventory included above that has been estimated is £2,650k.

Note 20.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables (a)	43,913	10,758
Allowance for impaired contract receivables / assets	(328)	(474)
Prepayments (non-PFI)	2,748	1,167
PFI lifecycle prepayments	1,478	0
Interest receivable	16	0
PDC dividend receivable	0	72
VAT receivable	0	81
Other receivables (c)	10	260
Total current receivables	**47,837**	11,864
Non-current		
Contract assets (a)	644	0
Allowance for other impaired receivables	(106)	0
PFI lifecycle prepayments	14,047	0
Other receivables (b)	1,124	0
Total non-current receivables	**15,709**	0
Of which receivable from NHS and DHSC group bodies:		
Current	32,231	7,358

Note a: Included in current receivables at 31 March 2020 is £826k (2018/19: £nil) for the Injury Cost Recovery Scheme and in non-current £644k (2018/19: £nil). Credit scoring is not appropriate for the Scheme as it only includes person(s) who have been found to be, or accept, responsibility for injury caused. A provision of 16.42% has been applied for any potential non recovery costs based on the Trust's average withdrawal rates.

Note b: Other receivables relates to the Trust's loan to North Cumbria Primary Care Ltd to support primary care provision throughout Cumbria (2018/19: £1k).

Note c: Includes £723k (2018/19: £nil) which reflects the offsetting asset in respect of the provision for clinician pension tax charges for 2019/20. See Notes 1.15 and 26.1.

Note 20.2 Allowances for credit losses

	2019/20 Contract receivables and contract assets	2018/19 Contract receivables and contract assets	All other receivables
	£000	£000	£000
Allowances as at 1 April - brought forward	**474**	0	686
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018		686	(686)
Transfers by absorption	**345**	0	0
Changes in existing allowances	(385)	0	0
Reversals of allowances	0	(211)	0
Utilisation of allowances (write offs)	0	(1)	0
Allowances as at 31 Mar 2020	**434**	474	0

These allowances relate to contract receivables and contract assets.

Note 21 Non-current assets held for sale and assets in disposal groups

During 2019/20 the Trust transferred Voreda House with a net book value of £571k from PPE into assets held for sale. This building is used by the Trust as office space but is now surplus to requirements. Crozier Lodge (net book value of £46k and transferred as a part of the merger) and Voreda are being actively marketed and the Trust anticipates sales during 2020/21

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20	2018/19
	£000	£000
At 1 April	**7,239**	8,119
Transfers by absorption	1,852	0
Net change in year	15,494	(880)
At 31 March	**24,585**	7,239
Broken down into:		
Cash at commercial banks and in hand	20	14
Cash with the Government Banking Service	24,565	7,225
Total cash and cash equivalents as in SoFP	**24,585**	7,239
Total cash and cash equivalents as in SoCF	**24,585**	7,239

The Trust's cash position included Public Dividend Capital funding for capital projects for which invoices were outstanding and unpaid at 31 March 2020.

Note 22.2 Third party assets held by the Trust

The Trust held £396k cash at bank and in hand at 31 March 2020 (2018/2019: £398k) which comprises £71k monies held by the Trust on behalf of patients (2018/2019: £73k), and £325k held on behalf of the West, North and East Cumbria Sustainability and Transformation Partnership (2018/2019: £325k). These amounts have been excluded from the cash at bank and in hand figure reported in the accounts.

Note 23.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	10,365	12,135
Capital payables	7,125	427
Accruals	21,369	5,281
Social security costs	2,996	2,332
VAT payables	264	0
Other taxes payable	2,531	0
Other payables	3,898	5,069
Total current trade and other payables	**48,548**	25,244
Of which payables from NHS and DHSC group bodies:		
Current	7,381	12,135

Note 24 Other liabilities

Other liabilities as disclosed in the Statement of Financial Position relates to deferred income of £3,895k (2018/19: £1,005k).

Note 25.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	301,074	1,312
Obligations under finance leases	59	77
Obligations under PFI, LIFT or other service concession contracts	2,041	298
Total current borrowings	**303,174**	1,687
Non-current		
Loans from DHSC	858	2,831
Obligations under finance leases	0	59
Obligations under PFI, LIFT or other service concession contracts	49,020	5,026
Total non-current borrowings	**49,878**	7,916

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £299,319k are classified as current liabilities within these financial statements.

Loans from the Department of Health & Social Care total £301,932k at 31 March 2020 (31 March 2019: £4,143k) and consist of 51 separate fixed interest rate loans ranging from 3 to 15 years (31 March 2019: 3). Included in the value of current loans is £901k of accrued interest as at 31 March 2020.
The Trust makes principal repayments on 6 of the loans twice annually. Interest is also paid twice annually on all of the loans. The details of these loans and the principal remaining at 31 March 2020 are as follows:

£1,600k at 5.20% - 15 year loan commencing 22/03/07
£50k at 5.10% - 14.5 year loan commencing 15/09/07
£64k at 4.34% - 14 year loan commencing 15/03/08
£3,158k at 1.32% - 10 year loan commencing 14/12/15
£3,800k at 1.08% - 10 year loan commencing 18/03/19
£1,723k at 0.29% - 10 year loan commencing 16/03/20

Note 25.1 Borrowings (cont'd)

The principal remaining on the other 45 loans totals is £290,639k. They all have terms of 3 years and a fixed interest rate of 1.5%. Principal is not repaid until the end of the term and interest on each loan is payable twice annually. During 2019/20 the Trust took out 6 of these loans totalling £41,855k.

As at 31 March 2020 9 loans with a remaining balance of £5,388k were past their repayment dates. The Trust received revised repayment dates for each loan in advance from the Department of Health & Social Care.

As 99.4% of the DHSC loan principal is current and due to be replaced with PDC in 2020/21 the carrying value of DHSC loans is considered to be the fair value.

The fair value of the outstanding PFI liabilities at 31 March 2020 is £72,208k (31 March 2019: £8,731k). The fair value of these liabilities has been obtained with reference to the current fixed interest rates offered by the Department of Health & Social Care for similar loans for period matching the remaining life of the existing loans/liabilities.

The PFI liabilities are discussed further in Note 30.

Note 25.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	**Finance leases**	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**	**£000**
Carrying value at 1 April 2019	**4,143**	**136**	**5,324**	**9,603**
Cash movements:				
Financing cash flows - payments and receipts of principal	41,205	(77)	(476)	**40,652**
Financing cash flows - payments of interest	(2,079)	(14)	(1,523)	**(3,616)**
Non-cash movements:				
Transfers by absorption	256,526	0	46,213	**302,739**
Application of effective interest rate	2,137	14	1,523	**3,674**
Carrying value at 31 March 2020	**301,932**	**59**	**51,061**	**353,052**

Note 25.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	1,757	215	5,598	7,570
Cash movements:				
Financing cash flows - payments and receipts of principal	2,383	(79)	(274)	2,030
Financing cash flows - payments of interest	(26)	(14)	(523)	(563)
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	1	0	0	1
Application of effective interest rate	28	14	523	565
Carrying value at 31 March 2019	4,143	136	5,324	9,603

Note 25.3 Finance leases

Obligations under finance leases where the Trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**69**	161
of which liabilities are due:		
- not later than one year;	69	92
- later than one year and not later than five years;	0	69
Finance charges allocated to future periods	(11)	(25)
Net lease liabilities	**59**	136
of which payable:		
- not later than one year;	59	77
- later than one year and not later than five years;	0	59

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2019	**240**	**1,291**	**171**	**125**	**468**	**2,295**
Transfers by absorption	216	1,928	247	0	0	**2,391**
Change in the discount rate (a)	10	294	0	0	0	**304**
Arising during the year	11	16	302	0	723	**1,052**
Utilised during the year	(60)	(112)	(56)	(125)	(42)	**(395)**
Reversed unused	(5)	(137)	(167)	0	0	**(309)**
Unwinding of discount	1	10	0	0	0	**11**
At 31 March 2020	**413**	**3,290**	**497**	**0**	**1,149**	**5,349**
Expected timing of cash flows:						
- not later than one year;	77	163	497	0	426	**1,163**
- later than one year and not later than five years;	211	632	0	0	0	**843**
- later than five years.	125	2,495	0	0	723	**3,343**
Total	**413**	**3,290**	**497**	**0**	**1,149**	**5,349**

Note a: The discount rate used in the calculation of the Pensions and Personal Injury Benefit provisions was minus 0.50% in 2019/20 compared to positive 0.29% 2018/19

Pensions: Early departure costs

The Pensions provision is based on an estimate of the number of years individual pensions will continue to be paid and is considered a realistic assessment of future pension costs.

Pensions: Injury benefits

The Injury Benefits provision is based on an estimate of the number of years individual pensions will continue to be paid and is considered a realistic assessment of future pension costs.

Legal Claims

Provisions for legal claims includes claims made through NHS Resolution. This includes on-going cases where the date of conclusion and settlement figures are not certain. The total value of the provision made for the Trust through NHS Resolution is £496k for 2019/20 (£96k 2018/19)

Other

Other provisions includes a claim for retrospective reimbursement of premises costs and also £723k in respect of clinician pension taxes. Senior clinicians who face a tax charge in respect of the growth of their NHS benefits above their pension savings annual allowance threshold will be able to have this charge paid for by the NHS Pension Scheme. See Note 1.15.

Also included is a provision in respect of the costs of restoring leased properties to the condition they were in at the date the lease was signed and a claim for retrospective reimbursement of premises costs.

Note 26.2 Clinical negligence liabilities

At March 2020 £148,665k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities for North Cumbria Integrated Care NHS Foundation Trust (2018/2019: £285k)

Note 27 Contingent assets and liabilities

The Trust recognises a contingent liability of £245k at 31 March 2020 (31 March 2019: £43k) relating to employer's liability claims made against the Trust as advised by NHS Resolution, which handles claims on the Trust's behalf. These claims are expected to be resolved within 1 year.

Note 28 Contractual capital commitments

The Trust has capital commitments totalling £14,885k as at 31 March 2020, £14,509k relating to the ongoing redevelopment of West Cumberland Hospital and the remainder for medical and IT equipment. As at 31 March 2019 capital commitments of £297k related to IT equipment and support, to equip two new data centre buildings.

Note 29 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2020	31 March 2019
	£000	£000
not later than 1 year	1,008	1,280
after 1 year and not later than 5 years	465	1,412
Total	**1,473**	2,692

The Trust has revenue commitments for IT equipment and software support for its two data centre buildings, electronic patient record system and Community of Interest Network connections.

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has two PFI schemes, both for the provision of hospital facilities, with one at the Cumberland Infirmary in Carlisle and the other at Workington Community Hospital.

The Cumberland Infirmary scheme was completed in 2000 and the contract runs for 45 years with a break clause after 30 years. At the end of the contract period, or at the break clause, the buildings included in the contract will transfer to the Trust.

The Workington Hospital scheme transferred to the Trust on the 1 April 2013 as a part of the Cumbria Primary Care Trust asset transfer. The agreement is for a 25 year term ending 31 March 2030. The Trust is in an ongoing dispute with its Private Finance Initiative (PFI) provider and has claimed penalties and deductions relating to fire defects and other issues at Workington Hospital. The fire dispute is subject to a legal process which is ongoing but is expected to be concluded during 2020/21.

Payments made to the Health Management (Carlisle) consortium in respect of the Cumberland Infirmary for the period 1 October 2019 to 31 March 2020 were £12.0m. Payments made for Workington Hospital during 2019/20 are not disclosed due to the commercially sensitive nature of the dispute. The recurring annual commitment for both schemes is £25.8m (at March 2020 prices) subject to changes in inflation, performance of provider, availability of asset, and agreed variations to services provided by PFI operator.

Note 30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020	31 March 2019
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**80,912**	8,731
Of which liabilities are due		
- not later than one year;	6,951	794
- later than one year and not later than five years;	33,754	3,175
- later than five years.	40,207	4,762
Finance charges allocated to future periods	(29,851)	(3,407)
Net PFI, LIFT or other service concession arrangement obligation	**51,061**	5,324
- not later than one year;	2,041	298
- later than one year and not later than five years;	17,669	1,498
- later than five years.	31,351	3,528

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020	31 March 2019
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**301,324**	14,534
Of which payments are due:		
- not later than one year;	26,697	1,272
- later than one year and not later than five years;	114,205	5,179
- later than five years.	160,422	8,083

Note 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	**11,541**	(792)
Consisting of:		
- Interest charge	1,523	523
- Repayment of balance sheet obligation	476	273
- Service element and other charges to operating expenditure	6,072	(1,588)
- Capital lifecycle maintenance	850	0
- Contingent rent	1,021	0
- Addition to lifecycle prepayment	1,599	0
Total amount paid to service concession operator	**11,541**	(792)

Note 31 Financial instruments

Note 31.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in contract receivables, as disclosed in note 20.

Liquidity risk

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

Note 31.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	**Total £000**	Carrying values of financial assets as at 31 March 2019	Total £000
Trade and other receivables excluding non financial assets	44,540	Trade and other receivables excluding non financial assets	10,544
Other investments / financial assets	35	Other investments / financial assets	0
Cash and cash equivalents	24,585	Cash and cash equivalents	7,239
Total at 31 March 2020	**69,160**	Total at 31 March 2019	17,783

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	**Total £000**	Carrying values of financial liabilities as at 31 March 2019	Total £000
Loans from the Department of Health and Social Care	301,932	Loans from the Department of Health and Social Care	4,143
Obligations under finance leases	59	Obligations under finance leases	136
Obligations under PFI, LIFT and other service concession contracts	51,061	Obligations under PFI, LIFT and other service concession contracts	5,324
Trade and other payables excluding non financial liabilities	39,070	Trade and other payables excluding non financial liabilities	22,912
Total at 31 March 2020	**392,122**	Total at 31 March 2019	32,515

Note 31.4 Fair value of Financial assets and liabilities

The financial instruments above are shown at carrying (book) value. The PFI finance lease creditors are considered to have fair values that are not the same as their carrying values the value of which is £72,208k.

Note 31.5 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	342,244	24,600
years	4,879	741
years	13,648	3,646
In more than five years	31,351	3,528
Total	**392,122**	32,515

Note 32 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	75	8	0	0
Stores losses and damage to property	3	67	0	0
Total losses	**78**	**75**	0	0
Special payments				
Ex-gratia payments	32	45	9	29
Special severance payments	1	18	0	0
Total special payments	**33**	**63**	9	29
Total losses and special payments	**111**	**138**	9	29

Note 33 Related parties

Dr Howarth, Deputy Chief Executive, is also a director of North Cumbria Primary Care (NCPC) which is a not for profit model for primary care. The Trust has a facilities agreement in place with NCPC and during 2019/20 it injected £400,000 of working capital into the arrangement (2018/19: £1,000). This is repayable to the Trust and is included in the Trust's non-currrent receivables (See Note 20.1).

No other Board Members or members of the key management staff or parties related to them have undertaken any material transactions with North Cumbria Integrated Care NHS Foundation Trust during 2019/20. For the first 6 months of 2019/20 the Cumbria Partnership NHS Foundation Trust, as a part of developing an integrated health and care system, continued working closely with North Cumbria University Hospital NHS Trust until acquiring it on 1 October 2019. The Trust was renamed as North Cumbria Integrated Care NHS Foundation Trust on the same date.

The Department of Health & Social Care is regarded as a related party. During the year North Cumbria Integrated Care has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These include:

Health Education England
NHS England
NHS North Cumbria CCG
NHS Resolution
North Cumbria University Hospitals NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the NHS Pensions Agency, HM Revenue & Customs, the Scottish Office (in respect of Scottish Health Boards) and the local councils.

The Trust was the sole corporate Trustee for the Cumbria Partnership Charitable Fund until it was transferred to Cumbria Community Foundation at 30 September 2019. The North Cumbria University Hospitals NHS Charitable Fund was transferred to the Trust as part of the acquisition process. North Cumbria Integrated Care NHS Foundation Trust is the sole corporate Trustee for the Charity which has been renamed North Cumbria University Hospitals Charitable Fund. In 2019/20 the Trust's Charities spent £154k on medical and education equipment, salaries and training courses from which the Trust benefitted.

Note 34 Transfers by absorption

	North Cumbria University Hospital NHS Trust £000 Incoming	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust £000 Outgoing	Lancashire Care NHS Foundation Trust £000 Outgoing	University Hospital of Morecambe Bay NHS Foundation Trust £000 Outgoing	Total North Cumbria Integrated Care NHS Foundation Trust £000 Net
Non Current Assets	216,135	(19,421)	(8,434)	(2,323)	185,957
Current Assets	57,658	0	0	0	57,658
Current Liabilities	(170,583)	0	0	0	(170,583)
Non Current liabilities	(162,072)	0	0	0	(162,072)
	(58,862)	**(19,421)**	**(8,434)**	**(2,323)**	**(89,040)**

North Cumbria Integrated Care (formerly Cumbria Partnership NHS Foundation Trust) acquired North Cumbria University Hospital on 1 October 2019 and all assets and liabilities transferred as detailed above.

Note 35 Events after the reporting date

a On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 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 loan principal totalling £299,319k as at 31 March 2020 in these financial statements has been classified as current as it will be repayable within 12 months.

b The valuer has declared a 'material valuation uncertainty' in the valuation report on the basis of uncertainties in markets caused by COVID-19. The valuer's report states that *'less certainty - and a higher degree of caution - should be attached to our valuations than would normally be the case'.* This does not mean that the valuation cannot be relied upon and the values in their report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. A 10% change in the valuation of land and buildings would have £18.7m impact on the value of Property, Plant & Equipment held on the Statement of Financial Position. The potential impact on the Statement of Comprehensive Income and Revaluation Report is included at Note 1.24.

c Due to the need for the NHS to focus on responding to the COVID-19 pandemic the 2020/21 contracting and financial planning processes were suspended in March and a COVD-19 financial framework put in place to cover the period to 31 July 2020 in the first instance. This framework ensures that providers receive block payments in advance to reduce the need for invoicing between NHS bodies and to support cashflow. In addition, providers are receiving "top up" income to achieve financial breakeven for this period. At the date these financial statements have been signed the Trust does not have final signed contracts with its commissioners for 2020/21 and it is unclear what the contracting arrangements will be for 2020/21 and beyond.

However, Trusts and other NHS providers have been advised by NHS England & NHS Improvement that they can continue to expect NHS funding to flow at similar levels to that previously provided where services are still expected to be commissioned. DHSC has also confirmed that temporary revenue support arrangements will continue in order to support providers who are demonstrating cash needs.

Taking these factors into account therefore, and in accordance with the GAM 2019/20 and the Treasury FReM, the Trust’s directors are satisfied that the accounts have been prepared appropriately on a going concern basis.