#PROUD OF THE PAGET

NHS
James Paget University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2020/21

James Paget University Hospitals NHS Foundation Trust

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

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A challenging year: The Chair's Report

Anna Davidson
Chair of the Trust

It has been a year like no other.

The global pandemic presented the NHS with an unprecedented challenge, affecting our staff on both a professional and personal level, while bringing an urgency to adapt and innovate at pace.

Our hospital was reconfigured so that it could provide the care needed by patients with COVID-19 and, as a result, there were inevitably changes to the way in which we provided services, particularly during the local peaks of the pandemic. I would like to give the Board's heartfelt thanks to all our staff for their commitment and passion in delivering safe and effective care, whatever the circumstances. We recognise that staff have been affected in many different ways and the impact will be felt for some time to come.

As Trust Chair, I was keenly aware of my responsibility to ensure that the Board of Directors could continue its crucial work of guiding the operational running of the hospital. We were also required to seek sufficient assurance on the new ways of working that the pandemic necessitated through scrutiny and challenge, with the support of our Council of Governors as the representatives of our community.

While our meetings could no longer take place on site, technology meant that governance and assurance could continue remotely – and we could also hear from our patients, including those who had been treated for COVID-19, which sadly claimed so many lives in our community.

Inevitably, the pandemic meant we could not always provide the levels of service that we would normally want for our patients. Urgent and emergency care continued throughout the year and our focus was on minimising clinical harm for those patients who were waiting for operations. We know how distressing and frustrating it is for people to have their treatment delayed. Our priority in the months ahead will be to fully restore our services and maximise the number of patients having their procedures to reduce the backlog.

But there have been some positives to emerge over the last year. New ways of working, introduced at speed, have made their mark. For example, Attend Anywhere is now very much business as usual, using video technology to link our patients with their consultants so they can have their appointment in the comfort of their own home, with no need to travel to the hospital.

As well as adapting to the demands of COVID-19, the Trust has continued to develop its estate for the benefit of both patients and staff. The most obvious example is right at the front of the building, where our new expanded Emergency Department has been constructed, offering modern, spacious accommodation to replace a unit which was ageing, cramped and no longer suitable.

This commitment to continuous improvement and innovation, even in the most challenging of circumstances, is very much a hallmark of our Trust: it has stood us in good stead over the last 12 months and will continue to do so as we develop our services in the future.

Performance Report

Supporting our staff to care for patients

The importance of strong teamwork and effective partnerships has been absolutely crucial in this most challenging of years when sadly some of the patients we were caring for lost their lives after testing positive for COVID-19. My condolences and my thoughts are with everyone who has been affected.

Anna Hills
Chief Executive

At a national level, all Trusts worked closely with NHS England and NHS Improvement, Public Health England and other organisations to ensure that the latest guidance was followed consistently, whether relating to infection control measures, deployment of personal protective equipment, or visiting restrictions.

More locally, our Trust was in constant contact with our system partners in Norfolk and Waveney so that we could support each other operationally in managing the peaks in demand created by the pandemic.

Our staff once again demonstrated the excellent teamwork, which has secured us consecutive 'Good' ratings from the Care Quality Commission in previous years, to maintain patient care often in the most testing of circumstances. Inevitably, difficult decisions had to be made as we grappled with increasing infection rates in the community which quickly translated into rising numbers of COVID-19 patients in the hospital.

While cancer and urgent surgery continued, elective operations had to be cancelled and visiting was severely curtailed – decisions which were essential but nevertheless concerned us all as healthcare professionals who put patient care at the heart of all we do. The pandemic changed how we delivered care. This has impacted on our performance during the year, though improvements are being seen towards the end of 2020/21. Fortunately reducing infection rates in the community meant we could prepare to re-start our elective programme using additional theatre and diagnostic capacity created during the year. This will help us treat patients more efficiently, as well as gradually relaxing our visiting restrictions.

But the Trust's leadership hasn't just been focused on patients. We have been fully aware of the constant demands placed on our staff, who we have asked time and again to step up to the mark. The support of our local community during the pandemic has made a real difference, and we were overwhelmed with the generous donations made by so many individuals, groups and organisations which gave our staff such a boost.

Clear communication from the top of the organisation has been crucial, not only so that staff are aware of the latest operational guidance but also that they know where to go if they need support for their own health and wellbeing.

As we enter the new financial year, we are committed to using our experiences over the last 12 months not only to improve the way we work for the benefit of our patients but also as a springboard to engage with our staff so that together we can develop our organisation as a great place to work.

Our purpose

This section provides a summary of what we set out to do in the last year prior to the pandemic, what we have achieved despite the challenges, and the work we still want to do.

The James Paget Hospital was built in 1981 and officially opened on 21 July 1982. In the coming year we will celebrate what we have achieved in those 40 years, as we start our planning for a new hospital in the longer term.

We were the first Foundation Trust in Norfolk and Suffolk, authorised on 1 August 2006. We are governed by a Board of Directors and the Council of Governors. Our activities are overseen by NHS England/NHS Improvement (NHSE/I) and by legislation. Our quality of care is assessed by the Care Quality Commission (CQC).

Like all NHS Foundation Trusts, there are three components:

- The Membership community - open to anyone over 16 who has either been a patient or carer at our hospital, is a member of staff, or who lives in our defined catchment area. We have just under 11,000 public and staff members
- Council of Governors - 20 Governors including the Chair of the Board of Directors who also chairs the Council. Elected public and staff Governors form the full Council with representatives of NHS partner and local authority organisations
- Board of Directors - Non Executive and Executive Directors, including two non voting members and the Trust Secretary.

Our vision is to be outstanding in everything that we do, supported by the values and behaviours that we expect from every single member of our team.

We provide a full range of district general hospital services for the people of Great Yarmouth, Lowestoft and the surrounding areas. This includes the many visitors to this holiday destination. We support a population of just over 250,000 local residents, from Martham in the North, to Southwold in the South. The geography spans two counties – Great Yarmouth and Gorleston in Norfolk, and Lowestoft and South Waveney in Suffolk.

The population in Norfolk and Waveney is generally older than the rest of England, with growth anticipated in the longer term of over 11%.

Great Yarmouth and Waveney faces particular challenges with Great Yarmouth having the lowest life expectancy for men and women. The Joint Strategic Needs Assessments for Norfolk and Suffolk review the current health of the population and are used to underpin our future priorities.

The COVID-19 pandemic

The pandemic meant changes in the way that we worked over the entire year.

In mid-March 2020, the Prime Minister announced this was now global, the likes of which we have never seen. Plans already agreed were set to one side as we focussed on managing the impact on our patients and our staff, using existing emergency planning processes, enhanced by national requirements.

We asked our staff to work differently, responding to national guidance on a daily basis, whilst continuing to support one another.

Staff safety and support for their health and wellbeing was a priority.

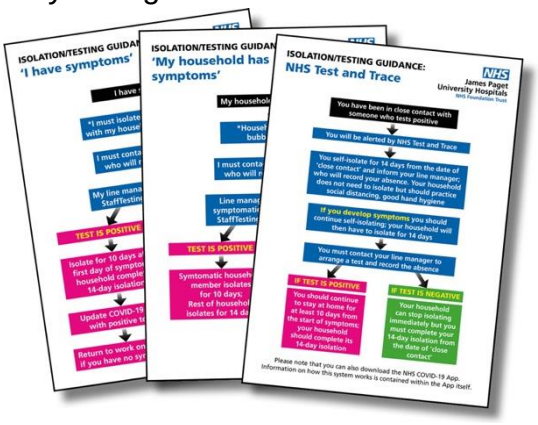
By 1 April 2020 and the new financial year, anxieties were continuing to increase, with many worried about passing the virus on to their families. We risk assessed our staff and those at higher risk were moved into other areas of work. This process of reviewing where members of staff worked continued throughout the year. Some were required to shield, and many were working at home if they were able to in response to the Government's requirements.

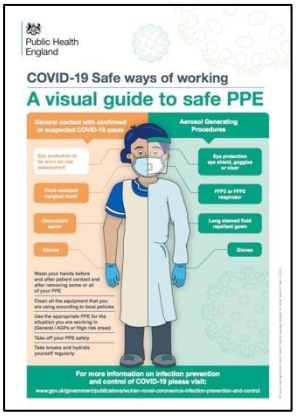
Daily staff messages provided updates on what was happening – with the frequency changing depending on the challenges being faced. A significant amount of information was published almost daily, and refining this into easily understood messages was critical.

We put a process in place to make sure that appropriate levels of Personal Protective Equipment (PPE) were available, with training and face fit testing, which continues into 2021/22.

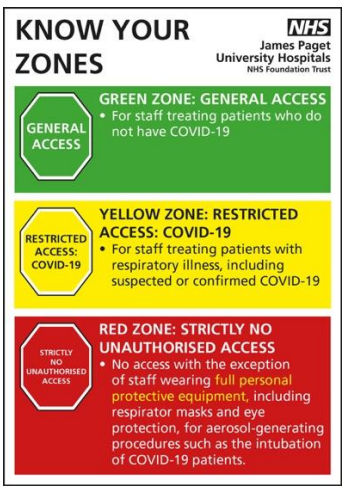
Our updates throughout the year included:

- The symptoms to watch out for, adding to this as they changed
- When you need to self-isolate and what to do if someone you lived with tested positive for the virus
- The move from face to face to virtual meetings and the roll out of MS Teams
- How to use PPE – posters and written information, films on 'donning and doffing', and the introduction of PPE Champions to support our staff and answer their questions



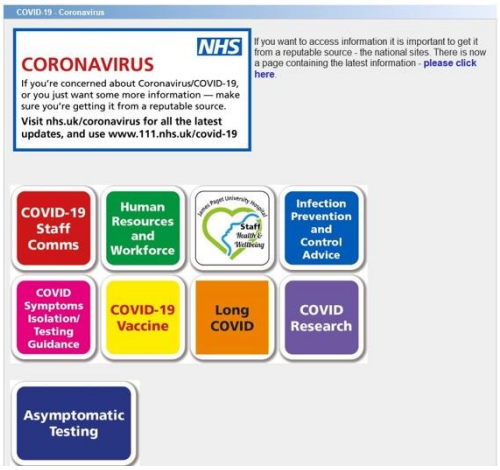


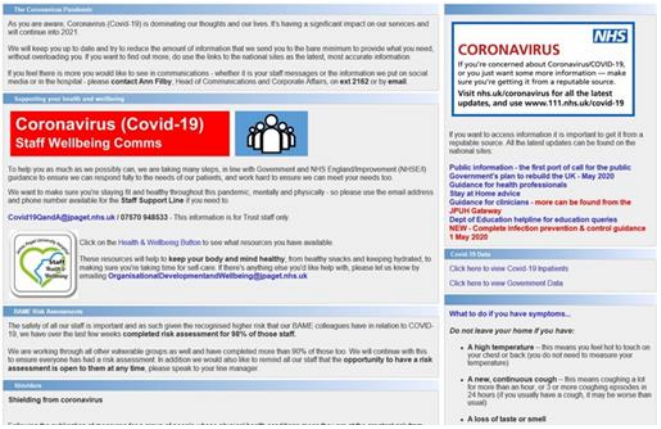
- Why social distancing was so important, with signage throughout the hospital and one way systems



- Developing our estate to ensure new changing facilities and showers, utilising spare or little used accommodation to provide rest areas, with small treats for staff when they were able to get a break
- Supporting those staff that were able to work at home, particularly important for those that were parents as schools closed for periods during the year

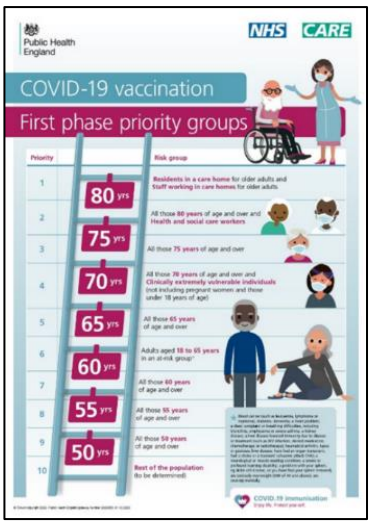
- Easy to access links to national information, our own data/dashboards and training guides – keeping our intranet up to date





- Implementing a 'newsletter to home' for all those shielding, working at home or on sick leave. The hospital changed quickly and we had received feedback that staff were concerned about returning – the newsletter was well received and was sent fortnightly for most of the year

- Setting up a staff foodbank for those in need – encouraging donations from those able to give them and regular reminders that full bags of groceries and toiletries could be picked up, no questions asked, and no forms to fill in – this remains in place
- Rolling out lateral flow testing from November 2020, initially for patient facing staff, then Trust-wide later in the year
- The success of our COVID-19 vaccination programme – giving vaccinations as a hospital hub the day after the first person in the world received the Pfizer vaccination – focussed throughout on the priority groups confirmed by the JCVI – the Joint Committee on Vaccination and Immunisation.



For our patients, elective surgery was cancelled very early in the pandemic to make sure that we had the capacity we needed to treat those patients with the virus.

Our external messages as we moved into early May focussed on encouraging patients to come forward if they required treatment – NHS Open for Business – with a series of films containing important messages from our clinical staff.

With the other hospitals in Norfolk and Waveney we sought to reassure the public and to restart some operations from late April. Recovery was slower than we would have liked as we zoned the hospital to create separate areas for those with coronavirus symptoms and those who had none.

The number of operations continued to increase until late autumn, when capacity again became challenged as we started to see significant increases in the number of cases in the second wave.

On 4 January 2021 a second national lockdown was announced, with a move to the highest COVID alert level, 5, which reflected a material risk of healthcare services being overwhelmed. The Government's message to the public was Stay Home – Protect the NHS – Save Lives.

As the situation eased towards the end of the financial year, the number of operations started to increase and this continues into 2021/22. More detail can be found on page 22, How we have performed.

Our objectives

Each year the Board of Directors sets objectives for the next 12 months to ensure we focus on what we want to achieve for patients.

Once objectives have been agreed, we oversee progress through the Board Assurance Framework (BAF). This is considered at each Board of Directors' meeting with Board Committees reviewing those elements specific to their responsibilities. The BAF is developed by identifying the key risks to achievement of the objectives and the mitigation and assurance required – the action to be taken – to monitor progress.

In March 2020, the Board considered the objectives for the coming year. Whilst these were approved, the milestones and timeframes presented at that time were not agreed due to the pandemic. The position was reviewed in July 2020 when recovery options were clearer. Revised objectives were approved, with the first BAF presented to the Board in September.

This is what we planned to achieve and our assessment at the end of the year. Green indicates fully achieved, amber is partial achievement and red is not achieved.

AMBITION 1 – Deliver the best possible level of safe and effective care

- **Provide safe, effective and patient centred care in the right place at the right time.**
- **Continuously strive to improve the care we provide by learning from best practice, research, making use of patient feedback and**
- **learning from incidents.**
- **Prioritising improvements, setting goals and measuring progress while focusing on key indicators of harm.**
- **Use data effectively to drive continuous quality improvement through a consistent improvement methodology.**

1.1 Deliver the Trust's 12 Quality Priorities across the three national domains for patient safety, clinical effectiveness and patient experience

	How will we know we are delivering?	March 2021 update	
1.1a	Approval of 12 Quality Priorities	Achieved and presented to Board in July 2020	**G**
1.1b	Quarterly reporting to Board from Patient Safety and Quality Committee on progress	Of the 12 quality priorities, 5 achieved, six partially achieved and one not achieved	**A**

1.2 Improve the experience and timeliness for patients with cancer

	How will we know we are delivering?	March 2021 update	
1.2a	Report JPUH performance against national cancer standards to Board monthly, with clear actions for improvement as required	Monthly reporting in place. Patients waiting over 104 days increased in last quarter following second wave of COVID and reduction in operating capacity at tertiary centre. Local improvement actions in place to reduce diagnostic/pathway delays	**A**
1.2b	Quarterly reporting to Board against objectives of JPUH STP Cancer Implementation Plan	Quarterly reporting and monitoring process in place, addressing areas of escalation. Reporting methodology being improved. Chemotherapy closer to home initiative via 'Hope for Tomorrow' bus launched	**G**

1.3 Produce a new JPUH Clinical Strategy to ensure we provide the best services possible in a sustainable way; and it is aligned to the developing Norfolk & Waveney Clinical Strategy

	How will we know we are delivering?	March 2021 update	
1.3a	Complete high level speciality development plans across all specialities by end October 2020 to inform development of Trust Clinical Strategy	Specialty Development Plans approved by Hospital Management Board November 2020. Specialties identified by Divisions as having most impact on New Hospital Programme contributing to Trust Clinical Strategy	G
1.3b	Complete and agree a 2 year JPUH Clinical Strategy by end November 2020 that links to the emerging Norfolk & Waveney Clinical Strategy (see 4.1a)	Remains a priority but timescale extended to ensure it contributes to both emerging Norfolk & Waveney Clinical Strategy and timeline requirements of Strategic Outline Case for new hospital	A

1.4 Restore and transform our services following the COVID-19 pandemic. To ensure processes are efficient, effective and provide value for money, whilst maximising the use of technology for the benefit of all our patients and their families

	How will we know we are delivering?	March 2021 update	
1.4a	Reduce the number of face to face follow up appointments using appropriate technology e.g. telephone/ video conferencing including the Attend Anywhere platform. The trajectory to be agreed by Board, September 2020	Trajectory of improvement agreed by Board with performance monitored. Second COVID wave impacted on performance and revised trajectory for 2021/22 in line with new operating guidance being developed	G
1.4b	Reduce the number of patients waiting for a follow up appointment past their target date. The trajectory to be agreed by Board, September 2020	Trajectory for improvement not agreed. Exploring use of Independent Sector Providers	R
1.4c	Develop plans to transform theatres, outpatients, and diagnostics, and deliver the SAFER patient flow bundle by December 2020	Improvement plans in place, achievement significantly impacted by second wave of COVID. All will be reviewed for 2021/22 in line with new operating guidance	A

AMBITION 2 - Provide education, support and development for our staff to deliver excellence in practice and be employer of choice

2.1 To be a high performing organisation where staff feel valued and respected

	How will we know we are delivering?	March 2021 update	
2.1a	A People and Culture Strategy to be signed off by Board	Complete – Strategy signed off September 2020	G
2.1b	Deliver the targets in the People & Culture Strategy including:		
	- Achieve and maintain 90% compliance rate for mandatory training in 2020/21	Approximately 86% but further validation work being completed to provide assurance in case of under reporting	R
	- Achieve 90% compliance rate for staff appraisals in 2020/21	Corporate Heads of Department asked to significantly improve compliance. Review of appraisal system scheduled and pilots for group appraisals/reducing number of direct reports to be developed	R
	- Reduce underlying sickness absence from 4.7% to 4.0% by March 2021 for non-COVID-19 related absence	End of March 2021 underlying position 3%. Reduction in overall long term sickness in Quarter 4	G
	- £350K reduction in agency spend in year 2020/21	Improved sickness absence making positive contribution to agency spend; reduction achieved	G
	Quarterly reporting on progress to Board from the People and Culture Committee with exception reporting in the interim	In place	G

2.2 Provide a high performing recruitment service to fill vacancies quickly and minimise vacancies

	How will we know we are delivering?	March 2021 update	
2.2a	Agree a marketing and retention plan to increase retention. To be monitored by People and Culture Committee with an outcome to increase retention of Band 5 and 6 nursing workforce by 40%	Plan agreed; monitored by Board's People and Culture Committee bi-monthly. Band 5 nurse retention improved by 17% compared to 2019/20; Band 6 nurse by 58%. On track overall and work continues to improve range of options available for staff to encourage them to remain longer	**G**
2.2b	Work in collaboration with the local health system partners to reduce reliance on agency staff by a minimum of £30k per month and introduce monthly reporting to Board from July 2020	The JUST-R campaign launched; retention plan developed and approved December. Leavers remained relatively stable partly due to pandemic. Digital Workforce team leading system-wide projects on bank/agency staffing; target reduction of £30K per month achieved and in some cases exceeded	**G**
2.2c	Reducing 'time-to-hire' in line with East of England streamlining best practice	Overall objective met with more to do to further improve. Part of successful STP bid for NHSE/I funds to support streamlining work. Overall reduction in agency costs year to date but some longer standing medical agency costs under review. Time-to-hire data shows gradual improvements in Quarter 4	**G**
2.2d	Implement a staff feedback mechanism for newly recruited staff to inform improvements to the induction programme. Feedback will be sought after induction, and 6 months later. To be approved by the People and Culture Committee, November 2020	Revised induction programme re-launched December 2020 covering 2 days with more content in day 1 focussed on values and behaviours. Managers' induction launched. Both include mix of direct/virtual content and will be reviewed at end of each session to provide continuous feedback and improvement	**G**

2.3 To be in the best performing third of hospitals in the country for our staff survey results

	How will we know we are delivering?	March 2021 update	
2.3a	Raising our staff engagement score from 6.96 to above 7.0 by March 2021 as measured annually and monitored by People and Culture Committee	New starter feedback process including 'Day 1 to 6 month and 1 year catch' up. Engagement score improved slightly from 2019 to 7.0. Full action plan to be developed following April 2021 listening events	**G**
2.3b	Deliver an additional pulse survey mid-year – September 2020	Pulse survey September/Quarter 4 paused with Paget's People conversation feeding into this and themes/a programme of activity agreed November 2020. Paget's People and further pulse surveys to be carried out 2021/22 as part of Operation Reset	**A**
2.3c	Improve scores for staff feeling valued at work from 69% to above 72% by March 2021	No change. Actions to improve performance part of Operation Reset, to be presented to Board in May 2021	**A**
2.3d	Human Resources/Organisational Development function to review good practice from top performing organisations and bring learning to the Trust by end of Quarter 4 2020/21	Achieved, with changes to recruitment process being implemented, improvements in digital workforce and reducing sickness absence.	**G**

2.4 Improve the health and wellbeing of our staff through a comprehensive programme to support physical and mental wellbeing

	How will we know we are delivering?	March 2021 update	
2.4a	Integrate Trust wellbeing staff engagement initiatives into overarching plan to provide staff with access to seamless, structured and specialist support by November 2020. To be monitored by the People and Culture Committee.	Achieved via new staff engagement and wellbeing plan.	**G**

2.5 To ensure our leadership is compassionate and focused on managing all aspects of our performance

	How will we know we are delivering?	March 2021 update	
2.5a	Implement a talent management approach to identify and encourage/support those staff with leadership potential for the future by Q4 2020/21 with quarterly reporting to Board on progress	Deputy Director of People & Culture and Head of OD continue to develop revised process based on best practice, for delivery June 2021 following implementation of revised leadership and management development programme in Q4	**A**
2.5b	Enhance our leadership and management programmes to create improved development opportunities for our staff and promote our compassionate leadership initiatives. Plan for implementation to be agreed by the People & Culture Committee in September/October, dependent on meeting cycle of Committee. Implementation from November 2020	Head of OD led review of all current leadership and development programmes presented February 2021. Funding was previously under review and now agreed	**G**

2.6 Improve staff engagement to support the delivery of patient centred services through a well-informed and empowered workforce

	How will we know we are delivering?	March 2021 update	
2.6a	Commence roll out of new initiatives based on staff feedback from July 2020, monitored by People & Culture Committee with exception reporting to Board	2.6(a) and (b) achieved. Initiatives published in one location on staff intranet proactively managed by Staff Engagement and Well-Being Manager	**G**
2.6b	Review and amend the support and tools available to staff and managers to reflect this - July 2020	See above	**G**

2.7 Provide greater opportunities for our staff though training and education to support the improved delivery of care

	How will we know we are delivering?	March 2021 update	
2.7a	Develop a plan to evolve the Education & Training Centre into a Centre of Excellence in collaboration with NNUH and QEH, including a 5 year plan to enhance the Trust's education and research provision by Q4 2020/21	Not progressed further due to second wave of pandemic. Revised objective agreed for 2021/22 and revised Education Strategy to be considered June 2021 including changes to structure and plans to develop a Centre of Excellence	**R**
2.7b	In line with long term workforce plans, develop new clinical roles e.g. Physician Associates, aligned with education and training commissions by December 2020	Broadly on track, with slight slippage on timescale for delivery. Long term workforce planning built into workforce work stream within the New Hospital Programme Board	**G**

2.8 Build and develop our approach to equality, diversity and inclusion in all we do

	How will we know we are delivering?	March 2021 update	
2.8a	Establish an inclusion task group and plan by 30 September 2020 with progress monitored twice per year by the People and Culture Committee	Inclusion Group established, regular reporting in place and outline programme of work agreed, with positive engagement and networking events planned from February 2021	**G**
2.8b	Support staff through the development of networks linking into national networks where appropriate, such as the national Black, Asian and Ethnic Minorities (BAEM) network, by 31 October 2020	Achieved. See above	**G**

	How will we know we are delivering?	March 2021 update	
2.8c	Improving our equality, diversity and inclusion score from 8.98 to 9.30 by March 2021	Slight reduction from 9.0 to 8.8; a number of diversity issues raised and Inclusion Network developing plans to address. Chief Executive now Executive Lead for EDI/lead NED identified	R
2.8d	Provide opportunities for all Board members to participate in reverse mentoring to learn from the experiences of different staff groups by September 2020	Achieved. Programme of reverse mentoring established and second round launched March 2021	G

2.9 Get the best from our staff through innovation and flexible working arrangements

	How will we know we are delivering?	March 2021 update	
2.9a	Establish new ways of working, as a result of learning from the pandemic, including increased flexibility and remote/ online working by August 2020	Achieved, supported by revised homeworking policy. IMT/SMT engagement and approval at pace were key enablers	G
2.9b	Collaborate with the local healthcare system to align new working practices, workforce policies/procedures and employment models for service re-configuration – collaboration proposal drafted June 2020 (linked with Ambition 4 - Objectives 4.1 - 4.3)	Good progress achieved on single policy for mandatory training as a pilot, and scope widened to all workforce policies with a programme being developed to review each in turn	G

2.10 In support of the increased acute collaboration, appoint a Group People and Culture Director across the three hospitals to lead on workforce change, new employment models and alignment of employment practices

	How will we know we are delivering?	March 2021 update	
2.10a	Appoint a Group People and Culture Director by October 2020	Paused pending further discussion with NNUH/ QEH. No further progress in Q4. To be addressed in emerging Acute Provider Collaborative	N/A
	How will we know we are delivering?	March 2021 update	
2.10b	Commence development of an integrated workforce function across the three Trusts leading on the alignment of policies, working practices, economies of scale and building on current expertise by November 2020	As 2.9(b)	G

AMBITION 3 - Effectively manage our financial resources, our estate and our infrastructure to ensure we are sustainable

- **Deliver strong financial management, ensuring we meet our financial plan.**
- **Demonstrate sound asset management principles in respect of our sites and buildings.**
- **Develop and utilise our information management and technology systems to underpin and enable all our strategic ambitions.**

3.1 Ensure financial sustainability of the Trust through delivery of our financial plan 2020/21

	How will we know we are delivering?	March 2021 update	
3.1a	Control costs to ensure the Trust achieves break-even performance under block contracts	Achieved, reporting £2.7m surplus and £3.3m favourable variance against plan on a Control Total basis	G
3.1b	Control capital expenditure to remain within agreed Capital Departmental Expenditure Limit (CDEL) allocation	Achieved, reporting delivery on plan against agreed CDEL expenditure. Actual non-PDC funded CDEL £8.5m, comprising original plan £6.0m, additional system CDEL £2.3m, and supplementary system CDEL agreed £0.2m	G

3.2 Complete the Estates Projects as prioritised by the Trust to underpin the restoration and recovery of operational services

	How will we know we are delivering?	March 2021 update	
3.2a	Agree and commence delivery of the key estates schemes - 30 June 2020 (Phase 3 National funding awaited) and report progress to Board quarterly	New Estates Programme Delivery Group formed September 2020 to monitor and track progress. Updates reported to Hospital Management Board (HMB), Strategic Projects Committee and Board	G

3.3 Agree and progress plans for a 'new build' hospital, working with the other two hospital trusts and key partners to ensure the provision meets the needs of the local population

	How will we know we are delivering?	March 2021 update	
3.3a	Finalise the Strategic Outline Case (SOC) for a new hospital, as part of the National HIP2 process that incorporates a system approach to meeting the future clinical demand for services – 31 March 2021	New Hospital Programme Board inaugural meeting October 2020, Board Strategic Projects Committee from January. Recruitment progressed with most key posts filled/ good progress made. Revised timeline to deliver draft SOC 2021/22	A

3.4 Deliver effective patient services through maximising digital opportunities supporting the delivery of the Norfolk and Waveney digital plan

	How will we know we are delivering?	March 2021 update	
3.4a	Delivery of the Trust's Digital Strategy objectives relevant for 2020/2021 which include single sign-on, by end Q4. Monitored by the Finance & Performance Committee with quarterly updates for Board.	e-TR (Order Comms) and Single Sign-On moving into preparations for piloting. E-Obs in development. A range of priorities supported through Digital Aspirant fund; IT support during pandemic including development of WardBoard service, rollout of laptops for remote working and Virtual clinic system (Attend Anywhere)	A
3.4b	With partners, complete a full business case for Electronic Patient Record by end of Q4	Programme delayed due to Strategic Outline Case and Outline Business Case both being updated following regulator advice. Outline Case returning to Boards in early 2021/22	R

AMBITION 4 - Actively participate in innovation, research and partnerships to transform our services

- **Explore and lead the development of efficient and effective models of care with our partners**
- **Work with our Acute partners to jointly redesign pathways to align capacity with demand**
- **Take an active role in developing new models of care with our health and social care partners to ensure our services are as effective and efficient as possible.**

4.1 Improve the sustainability of services, reduce unwarranted variation and health inequalities by working with partners in the delivery of the Norfolk & Waveney Hospital Services Strategy

	How will we know we are delivering?	March 2021 update	
4.1(a)	Develop and agree a high level Norfolk & Waveney Clinical Strategy, setting out the core principles for the delivery of clinical services by January 2021	Revised timeline for development of outline strategy June 2021 covering acute, primary, mental health and community. Delivery through ICS Strategic Planning & Transformation Group and Clinical & Care Transformation Group. JPUH a key partner	R
4.1(b)	Agree a programme of specialities, developed jointly across the three Acute Trusts by end of July 2020 and produce/agree a fully resourced rollout plan by September 2020 with the first of the newly designed services in place by April 2021 (monitored by the Acute Collaboration Programme Board)	Clear focus on producing Norfolk & Waveney Clinical Strategy taking precedence over Acute Services Strategy. JPUH Clinical Strategy to be developed in parallel to ensure alignment. Work continues to transform ENT/Urology into 2021; integration of Haematology & Oncology restarting following pause due to pandemic. Hospital Services Strategy programme now reporting to Norfolk and Waveney Hospitals Group (Committees in Common)	R

	How will we know we are delivering?	March 2021 update	
4.1(c)	Agree a programme of work to standardise clinical protocols and policies across the three Trusts. Out of three policies chosen to commence integration - one to be complete by October 2020 and two to be complete by January 2021 (monitored by the Acute Collaboration Programme Board)	Review and alignment of policies part of Hospital Services Strategy for three acute trusts; pandemic impacted timescales for roll out, revised as follows: • Completion of draft aligned Consent Policy by end April 2021 • Policy Development Processes – ratification required once work restarts • Thromboprophylaxis – initial meeting January 2021; gap analysis first piece of work underway Update on positive progress of a single mandatory training policy included in 2.9(b), now widened to all workforce policies	**G**

4.2 Bring about increased acute collaboration through the Norfolk and Waveney Hospital Group

	How will we know we are delivering?	March 2021 update	
4.2(a)	With the other two acute Trusts establish the 'Norfolk & Waveney Hospital Group' and agree supporting delivery plan in September 2020	Norfolk and Waveney Hospitals Group progressing to become Acute Provider Collaborative within Norfolk and Waveney ICS. Work continues to agree an operating model for the three acute trusts	**G**
4.2(b)	Deliver the agreed work programme for the Norfolk & Waveney Hospital Group with update reports to the Trust Board after each meeting	Progress from Norfolk & Waveney Hospitals Group formally reported to Board after each meeting, with consistent reporting across all three Trusts	**G**

4.3 With health and social care partners, agree and commence the transition to become an Integrated Care System by Autumn 2020

	How will we know we are delivering?	March 2021 update	
4.3(a)	Agree and commence delivery, with Health and Social Care partners, the agreed plan to become an Integrated Care System (ICS). Plan agreed by August 2020 (TBC)	Norfolk and Waveney now an ICS 1 April 2021 with plans for full implementation 1 April 2022 and governance structures aligned accordingly	**G**
.3(b)	Fully participate in development of 'place based' delivery to support the emerging ICS by Autumn 2020	Fully engaged with local partners and Place-based model proposed to be rolled out across ICS as a key part of development plan. Progress will continue in Q1 2021/22 whilst awaiting outcome of potential boundary changes linked to White Paper on integration and innovation	**G**

4.4 Develop opportunities to maximise research opportunities

	How will we know we are delivering?	March 2021 update	
4.4a	Deliver the objectives set out in the Research Strategy	Progress reported to Board November via Patient Safety & Quality Committee. Commercial research opportunities reduced due to pandemic. Updated strategy to Committee May 2021 to include new Clinical Research Network key performance indicators	**A**
4.4b	Secure appropriate opportunities to contribute to COVID related research, and to bid for and deliver at least one successful bid including from the National Institute for Health Research funding streams etc.	Achieved	**G**

The new year's objectives were confirmed slightly later this year to take account of the planning guidance published in March 2021. They have been approved by the Board:

Principal risks

The Board considers the Trust's significant risks at each of its meetings. At year end, there remained two extreme risks on the risk register:

- Patients, Visitors and Staff may be harmed by failing Reinforced Aerated Autoclaved Concrete (RAAC) roof panels
    - Oversight of risk by Patient Safety and Quality Committee, with reporting direct to the Board on a monthly basis since July 2020

- Risk of harm to patients on the Referral to Treatment (RTT) waiting list
    - Oversight of risk by Patient Safety and Quality Committee, with direct reporting on the elective backlog and harm review process to the Board from May to October 2020, reporting returning to Committee from November 2020. Updates contained within the Quality and Safety Report to Board. Detailed discussion on performance takes place at the Board's Finance & Performance Committee, with the Operational Performance Report presented to each meeting of the Board.

The Annual Governance Statement, within the financial statements, provides more detail on the risk mitigation.

How we have performed

Our strategic ambitions underpin everything that we do, enable us to achieve our vision and to provide the right care for our patients.

During the pandemic working together in Norfolk and Waveney has been essential to ensure we provide the best we can for staff and patients in challenging circumstances. It was inevitable that performance would worsen, with urgent and emergency work continuing, whilst national requirements for elective surgery to be paused early in the year resulted in increased Referral to Treatment (RTT) times for patients. Once the worst of the first wave receded, planning for the recovery of services began in earnest across the health and care partnership, with some patients waiting over 52 weeks for treatment, a rare occurrence prior to the start of the year.

The Board has focussed on mitigating clinical harm with direct reports on how patients were being assessed as they waited much longer than we would like. Clinicians and operational managers have been leading this assessment of those waiting as services recovered, in line with regulatory requirements. This is led by the Medical Director and Assistant Medical Directors and ongoing assurance is provided to the Board by its Patient Safety and Quality Committee.

As part of the recovery planning, work is continuing on a single patient treatment/waiting list across the three acute trusts. The aim is to make sure that those in most need across all three hospitals are treated first to ensure that inequalities are reduced. This work is continuing in 2021/22, to be overseen by the Committees in Common.

Performance continued to be monitored through the Board of Directors'. Metrics cover national, contractual, quality and performance standards with local performance measures that the Board has agreed to monitor. The report presented is detailed. It includes the dashboard of metrics, together with a summary on each one that is not being achieved including trends, benchmarking information, action taken and the action planned to recover performance.

As a result of the pandemic there have been significant and sustained changes to the delivery of acute hospital care. The year-end performance report identified notable improvement in a number of performance metrics as the impact of the pandemic reduced:

- Positive changes in the Urgent and Emergency Care standards. The work with system partners and changes in capacity led to a slight increase in the number of patients which demonstrates that further work is required to ensure sustained improvement

- Building works continue in the Emergency Department focussed on support areas and the main patient waiting area. Staff are continuing to adjust and manage the disruption alongside the changes to culture, processes and pathways being implemented. Improvements in performance despite all these challenges is highly commendable
- Cancer standards performance targets remain challenging with referrals increasing, diagnostic delays and treatment and capacity constraints at the tertiary centre. Tangible actions are in place to increase elective capacity which will have a positive impact on further delays.
- Elective care standards - routine elective work has gradually returned, initially with day cases then inpatients as ring fenced green capacity was made available. Outpatients has returned to previously planned levels. Patients waiting over 40 weeks continue to reduce partly due to dermatology activity but also due to the impact of reduced referrals in March to June 2020 becoming evident. Those over 52 weeks continue to increase in a number of specialities and actions have been identified.

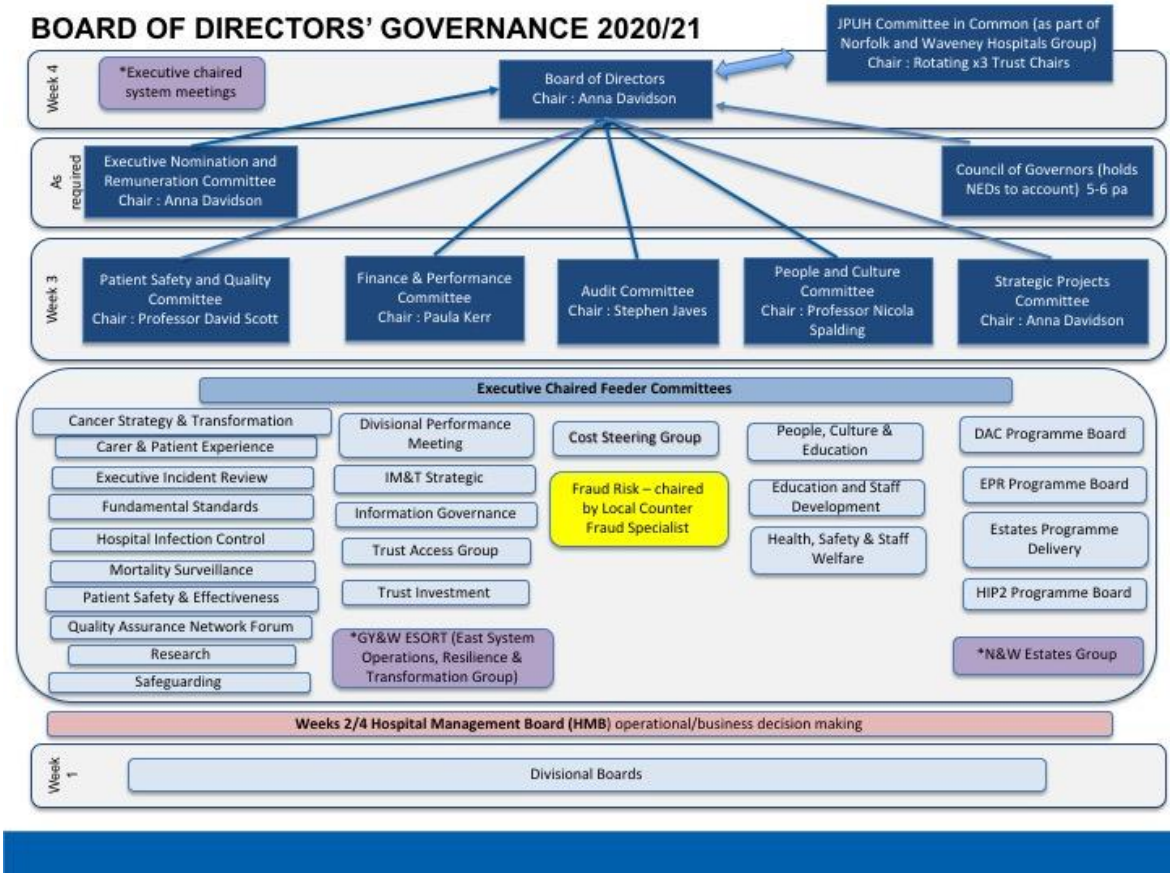
A three year activity trend shows that previous increases in demand in A&E have continued:

Activity	2017/18	2018/19	2019/20
Elective Inpatients	4,022	4,048	3,287
Day Cases	31,342	32,562	31,539
Non-Elective	27,525	29,476	29,522
Outpatients	204,515	220,014	210,712
A&E (Emergency Department)	77,678	80,866	81,728

The final position against the key performance indicators (KPIs) we measure is set out below:

	Indicator		Threshold 2020/21	JPUH 2020/21
1	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway		92%	58.14%
			18,389 patients	14,824 patients
2	A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge		95%	83.19%
3	Cancer urgent referral to first outpatient appointment		93%	96.83%
4	Breast symptoms urgent referral to first outpatient appointment		93%	98.72%
5	All cancers: 62 day wait for first treatment from:	urgent GP referral for suspected cancer	85%	71.05%
		NHS Cancer Screening Service referral	90%	87.35%
6	All cancers: 31 day wait for second or subsequent treatment, comprising:	Surgery	94%	100%
		Anti-cancer drug treatments	98%	100%
		Radiotherapy	94%	N/A
7	All cancers: 31-day wait from diagnosis to first treatment		96%	99.16%

Performance is assessed through our Committee structure, as set out below:



The Board's Finance and Performance Committee considers the finance and operational performance reports in detail at each of its meetings. In-year the Safety and Quality Governance Committee became the Patient Safety and Quality Committee, considering all quality-related and patient safety issues. The Workforce, Education and Research Committee does the same for workforce related reports – now renamed the People and Culture Committee.

All reports are presented to the Board each month and are available on the Trust's website.

Details of the Audit Committee can be found on page 39 and the Executive Nomination and Remuneration Committee on page 58.

As part of the annual review of how the Board and its Committees operate, reporting to the Board in September 2020, Committees moved into week three from January 2021 to enable more effective reporting. This also enables changes to be made to the BAF following Committee meetings and prior to presentation to the Board. More work is planned during 2021/22.

Our strategic thinking

It has been more difficult this year to give sufficient time to thinking about the strategic direction and what is needed for patients. However, the three acute trusts in Norfolk and Waveney – ourselves, the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and The Queen Elizabeth Hospital NHS Foundation Trust King's Lynn (QEH) – have worked together to enhance the services we provide. We moved to a Committees in Common (CiC) structure from September 2020, building on the previous work we have done together. The hospitals have a good track record including the Eastern Pathology Alliance, joint posts, staff working across different sites including running clinics and joint research projects.

The Norfolk and Waveney Hospitals Group includes representatives from each organisation's Board of Directors who attend regular meetings to take joint decisions on future strategy and development of acute services. This provides oversight and will support teams' innovation and collaboration. In line with the emerging ICS structure, it has been proposed that the CiC is developed into an Acute Provider Collaborative.

Our approach to collaborative working will help to secure our hospitals' future and make sure that services are more sustainable and resilient. The three organisations remain distinct and each Trust's Board of Directors is accountable to their local population and will continue to lead their own organisations.

Two joint services were launched at the start of 2020 to improve services for patients and provide better access to care. A single clinical team now runs the Norfolk and Waveney Urology Service across JPUH, NNUH and QEH and JPUH and NNUH run the Norfolk and Waveney Ear, Nose and Throat service. A range of benefits for patients is expected to result from bringing together skilled teams across these services. These include sharing best practice and the same access and quality of care, so that all patients get the same experience and opportunities to help improve services and create new pathways of care. The pandemic unfortunately delayed the transformation of those services, work which will progress early in 2021/22.

This year we are developing the James Paget University Hospitals (JPUH) Clinical Strategy from the recently completed Speciality Development Plans. It will help inform the new hospital design and will be presented for approval early in 2021/22.

Norfolk and Waveney Health and Care Partnership

ICSs', which require all parts of the NHS to work with each other, local councils and other partners, are being rolled out across the country. We are one of 42 systems across England, involving local hospitals, community and mental health trusts, GP practices, local councils and other care providers.

The Trust has participated in the Norfolk and Waveney Health and Care Partnership, and supported preparations to become an ICS. Norfolk & Waveney will become a fully Integrated Care System from April 2022: in the meantime significant work is underway in relation to the shadow arrangements from April 2021. This will bring closer collaboration to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population.

Work continues on development of a system clinical strategy that will include acute, primary community and mental health providers. This will be completed in 2021 and will be preceded with a framework that sets out the broad principles; this is likely to include the need for three acute hospitals, 3x Emergency Departments, 3x Stroke Units, 3x Maternity Units etc. A facility for 'cold elective' provision for Norfolk is also to be considered.

This is in the very early stages of consideration and no decisions have been taken by any sovereign Board at this stage. A priority is to help key stakeholders understand the nature and scale of the challenges the system faces and to inform them that a strategy is being developed to address these. A communications and engagement plan is being developed which will outline the approach and timescales for engaging all key stakeholders, including staff and service users.

The JPUH is actively engaged in helping shape how this would develop including the Director of Strategy and Transformation being a member of the ICS Partnership Development Group and the Great Yarmouth & Waveney Place-based development group so we can support the needs of the local population.

The partnership has three overarching goals:

1. **To make sure that people can live as healthy a life as possible**. This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer and how healthy you are should not depend on where you live. This is something we must change.

2. **To make sure that you only have to tell your story once**. Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. **To make Norfolk and Waveney the best place to work in health and care**. Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The first meeting of the Interim Partnership Board took place on 8 April 2021. Further information can be found here: https://www.norfolkandwaveneypartnership.org.uk/

Hospital Services Strategy (HSS) Programme

There have been recent system-wide governance structural changes including establishment of the ICS Norfolk & Waveney (N&W) Strategic Planning & Transformation Group (SPTG) and the move to develop the CiC into an Acute Provider Collaborative.

The system-wide transformation programmes are overseen by the SPTG and all acute-centric activity will remain within the oversight of the Hospital Services Strategy Board which will report to the CiC. This change will see the N&W Clinical Strategy being overseen by the SPTG, the underpinning acute clinical strategy by the HSS and the CiC.

Despite the challenges posed by the COVID-19 pandemic work, has continued within the Hospital Services Programme including:

- **Specialty Review and Redesign**

The redesign and transformation planning for the integrated services ENT and Urology remains a system priority and work continues to ensure this happens. The ENT service has developed a process for redirecting selected urgent referrals from the NNUH to the JPUH to help alleviate waiting times. This is being piloted with 104 patients initially, followed by a review into how well this has worked, the impact to patients and the services at the JPUH.

In Urology, selected non-cancer (priority 2) patients are being transferred to the JPUH for their procedures; pre-operative processes are currently being reviewed to ensure lists are optimally utilised.

- **Policy Convergence and Alignment work stream**

This work focuses on the alignment of clinical policies/protocols/procedures that sit above individual specialty level. Work currently focuses on the following policy areas:

  - Policy development processes: to standardise the processes by which Trust policies are developed. A first draft policy has been produced, which has been agreed in principle by the working group
  - Consent / pre-operative procedures: following a very successful accelerated design event to engage all key stakeholders, work is progressing on development of the joint policy.

Going concern

The Board of Directors has been regularly updated on the financial plans of the Trust, via its Finance and Performance Committee. The Audit Committee also reviewed the Trust's position in relation to going concern at its meeting held in February 2021, where it considered continuation of service and financial sustainability in reaching its recommendation to the Board to adopt the going concern basis in preparing the Financial Statements. This is consistent with the Department of Health Group Accounting Manual guidance which states that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

The Board has agreed expenditure budgets for 2021/22 and this forms the basis of the Trust's draft financial plan. The current financial regime in place for the NHS covers the six months 1 April 2021 to 30 September 2021, and provides NHS organisations with assurance over future funding for the continued provision of NHS services through the allocation of financial envelopes to ICSs. The draft financial plan includes block contract income which provides the Trust with revenue stability for the period ahead. The Board is reviewing the financial position on at least a monthly basis as the situation develops during 2021/22.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Anna Hills
Chief Executive and Accounting Officer
15 June 2021

Accountability report: Directors' report

Our Board of Directors

The Board's role

The Board provides leadership and sets the tone for the organisation. It has four key roles:

- Formulating strategy; ensuring there is a clear vision and strategy
- Holding the organisation to account for delivery of the strategic objectives and through seeking assurance that systems of control are robust and reliable
- Ensuring the Trust is an excellent employer
- Shaping a positive culture for the Board and the organisation.

As a unitary board, the Non Executive Directors share responsibility with the Executive Directors for ensuring that the right resources are in place to meet the objectives set. In an emergency, powers are exercised by the Chief Executive and Chair after having consulted at least two Non Executive Directors.

The way that the organisation works is set out in its corporate governance framework which includes the Trust Constitution, Board and Council of Governors' Standing Orders, Standing Financial Instructions and Scheme of Delegation. This confirms the decision making process and financial limits.

The Chair leads both the Board and the Council of Governors, ensuring that the Board and Governors work together and there is an accurate record of decision making. Terms of reference, reviewed at least annually, set out the detailed responsibilities of the Board, and each Director, including promoting the success of the organisation to maximise the benefits for members and the public.

A clear schedule of business is in place and regularly reviewed. This is supported by monthly review meetings between the Chair, Chief Executive and Trust Secretary which includes future planning and development.

The Board sets the strategic direction and the objectives, having taken account of staff, Governor and stakeholder views, and oversees the running of the Trust by annually assessing that the conditions of the organisation's Provider Licence are being met. Compliance was confirmed most recently in February 2020, and is due for consideration on 30 April 2021. This includes the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Our meetings

The Board meets every month, either formally or informally through the Board Seminar, meeting in public on alternate months.

During the last year temporary governance and assurance arrangements were in place to ensure clear principles in a rapidly changing situation. In essence, this meant Board business being streamlined where necessary, papers kept brief and only critical items considered when the pandemic was at its most challenging. At times during the early part of the year, and in January/February 2021, business was undertaken through the Board rather than its Committees.

Throughout the year, meetings have been undertaken virtually. The Chair and Chief Executive have met frequently. The Chair ensures that meetings are held with the Non Executive Directors only, without the Executive Directors, as necessary. During the pandemic, these have been taking place on a regular basis. Non Executive Directors have provided support to the Executive Team as required.

There remains good, constructive challenge between both Executive and Non Executive Directors, a sense of common purpose and a focus on our staff and our patients.

The Executive Team meets separately, chaired by the Chief Executive as the Accounting Officer, on a weekly basis.

The usual Board face to face engagement sessions have not taken place this year, whilst quality walkrounds led by the Director of Nursing were reinstated in November 2020.

In March 2021, once the worst of the second wave had passed, virtual engagement restarted – the next best thing to the Board being able to meet with staff and patients in their work areas – hearing from our Emergency Department team about the developments undertaken and the work still planned. Our staff in the Intensive Care Unit also talked about the challenges they had faced, the support provided, and how services may be configured in the future.

Seven meetings have been held in public, with reports available on the Trust's website. For any item considered in private, justification for doing so is required.

More informal monthly Board Seminars are held for briefing, mandatory training and strategic development and debate. Further work is required to revise the Seminar and Board development programme for 2021/22.

From 6 April 2021, the Trust Secretary is handing over her communications responsibilities, enabling her to focus on this role full time and continually improve governance arrangements.

Membership of and attendance at the Board in year is set out overleaf:

Board of Directors 2020/21

NHS
James Paget
University Hospitals
NHS Foundation Trust

Voting Board Members

Anna Davidson - Chair

Appointed Chair by the Council of Governors in May 2017 for a first three year term of office; reappointed for a second term to 30 April 2023

Anna joined the Trust as a Non Executive Director in February 2016, becoming Deputy Chair in November 2016.

Anna has worked predominantly within the public and private sectors, most recently as a senior executive director within the Norse Group, which she left in August 2015. During her 10 years at Norse Property Services (NPS), Anna was a key member of the Strategic Leadership Team and her responsibilities included business development, strategic planning and the development of new joint ventures and consultancy services. Anna has previously been a Director on the boards of three subsidiary companies within the Norse Group as well as being a Director on the Board of the North Lincolnshire Local Education Partnership, where NPS was a founding partner.

Responsibilities: Chair of Board of Directors; Chair of Council of Governors and Committees; Chair of Charitable Fund Trustees; Chair of Executive Nomination and Remuneration Committee; Non Executive lead for STP partnerships, business developments and joint ventures.

Executive Directors

Anna Hills - Chief Executive

Acting Chief Executive from 1 March 2019. Appointed to the permanent role from 1 August 2019.

Appointed on the Board from December 2013 as Associate Director; Director of Governance role from October 2015, Deputy Chief Executive from 1 April 2018 having undertaken the role for six months in 2017.

Anna has worked at the Trust since 2010 and has held a number of previous roles within the NHS and private sector leading quality, assurance and service development activities. Anna has a clinical background, having originally trained as an orthoptist.

Responsibilities: Accounting Officer

Mark Flynn - Director of Finance

Appointed April 2014

Mark has worked at the hospital since 2007 initially as Deputy Director of Finance and then as Director of Finance from 2014. Mark previously held senior finance roles within the social housing sector, with over 25 years finance experience gained in both the public and private sectors.

He is a Fellow Chartered Certificated Accountant (FCCA) and is also a member of the Association of Accounting Technicians (MAAT).

Responsibilities: Finance; Contracting; Procurement; Commercial Strategy; Estates and Facilities; Sustainability: Energy Carbon Management; Charitable Fund; Counter Fraud.

Paul Morris – Director of Nursing and Patient Safety

Appointed April 2020

Paul is a registered nurse who has worked in the NHS for 20 years. He has worked in several organisations across both Suffolk and Norfolk including Acute Trusts and Public Health England. The majority of Paul's nursing practice has been in emergency medicine, in a variety of roles from registered nurse to Lead Nurse and then Senior Matron.

Responsibilities: Lead for Nursing, Midwifery and AHPs; Co-Director/Joint Executive with Medical Director for Clinical Practice; Director of Infection Prevention and Control (DIPC); Safeguarding Lead; Nurse/Midwifery Revalidation; End of Life; Learning Disabilities; Dementia; Non-medical education; Chaplaincy.

Dr Hazel Stuart - Medical Director

Appointed from 5 March 2018

Hazel has been a Consultant Anaesthetist at the Trust since 1999 and was Deputy Medical Director from 2013. Born in Great Yarmouth General Hospital, Hazel went to Great Yarmouth Grammar School before beginning her career at the James Paget Hospital in 1981 as a nursing auxiliary, prior to going to medical school. Qualifying in 1987, Hazel's work then saw her training in obstetrics and gynaecology, paediatrics and emergency medicine and her varied career has seen her working at St George's Hospital in London, as well as in the Australian outback.

Responsibilities: Lead for Medical and Dental practitioners including medical education; Co-Director/Joint Executive with the Director of Nursing for Clinical Practice; Medicines Management Lead (including lead for pharmacy); Clinical Audit and Effectiveness; Radiation; Seven day services; Caldicott Guardian; Mortality; Medical revalidation; Cancer; Research.

Jonathan Barber - Director of Strategy & Transformation (non-voting)

Appointed February 2018; permanent role from 1 March 2019

Jon has worked at the hospital since 2014, initially as a joint appointment with the Great Yarmouth and Waveney CCG. He was appointed as Deputy Director of Strategy and Transformation in 2016 and, as a result of changes in Executive portfolios took on this role on a temporary basis. Jon previously held senior management roles in both local and central government and holds an MBA in public sector management.

Jonathan is Vice Chair of a Housing Association and has held a number of other non-executive positions.

Responsibilities: Strategic planning, internal transformation; Trust lead for the Norfolk and Waveney Sustainability and Transformation Partnership; Partnership working.

Joanne Segasby - Chief Operating Officer

Appointed as Acting Chief Operating Officer from 1 April 2019; permanent in the role from 1 July 2019.

A registered nurse, Jo has worked in the NHS for over 25 years, carrying out clinical work in Accident and Emergency and Critical Care, at Ipswich, Addenbrooke's and the Norfolk & Norwich University Hospitals. She has held managerial roles in Cancer Services, as General Manager in Women and Children's Services and was Operational Director for Surgery at the Norfolk & Norwich University Hospital from 2014. Jo joined the James Paget team in October 2018 as Associate Chief Operating Officer.

Responsibilities: Operational delivery and performance, Hospital Management Board; Emergency Preparedness and Business Continuity; Health and Safety; Security Director; Decontamination; Performance management framework; Information Governance; Informatics; Health Records.

Karen Hansed – Director of Governance (non-voting)

Appointed December 2019.

Karen has held a number of senior roles whilst working at PwC and in the NHS. She brings a wealth knowledge and experience having worked in the NHS for over 17 years. During her career, she has focused her time on identifying sustainable quality improvements for patients and staff to reduce unwarranted clinical variations. In addition, her roles have involved liaising with staff to identify new ways of working to achieve efficiency and productivity improvements across a range of clinical and non-clinical areas. Karen has also had operational experience working as a Divisional Director at an acute hospital trust.

Responsibilities: Risk and Governance, Complaints, Litigation, PALS, Clinical Audit and Effectiveness, Incidents, Serious Incidents, Never Events, Compliance (CQC, NHSI etc), Patient Safety, NICE guidance, NPSA alerts, Health & Safety.

Trust Secretary

Ann Filby - Head of Communications and Corporate Affairs (non-voting)

Appointed to Trust 2006; Head of Communications from September 2010

Ann joined the Trust in 2006 to manage the Monitor assessment process for becoming a Foundation Trust, having previously worked in a community NHS Trust and a Primary Care Trust in Norwich. Ann has since held a number of slightly different roles, but all encompassing elements of communications and has managed Board processes since joining the Trust. From 2015 Ann took over responsibility for the Trust's corporate office supporting the Board of Directors and management of Freedom of Information requests.

Ann is an accredited PR practitioner and Member of the Chartered Institute of Public Relations.

Responsibilities: Trust Secretary: Board of Directors, Council of Governors, Trust membership; Trust's corporate office: compliance and constitutional issues; Conflicts of Interest and Hospitality policy; Fit and Proper Person requirement implementation; Internal/external communications; Freedom of Information Act; Corporate publications and Patient information.

Non Executive Directors Appointed by the Council of Governors for a three year term of office

Professor David Scott - Non Executive Director - Senior Independent Director (from 1 April 2019)

Appointed by the Council of Governors for his first three year term of office from 1 September 2017 until 31 August 2020. Reappointed for a second three year term to 30 August 2023

Previously an Honorary Professor of Rheumatology at the Norwich Medical School (UEA) for over 20 years, and was a consultant rheumatologist and fellow of the Royal College of Physicians. David has undertaken a range of roles during his career including director of research and development at the Norfolk & Norwich University Hospital and Clinical Director of Norfolk & Suffolk Comprehensive Local Research Network. David's last role was for the Clinical Commissioning Group.

Responsibilities: Chair's the Board's Patient Safety and Quality Committee; NED lead for Maternity Safety; Mortality; Care of the Dying (End of Life); NED oversight of Guardian of Safe Working requirements; Medical Revalidation; CEA Awards; Quality; Infection Prevention.

John Hennessey - Non Executive Director

Appointed by the Council of Governors in January 2021 for a three-year term of office.

John grew up in Minnesota in the USA before moving to the UK in 1990. He worked for business consultancy Deloitte before joining the NHS in 1993. He was an NHS Finance Director for 24 years, working at several London-based organisations including Great Ormond Street Hospital. His last NHS post was at the Norfolk and Norwich University Hospital where he was Chief Financial Officer from 2018-20 as well as the Norfolk and Waveney STP Finance Director.

Responsibilities: John will take on the role of Maternity Safety with effect from April 2021

Stephen Javes – Non Executive Director

Appointed by the Council of Governors for his first three year term of office from 1 January 2019 until 31 December 2021.

Stephen was Chief Executive of the Orwell Housing Group for 27 years until September 2018, setting strategy, policy and the tone of the business. His oversight sought to ensure that solutions were found to care for people in an ever more challenging world and with an ageing population. Stephen brings a range of skills and a wealth of experience into this Non Executive role having served on many private and public Boards; he is currently Chair of the Lowestoft Places Board.

Responsibilities: Chairs the Board's Audit Committee; Security, EPRR (Emergency Preparedness, Resilience and Response).

Paula Kerr - Non Executive Director

Appointed by the Council of Governors for her first three year term of office from 1 November 2016; reappointed for a second term of office to 31 October 2022

A former group director at pharmaceutical company SmithKline Beecham and chair of a national charity Paula has experience at board level in private, public and voluntary sector organisations in the fields of health, social care and education. She joined the Trust after spending more than three years working as a trustee, vice chair and chair of trustees at Livability, a national charity providing disability and community services. Prior to that, Paula has had Non Executive roles in an acute hospital, a Mental Health Trust and a Strategic Health Authority.

Responsibilities: Chair's the Board's Finance and Performance Committee (from January 2021); safeguarding.

Karen Knight - Non Executive Director

Appointed by the Council of Governors in January 2021 for a three-year term of office.

Karen has a long career working in many roles within health and social care. For nine years, she was an Executive and Non Executive Director of the NorseGroup, the country's largest local authority trading company. She has also been the Managing Director of Norsecare, leading one of East Anglia's largest residential care providers to achieve outstanding CQC ratings.

Responsibilities: Equality, Diversity and Inclusion

Roger Margand - Non Executive Director

Appointed by the Council of Governors for his first three year term of office from 1 September 2017 until 31 August 2020. Reappointed for additional six months to 31 January 2021.

A partner at Spire Solicitors LLP in Norwich, Roger has extensive experience in commercial legal transactions, advising management teams and drafting and reviewing commercial contracts. He has worked with charity and non-profit organisations alongside property developers, surveyors, banks and pension funds and has provided regulatory advisory and support for a variety of boards as well as company secretarial services.

A graduate of the University of East Anglia, he was admitted to the roll of the Law Society in 1996 after qualifying as a solicitor and also holds Chartered Institute of Marketing and Advanced Employment Law qualifications.

Responsibilities: Chair: Board's Finance and Performance Committee to December 2020.

Professor Nicola Spalding - Non Executive Director, representing the University of East Anglia

Reappointed for a second three year term of office from 1 April 2019 to 31 March 2022.

Nicola is an occupational therapist, who previously worked at the James Paget Hospital for nine years specialising in orthopaedics and palliative care. For over 20 years she has worked as a lecturer in occupational therapy, and was appointed as Professor of Occupational Therapy in 2013. Nicola teaches preregistration occupational therapy students, and also lecturers on a Masters programme in clinical education to support health and social care professionals who want to enhance their role as educators in the workplace.

As well as lecturing Nicola has had a number of leadership roles at the university, including Course Director for both the BSc and MSc preregistration Occupational Therapy programmes, Teaching Director for the School of Allied Health Professions, Associate Dean for the Faculty of Medicine and Health Sciences and Deputy Head of the School of Health Sciences.

Responsibilities: Chairs the Board's People and Culture Committee; workforce; Chairs the Trust's Remarkable People Organising Committee; Whistleblowing (Raising Concerns in the Public Interest) incorporating the lead NED role for Freedom to Speak Up Guardianship.

Andrew Palmer, previously Director of Transformation and Workforce, was on secondment to the Norfolk and Waveney Health and Care Partnership from November 2019. Andrew secured a permanent role and left the Trust on 31 August 2020.

During 2020/21 the Board has been supported by Associate Director of Finance Ed Taylor and Executive Lead for Workforce, Graeme Armitage, both of whom attended meetings, presented relevant reports and provided the Board with their professional guidance.

Board changes post year end

From 1 April 2021, a number of changes took effect:

- Director of Governance, Karen Hansed, left the Trust having been in this interim role since December 2019, supporting risk, governance and patient safety

- Director of Nursing Paul Morris becomes Director of Nursing and Patient Safety. Paul is now responsible for patient safety and experience as well as clinical governance. This is in addition to his lead professional role and Director of Infection Prevention and Control, making sure all our processes enable us to minimise infections. Paul will be supported by the Assistant Director of Patient Safety & Quality

- Mark Flynn is relinquishing the role of Director of Finance on a temporary but long-term basis to become Director of Strategic Projects. Mark is focussing on the New Hospital project following confirmation of seed funding to develop our plans. We are also planning for an Electronic Patient Record across the three acute hospitals. Mark has also taken on responsibility for Health and Safety

- Ed Taylor moves from his Associate Director of Finance role to become Director of Finance, enabling Mark to focus on the strategic projects. Ed has been leading on day to day financial management for several months and has now taken a voting role on the Board of Directors

- Jon Barber, Director of Strategy and Transformation, has taken over the leadership on quality improvement

- Graeme Armitage continues in his role as Executive Lead of Workforce, renamed People and Culture, joining the Board as a non-voting member. This reflects the importance of continuing to develop our support to staff and taking advantage of new ways of working developed during the pandemic. Graeme is supported by the Deputy Director of People and Culture.

Attendance

There have been no concerns raised this year. Where a member is not able to attend for any reason, this is confirmed with the Chair and Trust Secretary.

Name	Job Title	24/04/20	22/05/20	26/06/20	31/07/20	25/09/20	23/10/20	27/11/20	28/01/21	26/02/21	26/03/21	Meeting Count	% Attend
		Private		Private			Private			Private			
Members													
Anna Davidson	Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Anna Hills	Chief Executive	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Mark Flynn	Director of Finance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Paul Morris	Director of Nursing	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	90.00
Hazel Stuart	Medical Director	A	Y	Y	Y	Y	Y	Y	Y	Y	A	8	80.00
Joanne Segasby	Chief Operating Officer	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Professor David Scott	Senior Independent	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Roger Margand	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y			8	100.00
Professor Nicola Spalding	Non Executive Director	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	9	90.00
Paula Kerr	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Stephen Javes	Non Executive Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
Karen Knight	Non Executive Director								Y	Y	Y	3	100.00
John Hennessey	Non Executive Director								Y	Y	Y	3	100.00
Non Voting Members													
Jon Barber	Director of Strategy and Transformation	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	90.00
Karen Hansed	Director of Governance	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	9	90.00
Ann Filby	Head of Communications and Corporate Affairs (Trust Secretary)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10	100.00
In attendance:													
Graeme Armitage	Executive Lead for Workforce		Y	Y	Y	Y	Y	Y	Y	Y	A	8	
Edmund Taylor	Associate Director of		A	Y		A	Y	Y	Y	Y	Y	6	
Isobel LeGrice	Deputy Director for			Y	Y						Y		

The Trust Secretary ensures that the functions of the Board of Directors and the Council work effectively and in line with the Code of Governance. She leads on the Trust's Constitution. This sets out how Governors are consulted at the right time on any major changes that might be regarded as material or significant transactions.

There is a clear process in place for Governors to raise issues and, if these are not resolved satisfactorily, the Senior Independent Director will deal with any disputes.

The Trust Constitution was revised in June 2020 to take account of the pandemic. This included a relaxation of the previous limit to Governors' tenure and a reduction in the number of Public and Staff Governors. Any changes to the Constitution are approved by both the Council and the Board.

Board member interests

A Conflicts of Interest and Hospitality policy is in place in line with national guidance, which also reflects the potential for bribery.

On appointment, new Board members complete a declaration with any changes during the year declared immediately to the Trust Secretary and formally minuted at the next Board meeting. This includes signing up to the Board's Code of Conduct. It forms part of the annual review of the CQC's Fit and Proper Person Requirement for directors, with the Chair reviewing the evidence for all Board members. Further details are available from the Trust Secretary on request.

For some years, to ensure transparency, Board member interests have been included as part of the Board meeting papers, and these are available on the Trust's website.

This process has been enhanced to include all the Trust's nominated decision makers in line with national guidance. The Audit Committee continues its oversight including declarations and hospitality, with an annual review of policy effectiveness. The register has been published at least annually in line with the guidance. The aim now is to publish any changes in the register of decision makers at least six monthly and ideally on a quarterly basis. However, the pandemic has led to a delay in reviewing the policy and implementing new processes, including use of an additional module for the Electronic Staff Record which it is hoped will enable a more streamlined approach to declarations. The revised policy will be considered by the Audit Committee in 2021/22 prior to its approval through our usual policy review process.

The declarations register can be accessed on the Trust's website at this link https://www.jpaget.nhs.uk/about-us/declarations-of-interest/

Non Executive Director independence

In line with regulatory guidance, the Chair must on appointment meet the independence criteria which forms part of the recruitment process. The Board considers this on an annual basis.

Non Executive Directors serve a maximum of two, three year terms of office. These are only extended on an annual basis should there be exceptional circumstances as set out in the Trust Constitution, and this is approved by the Council of Governors. What constitutes such circumstances is reconsidered by the Council on an annual basis.

The Board of Directors has confirmed that all current Non Executive Directors remain independent.

The Code of Governance

These disclosures provide more detail on the Trust's governance arrangements and illustrate how the main and supporting principles of NHSI's Code of Governance (the Code) are used in how we work. The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

In accordance with the Code, the Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, the regulator and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. The Directors confirm their responsibility for preparing the Annual Report and Accounts.

The Trust has applied all the principles of the Code which underpin the governance processes in place. A full assessment of compliance against each element of the Code was conducted on first publication and updated in line with the revised version, July 2014, and again in 2016/17. This is kept under review.

There was a revision to the UK Corporate Governance Code during 2018 which has not yet resulted in a revised Code of Governance. The Trust Secretary advises the Board on any best practice considerations in-year and where processes can be streamlined or enhanced.

There have been no changes this year that would impact on the Trust's compliance with the Code. The main elements are set out within this section of the report:

Sections A/B: The role of the Board of Directors and its responsibilities; Governors

- Full details of the Board role, its membership, appointment dates, experience and areas of responsibility are set out from page 29
- The Council of Governors' membership and number of meetings can be found from page 79. Non Executive Director assurance is provided to the Council and continues to be well received as a major element of the meetings held in public, covering each Non Executive Director's portfolio area. This is enhanced with a Chief Executive's report, with full discussion and questioning from Governors
- Information on Governors' engagement as part of the membership strategy can be found at page 83
- Governors' involvement in developing the forward plan was not undertaken in the way that it usually does due to the pandemic. Objective setting is generally considered through a workshop each January prior to the Board agreeing these. Strategic debate takes place in private at every meeting of the Council which enables free discussion on those issues being considered. This includes development of the Norfolk and Waveney Health and Care Partnership and the ICS, closer working with the two Norfolk acute trusts and Trust developments. A 'strategic question' has been used during membership engagement to enable local people's views to be taken account of in service planning, whilst this has been on hold during the pandemic. More detail can be found in the membership section from page 83
- Appointments and performance reviews are included within the Remuneration Report from page 53
- There have been no changes to the Chair's commitments that required a report to the Council of Governors
- Non Executive Director independence is considered annually, see page 35
- In relation to Board diversity there remains a good gender mix. We seek candidates that will extend and challenge our Board's thinking, especially over diversity and ways in which we tackle inequalities. Great Yarmouth and its surrounding areas have a rich background of cultures and we are committed to ensuring our organisation reflects this at all levels. We welcome those with lived experience or people who have engaged with diverse social, economic and cultural groups, particularly the black, Asian and minority ethnic communities, those people living with disabilities and the LGBTQ+ community. Reverse mentoring was implemented in year, and whilst we have yet to link a member of staff with every Board member, the relaunch in March 2021 did see additional interest. This enables Board members to build a relationship with a member of staff and consider what it feels like to be from another culture or to be identified in one or more of the nine protected characteristics set out in the Equality Act 2010.

Section C: Accountability

- Requirements are discharged through this annual report and regulatory submissions to NHSE/I
- Information on the Audit Committee and effectiveness of the Trust's system of internal controls can be found at page 39
- The External Auditors, KPMG LLP, have been in place for four years, including a further one year extension in 2019/20. A full tender process took place this year, with disappointing responses and a single bid. The tender process was repeated in the autumn to encourage further competition. The Council of Governors was represented by three Governors for the detailed discussion. The appointment of KPMG was proposed by the Audit Committee and its recommendation approved by the Council in January 2021 for an initial three years until 31 March 2024.

Section D: Director remuneration

- Contained within the Remuneration Report.

Section E: Relations with stakeholders

- In previous years a full review of our stakeholder relations was undertaken by the Board at least every six months to ensure it remained current and our links with key stakeholders was continuing. The pandemic has meant this not being undertaken as we worked more closely together across the system. In 2021/22 a new full time Head of Communications and Engagement joins the Trust, and stakeholder relations will sit within their portfolio. Work has already begun to engage with stakeholders on our plans for a new hospital, which will increase steadily over the coming years
- We are a part of the Norfolk and Waveney Health and Care Partnership, confirmed as an ICS from 1 April 2021. Details of this can be found throughout this report
- The Board has considered its strategic position in previous years with a clear vision for longer term partnership working with the patient at the heart. This has underpinned our participation in the Norfolk and Waveney Hospitals Group and planning for the future of Acute Provider Collaboratives. We were instrumental in proposing and arranging the first three Trust Board meeting in November 2019, with a further meeting taking place early in 2021/22. This year our position has been reviewed, and remains largely unchanged, to develop and enhance the services we offer our communities across the ICS and proactively tackle health inequalities to deliver sustainable, high quality, patient centred services across the ICS.
- In addition to the number of Board members attending each Council meeting, a Council of Governors' report is presented to the Board of Directors so the Board is fully aware of the Council's priorities and any concerns can be escalated. The Chair and Chief Executive are in attendance at Council meetings, with other Executive Directors attending during the year as required. They also support the Governor induction process
- Board engagement has been challenging this year, as already stated. Departmental presentations have continued to every meeting, as the demands of the pandemic allowed.
- A one year membership strategy is in place, with the pandemic reflected in the small number of priorities, confirmed by the Council and Board. Further information is set out on page 87

- The elements that are not applicable in year are:
    - An explanation if neither external search nor open advertising was used to appoint a Chair or Non Executive Director – external recruitment was utilised for both appointments made in year. Reappointment for a second three year term, should a sufficient level of performance be reached, can be approved by the Council without open competition
    - Use of the Council's power to require one or more of the directors to attend a governors' meeting – not required as work planning and agenda setting ensures attendance when required to provide more information on specific subject areas. The Chief Executive, or another member of the Executive Team, is always in attendance at Council of Governors' meetings
    - No Executive Directors have been released to serve as a Non Executive Director elsewhere.

NHS Improvement's well-led framework

The most recent CQC Well-led inspection was undertaken in October 2019 with the award of a second Good rating in December 2019. This review covers the quality of leadership at every level and how well we manage the governance of the organisation. We continue to seek improvements and aspire to be Outstanding.

The full report can be found at this link https://www.cqc.org.uk/provider/RGP

Further information can be found in the Annual Governance Statement.

External review of governance arrangements

The last review was undertaken in 2016. On receipt of the final report in December 2016 a full action plan was implemented and completed.

In January 2020 the planning process began for a second review, and the Board considered the scope and a timetable. This was put on hold until the CQC revises their well-led framework and once normal working resumes following the pandemic. Planning will begin in the summer of 2021 with the review to be undertaken later in 2021/22.

Audit Committee

Stephen Javes, Non Executive Director, has been Chair of the Audit Committee throughout the year. The Director of Finance, the Director of Governance, the Head of Internal Audit, a Local Counter Fraud Specialist and a representative of the External Auditors normally attend meetings of the Committee. The Trust Chair and Chief Executive attend by invitation.

Meetings are held not less than five times a year. The Committee is responsible for reviewing the annual financial statements and recommending these to the Board for approval. It receives reports and assurance from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

In particular, the Committee reviews the adequacy of:

- All risk and control related disclosure statements, the Annual Governance Statement, together with the accompanying Head of Internal Audit opinion, prior to endorsement by the Board of Directors
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, effectiveness of the management of principal risks and the appropriateness of the disclosure notices
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Authority.

The Committee receives a monitoring report at each meeting on the progress of the internal audit programme in accordance with the agreed audit plan. The overall effectiveness of the work of the internal auditors is reviewed through annual monitoring against agreed KPIs.

Assurance is sought from a number of areas, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness:

- The work of Internal Audit
- The work of the Local Counter Fraud Specialists
- External Audit
- Through the representations given by Directors and managers as appropriate; and
- The findings of other significant assurance functions, both internal and external to the Trust, i.e. reviews by regulators or other professional bodies.

The significant issues considered by the Audit Committee in relation to the financial statements, operations and compliance are discussed in further detail within the Annual Governance Statement from page 3 of the financial statements.

The Trust has an internal audit function which is outsourced from an external third party provider, PWC, with the contract extended by two years during 2020/21. Their role is to provide the Trust with assurances around the effectiveness of internal controls. The internal audit plan is structured around corporate level objectives and risks and audit work is performed in alignment with Public Sector Internal Audit Standards. Progress against the plan is reviewed at each meeting to enable the Committee to seek sufficient assurance on progress. A detailed description of the work of internal audit for the year is provided in the Annual Governance Statement, providing overall assurance that "risk management processes and internal controls in relation to business critical areas are generally satisfactory".

The external auditors for the Trust were KPMG LLP. Current best practice is for a three to five year period of appointment. External audit services were subject to a full market evaluation and tendering exercise during 2020/21, as described at page 37.

The effectiveness of the external audit process is assessed by the Audit Committee, through direct receipt of reports from the external auditors to the Committee, and also through a formal management report on the work. The Trust's external auditors did not provide any non-audit services during the year.

Membership and attendance at the Audit Committee is set out below.

Name	Job Title	01/04/2020	10/07/2020	02/09/2020	04/11/2020	04/01/2021	18/02/2021	Meeting Count	% Attend
Members		Cancelled							
Substantive NED Attendance									
Stephen Javes	Chair/Non Executive Director		Y	Y	Y	Y	Y	5	100.00
David Scott	Senior Independent Director		Y	Y	A	A	Y	3	60.00
Roger Margand (to 31/1/21)/Karen Knight	Non Executive Director		Y	Y	A	Y	Y	4	80.00
Other JPUH Attendees									
Gareth Davies	Financial Accountant		A		Y	Y	Y	3	75.00
Mark Flynn	Director of Finance		A	Y	Y	Y	Y	4	80.00
Anna Hills	Chief Executive					Y	Y	2	100.00
Ed Taylor	Associate Director of Finance		Y	A	Y	Y	Y	4	80.00
Karen Hansed	Director of Governance and Transformation		Y	Y	Y	A			
External Attendees									
Hayley Ward/Tanatsa Jingura	PwC		Y	Y	Y		Y	4	100.00
Andy Grimbly	Head of Internal Audit - PwC		Y	Y	Y		Y	4	100.00
Juliette Meek/Lenka Carbonell-Marvan	Local Counter Fraud - PwC		Y	Y	Y		Y	4	100.00
Representative	KPMG		Y		Y		Y	3	100.00
Representative	KPMG		A	Y	A		N	1	25.00

Further refinements in the way that Board Committees operate will be progressed in 2021/22. This will include revising work plans and re-confirming attendance requirements for the Board and its Committees once the Trust objectives have been confirmed. The full time Trust Secretary will specifically support the Audit Committee from 2021/22 and enhance assurance processes where that adds values.

Our patients at the centre of their care

The Board's Patient Safety and Quality Committee considers quality issues in more detail, with regular reporting to the Board. This Committee now meets on a monthly basis.

The CQC monitors the quality of care that we provide. We have not had an inspection since 2019, with the CQC taking a balanced approach during the pandemic and focussing on those areas where there was most risk. We continue to develop our relationships with our local team, and highlight any concerns with them in-year.

At our previous inspection, no breaches of any legal requirements or elements of care were found that were in need of urgent attention.

The Safe domain remains as 'Requires Improvement' despite completion of the actions required. Neither medical care nor maternity core services were re-inspected, whilst all the areas inspected were rated as Good or Outstanding. Inspections are our 'time to shine'.

As we came to the end of the second wave of the pandemic, we asked staff to consider all the great things we have done during the last year, taking pride in the care that we have been able to deliver in very difficult circumstances.

We also continue to review our own processes, to keep up to date in changes that impact on patient care to enable us to continue improvements in the care that we provide to our patients.

The Trust's strategic objectives to enhance the care that we provide, and details of how we are working with partners, were set out earlier in this report.

Here are some examples of the support to our patients that has been possible during the last year, with more detail available in our Quality Report:

- **Emergency Department expansion** – aimed at providing more space to assess patients requiring emergency services, the new building extends the hospital's front façade out towards the main car park on the site
- **New Ultrasound rapid access service** - one of our ultrasound rooms was transformed into a rapid access service for Accident & Emergency, Ambulatory and Inpatients requiring immediate ultrasound scanning

- **Mobile cancer care unit launched** in March 2021 to support patients in Norfolk & Waveney in collaboration with the charity Hope for Tomorrow, the Norfolk and Norwich University Hospital and NHS Norfolk and Waveney Clinical Commissioning Group

- **Attend Anywhere video consultations**, implemented quickly early in the pandemic, allowing clinicians to continue to consult their patients, with positive feedback received
- **Maternity team developments** have continued throughout the year. This included responding to publication of the 49 recommendations of the Ockenden Report and identifying Executive and Non Executive leads for maternity safety:
    - Continuity of Carer was launched in February 2021, which enables a pregnant woman to build a relationship with her midwife, and a small team of midwives, and have that support through her whole maternity journey. This was the priority identified by women when they were asked how maternity services could be improved in our area
    - Kobi's Promise was published on 3 March 2021 following the sad death of Kobi two years earlier. The team worked with the family in his memory and pledged a promise to his family that they would learn from the events surrounding that day

- **A new one-stop clinic for patients with neck lumps** opened in August 2020 to provide a faster route to diagnosis and treatment for patients. They are examined and, where an immediate cause can't be identified, will be sent for an ultrasound and further tests, usually on the same day

- **Research** has continued with participation in COVID-19 trials. The team has played a key role in looking at ways of improving care and treatments for patients with the virus. Two of our staff have also been awarded national fellowships in clinical research - Rene Gray, a Physiotherapist who is Orthopaedic Therapy Team Lead at the Trust, and Senior Nurse for NMAHP (Nursing, Midwifery and Allied Health Professions) Research Claire Whitehouse – were successful in applying for 12-month bridging fellowships that commenced in November 2020.

The focus over the last year has been in supporting our patients through the pandemic, with many of our usual processes on hold:



- **COVID-19 specific information** has been prepared as required, or national information utilised. Letters have been sent to patients waiting for treatment, and all changes in service were considered at our Incident Management Team and approved at our Strategic Management Team
- **Patient Helpline**, available 7am-7pm, seven days a week. A dedicated COVID helpline was set up at pace to manage all COVID related enquiries during the pandemic. Managed by the patient experience team this operated initially seven days per week to manage the volume of calls being received. Calls varied from enquiries related to passing messages to loved ones, COVID swab testing, questions regarding appointments and routine surgeries booked and, in later months, vaccine bookings

- **Messages for loved ones** – a designated email address was set up to enable relatives and friends to send in a letter/message to their loved one (inpatient). These are printed, put in an envelope and hand delivered

- **iPads for virtual visiting** - donations of iPads enabled our patients to stay in touch with their loved ones in the absence of being able to visit during lockdown. The iPads are bookable through the COVID helpline number/Patient Experience Team and distributed to wards

- **Two Hearts: helping families feel connected to their loved ones** - we purchased some keepsake hearts to support patients and relatives to feel connected in the absence of visiting. The idea is that one heart remains with the patient and the other heart is given/sent to their next of kin/loved one

- **Staff photos for those wearing PPE** – it can be difficult for those patients that are in the hospital if they can't see the faces of the staff that are treating them. This service enables staff to take a photo of themselves to wear

- **Volunteers -** unfortunately, many of our volunteers had to be stood down during the pandemic due to lockdown, suspension of visiting and the need to maximise safety and minimise traffic throughout the organisation. This included our Butterfly Volunteers who support patients and their families during the patients' last days of life. Our Butterfly Volunteer Co-ordinator has continued to support patients who are at end of life in the absence of our volunteers. A small cohort of Trust volunteers continued to support our front of house reception team to manage the volume of patient essentials being dropped off by family members/friends

- **Patients attending our Board meetings** – later in the year we were able to reinstate our patient experience item at the start of our Board meetings held in private. This long-standing part of our meetings enables a patient to attend to share their personal experiences of accessing our services. The patient or carer is supported to provide a balanced overview, which also enables a two-way discussion between them and Board members. This has worked very well for both Board members and those attending and enhances our learning

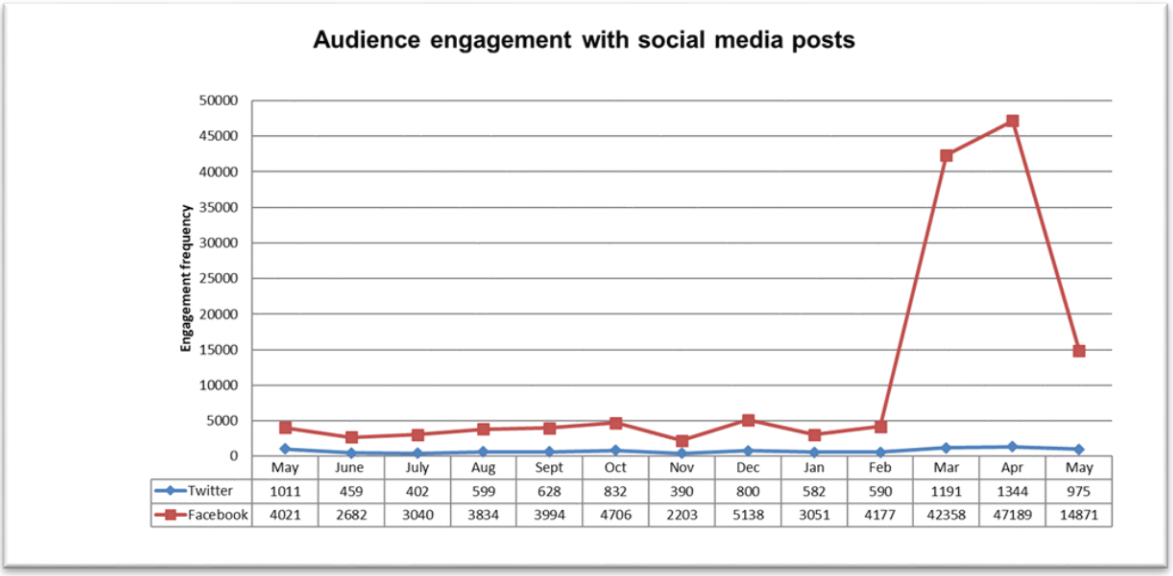
- **Services to nursing during the pandemic were recognised** with Jacky Copping, Deputy Director of Nursing, becoming an MBE in the New Year's Honours List. The pandemic has presented the biggest healthcare challenge, and Jacky said she was so proud of the teamwork displayed by the staff at the Paget:

"We're one big team – and the way staff have responded during the year has been amazing. The pandemic has really tested people's resilience but throughout, staff have given 110 per cent to keep the quality of patient care at a high level, while looking after each other too."

Improvements in patient/carer information

- **Social media** has been vital over the last year, particularly in the early stages of the pandemic, to make sure that local people had access to accurate information. Information is available on the Trust website and social media: www.jpaget.nhs.uk Twitter: @jamespagetNHS www.facebook.com/jamespagetuniversityhospital Engagement increases month on month, for both Twitter and Facebook, as we keep the public and those who use our services fully informed.

This graph was presented to the Board in June 2020. The figures show a remarkable jump in Facebook audience engagement in both March and April 2020. To give some context, this is the same format used in previous reports but the engagement frequency axis has been increased from 6000 to 50,000 to capture the changes.



	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Twitter	1011	459	402	599	628	832	390	800	582	590	1191	1344	975
Facebook	4021	2682	3040	3834	3994	4706	2203	5138	3051	4177	42358	47189	14871

Whilst not quite so dramatic, Twitter's engagement rates also doubled compared to the previous two months. This demonstrates the public appetite for information at what was a worrying time for all. We continue to use our social media channels to share information and good news, including the numerous films made during the year as an easily accessible way of communicating important information. Our patients continue to use this as an easy way to provide their feedback and to communicate with us when they have questions. The communications team works closely with the patient engagement team to ensure that responses are provided in a timely way.

- **The Trust website** this year has provided COVID-19 and vaccination programme information from a large banner on our home page, together with updates to a range of pages including Audiology and Maternity. The communications team works with staff from across the hospital to make sure that updates to content are made. Significant changes continue to progress to ensure that information provided is current and accessible. A process is in place to ensure that content is reviewed on a regular basis for this large site, seen as a critical resource for our patients and visitors. Significantly revised or new sections this year include:

    - A new section for the Newberry Child Development Centre - The Newberry Child Development. This includes 'About us', 'How to find us' 'Key staff' and 'video tour' pages plus several sections on ADHD (Attention Deficit Hyperactivity Disorder), ASD (Autistic Spectrum Disorder), Children's physio and occupational therapy and useful links and resources – all accessible via the landing page https://www.jpaget.nhs.uk/departments-services/departments-services-a-z/newberry-child-development-centre/

    - A new Haematology section, the first time we have had this level of detail on the website. It includes eight pages for patients and GPs and information about blood transfusion and the anticoagulation service https://www.jpaget.nhs.uk/departments-services/departments-services-a-z/haematology/

- Maternity has been updated with multiple new pages including information about the Eden team, the tongue-tie service, pelvic and maternal health physiotherapy, hypnobirth, your health during pregnancy, the rainbow service and information about complications https://www.jpaget.nhs.uk/departments-services/departments-services-a-z/maternity-services/

- A large number of information videos have been added including physiotherapy and occupational therapy, maternity and orthopaedics and Apprenticeship video case studies
  Pelvic and Maternal Health Physiotherapy Team (jpaget.nhs.uk)
  Occupational Therapy & Physiotherapy (jpaget.nhs.uk)
  Orthopaedics (jpaget.nhs.uk)
  Video case studies (jpaget.nhs.uk)

- We've maintained the Cancer Services section of the site, adding new information regularly - https://www.jpaget.nhs.uk/departments-services/departments-services-a-z/cancer-services/

- Attend Anywhere - we set up access so patients can access video consultations via our website.

- Staff asymptomatic testing – a new page to allow staff to register their test results.

Work is required to enhance the site's accessibility, to be undertaken in 2021/22.

- **A virtual patient information committee** is in place, although it didn't meet for parts of the year. Representatives from across the Trust review and approve essential patient leaflets as quickly as possible so our patients have the latest information available to them. We want this information to be easy to understand and enable patients to be clear what they need to do if they have concerns. The review of the patient information policy and processes has been delayed due to the pandemic, and this will be taken forward by the new Head of Communications and Engagement in 2021/22.

Complaints Handling

We know that we don't get it right every time for our patients. Where this is the case, we want to learn from their experience and improve our processes. Patients are encouraged to raise concerns with us and our management of complaints is in line with the NHS Complaints procedure.

Any complaint received is acknowledged within three working days and initial contact is made by the Complaints Investigator, wherever possible, to discuss the detail and context. This enables a response timescale to be agreed. Those raising a complaint are given the opportunity to express any desired outcome they would wish, following a complaint investigation.

This year a national directive was released to enable complaints to be paused during the initial wave of the pandemic. However, we continued to manage and respond to complainants wherever practically possible as we felt this was critical to our patients' experience of the services that we provide. Response timeframes have remained a challenge during the past year, with the Board focussed on making improvements. Revised processes are in place from April 2021.

This year 170 complaints were received compared with 207 the previous year.

Patient Advice and Liaison Service (PALS)

This service supports patients, relatives, carers and members of the public who need information about the health care system. PALS are pleased to help with any enquiry:

- Finding the information needed to answer questions
- Providing details about the services available within the hospital
- Resolving problems by identifying the right people to talk to
- Explaining what to do if a concern is unresolved.

An overall decline was seen in the number of PALS enquiries as the team supported the COVID helpline during the year. There were 1,963 enquiries received compared to 3,170 the previous year.

Consultation with other groups/other activities

A dedicated Service User Group is in place, which meets quarterly, and gives the opportunity for service users to comment on user feedback and offer support for any quality improvement initiatives from a patient perspective.

We recognise that we need to do more to ensure that the patient voice is fully embedded in everything that we do and that patient engagement in their care continues to increase. Planning has begun to develop a Patient Engagement Strategy to be considered and approved by the Board during the first half of 2021/22. The new Head of Communications and Engagement will support this work, ensuring that it is aligned to preparation of a communications and engagement strategy for the New Hospital programme.

We work closely with our local Health Overview and Scrutiny Committees in Norfolk and Suffolk, taking their advice on future items for consideration by the Committee, and providing information and support to their meetings.

Here are some of the other mechanisms that we use:

- **Service improvements following staff or patient surveys** - patient satisfaction surveys are carried out at local and national level. These enable us to develop our services based on patient feedback in terms of what works well and where improvements are required. Local patient surveys are registered with our clinical audit team to ensure they conform to the Trust format and progress through the necessary approval processes. During the past year the pandemic has impacted participation, specifically national surveys where the Trust sample size has not met the required numbers to reach the eligibility threshold. Two of the improvements made as a result of feedback gathered include ensuring regular contact with complainants during the investigation stage, and collaborative working between the catering manager and stoma services to enhance menu options for patients with stomas/ileostomies.

- **Governors** would usually engage with a range of local groups and provide feedback – this has been on hold due to the pandemic in line with regulatory requirements. More information can be found in the membership section on page 83

- **Healthwatch Suffolk** have previously carried out fortnightly-monthly engagement visits co-ordinated by the Head of Patient Experience. This provides them with the opportunity to visit different departments and speak with service users in person to gain their experiences regarding the service that they have received. Due to the pandemic, this has not continued during the year, whilst engagement has been undertaken by both Healthwatch Suffolk and Healthwatch Norfolk virtually. The Trust Chair, Chief Executive and Head of Communications meet with the Chief Executives of both organisations on a quarterly basis

- **Carers** - we continue to work in collaboration with the external carer agencies to ensure Family Carers are signposted and obtain the required support to fulfil their caring roles, covering both Norfolk and Suffolk. This has included ensuring that information is available to our staff during the pandemic

- **Enhancing patient engagement** was being discussed prior to the pandemic as part of the Hospital Services Strategy work and local implementation of the NHS Long Term Plan. This work will continue in 2021/22

- **Public engagement events** have been extremely limited this year.

Financial disclosures

Cost allocation and charging guidance

The Trust can confirm that it has complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

The Trust has made no political donations to any individual, body or organisation during 2020/21 or 2019/20.

Better payment practice code

The Better Payment Practice Code requires that all valid invoices be paid by their due date or within 30 days of receipt. The Trust's performance against the code during the year, split between NHS and non-NHS suppliers, is shown in the table below.

Value of invoices paid	NHS			Non-NHS		
	Total paid £'000	Paid in 30 days £'000	Paid in 30 days %	Total paid £'000	Paid in 30 days £'000	Paid in 30 days %
2020/21	27,346	24,257	89%	79,866	68,594	86%
2019/20	15,514	12,557	81%	65,161	35,157	54%

Number of invoices paid	NHS			Non-NHS		
	Number paid	Number paid in 30 days	Number paid in 30 days %	Number paid	Number paid in 30 days	Number paid in 30 days %
2020/21	1,592	1,369	86%	43,629	34,969	80%
2019/20	949	459	48%	42,551	14,888	35%

Liability to pay interest

There was no liability to pay interest, either accrued or actually paid, by virtue of failing to pay invoices within the 30 day period where obligated to do so.

Fees and charges (income generation)

The Trust does not levy any fees and charges raised under legislation, where the full cost exceeds £1 million, or where the service is otherwise material to the accounts. Full disclosure of other non-patient care income is included within note 4.2 of the financial statements on page 34.

Income disclosure

Under the requirements of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the Trust can confirm that income from the provision of goods and services for the purpose of health services in England is greater than the income generated from the provision of goods and services for any other purpose. Income to the Trust from non-NHS sources has a positive impact on the provision of goods and services for the purposes of the health service, as all income is used for the benefit of NHS patients.

Disclosure to the auditors

So far as the Directors are aware, there is no relevant audit information of which the Trust's auditors are unaware. The Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Income and expenditure

The Trust reported a small surplus of less than £0.1m for 2020/21 excluding the impact of consolidating its charitable funds (2019/20 deficit: £(5.1)m). This position includes within operating expenses an impairment charge of £2.7m (2019/20 £6.5m), which when excluded leaves a surplus excluding impairments of £2.8m (2019/20 £1.4m).

Non-operating income includes £12.6m of top-up income due to the Trust under the COVID-19 interim financial regime. This income was provided to the Trust as an estimate of the funding required to achieve a break-even position, to directly fund COVID-19 costs including lost non-NHS income as a result of the pandemic, and subsumes Provider Sustainability Funding (PSF) which the Trust was paid under the previous financial regime in 2019/20.

Capital investments

Capital investments of £**21.9m** were made during 2020/21 as shown in the table below.

Capital Investments 2020/21	£'000
Equipment replacement	4,276
IT Investments	4,022
ED Redevelopment	3,906
MRI Build & Equipment	3,075
CRI - Backlog Maintenance	1,995
Estates Work	1,890
Theatre 7	1,474
Additional MRI	881
HIP2	408
Total	**21,926**

Cash and financing

The Trust's non-consolidated cash position increased by £8.4m during 2020/21, with cash and cash equivalents of £25.9m held at 31 March 2021. Of the £21.9m of capital expenditure, £12.8m was funded through new Public Dividend Capital (PDC) issued to the Trust by the Department of Health and Social Care (DHSC), relating to a variety of projects including Critical Infrastructure, MRI facilities, Emergency Department upgrades and improved digital maturity. The Trust's DHSC borrowing of £7.3m was extinguished and replaced with the issue of PDC on 1 April 2020. The issue of PDC was then used to repay the loan, having a net neutral impact on the Trust's cash balance.

The Trust has £6.7m of finance lease liabilities. The largest contracts include decontamination scopes and washers procured as part of the Endoscopy Decontamination refurbishment recorded in the accounts as a finance lease, with a net liability of £1.5m as at 31 March 2021. The Trust also has finance lease contracts in place for Radiology equipment of £1.9m in total. One new finance lease was entered into during 2020/21 for IT hardware.

Savings and transformation

The COVID-19 interim finance regime incorporated a requirement to deliver the same non-recurrent efficiencies that were delivered during 2019/20. This represented a target of £4.8m. Despite the difficult circumstances of the pandemic, the Trust achieved savings during 2020/21 of £5.7m, of which £5.5m was non-recurrent and £0.2m was recurrent. The total of £5.7m represents 2.2% of the Trust's expenditure before efficiencies.

Single Oversight Framework

NHSI's Single Oversight Framework provides the structure for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources (UoR)
- Operational performance
- Strategic change; and
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support and 1 reflects those 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.

This framework was replaced by the NHS Oversight Framework. It set out how regional teams will review performance to identify support needs across Sustainability and Transformation Partnerships and Integrated Care Systems. A national consultation was released in March 2021 on a new NHS System Oversight Framework for 2021/22.

Segmentation

During the entire year 2020/21 the Trust has been classified as being within segment 2 and there has been no enforcement action taken. Current segmentation information for NHS trusts and foundation trusts is published on the NHSE/I website.

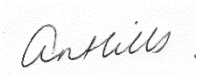
Finance and use of resources

This 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 UoR is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust will not necessarily be the same as the overall finance score here.

The UoR scores are shown in the table below.

Area	Metric	2020/21	2019/20 Scores			
		Full Year	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	2	2
	Liquidity	2	2	2	1	3
Financial efficiency	I&E margin	3	4	4	3	2
Financial controls	Distance from financial plan	1	1	1	1	2
	Agency spend	1	3	2	2	2
Overall scoring		**3**	**3**	**3**	**2**	**2**

Due to the pandemic, the Trust was not subject to a CQC UoR assessment during 2020/21. The UoR assessment report published by the CQC in December 2020 is therefore the most current position. It rated the Trust as Good following a full assessment by NHSE/I held in September 2020. This was an improvement on the 2018/19 'Requires Improvement' rating, and the first time that a combined Quality and Use of Resources rating was given.



Anna Hills
Chief Executive and Accounting Officer
15 June 2021

Remuneration Report

Annual statement on remuneration

The Trust has two Committees dealing with Board level pay and appointments, one for Executive Directors and the other for Non Executive Directors. Succession planning, appointments and remuneration are a key focus for each Committee. Both Committees are supported by a senior member of the Workforce team and the Trust Secretary.

We are a Medium Trust with a turnover of over £200m. Executive salaries are confirmed in line with the published national lower median and upper quartile salaries for different roles. Non Executive salaries are aligned with national NHSE/I guidance published in September 2019 to ensure parity of remuneration across all Trusts.

Executive Directors' salaries were revised in November 2020 following the national Very Senior Manager (VSM) pay review announcement for 2020/21 to take effect from 1 April 2020. This reflected a 1.03% basic pay uplift in line with those staff on the top pay point of Agenda for Change Band 9.

Whilst the Medical Director remains within the remit of the Executive Nomination & Remuneration (N&R) Committee, the majority of her contract is managed differently due to her clinical commitments, with only a small amount judged as VSM.

There were no significant awards made to past senior managers during 2019/20, nor were there any service contract obligations which would impact on remuneration payments.

For all new appointments made to the Board we seek to extend and challenge current thinking, especially over diversity and ways in which we tackle inequalities. Great Yarmouth and its surrounding areas have a rich background of cultures and we are committed to ensuring our organisation reflects this at all levels. We welcome candidates with lived experience or people who have engaged with diverse social, economic and cultural groups, particularly the black, Asian and minority ethnic communities, those people living with disabilities and the LGBTQ+ community. This experience could be gained through links with the voluntary or not for profit sectors, community involvement or business initiatives.

The level of remuneration for senior management in the Trust is assessed under the terms and conditions and pay arrangements for Agenda for Change staff. This involves a rigorous process of job evaluation to assess the banding level and associated pay scale and also aligns to like positions with similar levels of job demands and responsibilities, across the wider NHS.

Further detail on our diversity and inclusion policies can be found within the Staff Report.

Senior Managers' Remuneration Policy

Minimal changes have been made to the policy in recent years, with increasing national focus on Board level pay and additional information available from regulators on appropriate levels of pay to ensure sufficient restraint and value for money.

Executive Remuneration Policy 2020/21

1.0 Policy statement

1.1 This policy has been agreed by the relevant Committees – Executive Nomination & Remuneration Committee for Executive Directors and Governors' Nomination & Remuneration Committee for Non Executive Directors. Both are chaired by the Chair of the Trust.

1.2 This policy is reviewed each year and is included in the Trust's annual report in line with regulatory requirements.

2.0 Executive Directors

2.1 The remuneration policy for Executive Directors is set by the Executive Nomination & Remuneration Committee.

2.2 The policy for setting the appropriate level of remuneration for Executive members is to pay a fair market rate. This is assessed through annual benchmarking against the published review by regulators and NHS Providers, and is also reflective of organisational and individual performance.

2.3 The exact salary is determined by the Committee based on the Trust's performance and the individual's contribution.

2.4 A report will be presented annually following completion of the annual Fit and Proper Person review and national pay review as it relates to Very Senior Managers, by the Chief Executive for the Executive Directors and the Chair for the Chief Executive, using the annual performance review as the basis for decision.

2.5 Rates of pay should be uplifted annually on 1 April in line with regulatory guidance. During periods of economic difficulty, this will be reviewed as to appropriateness.

2.6 Newly appointed Executive Director remuneration will be assessed at the time of appointment and reviewed thereafter in the annual round as set out in this policy, subject to a minimum tenure of one year's service with the Trust being accrued at the time of that review.

2.7 Executive remuneration levels, benefits and pension entitlements are published in the Trust's annual report.

Senior Managers' Remuneration

3.1 The national Agenda for Change NHS pay system applies to the first layer of management below Board level. Any exceptions in relation to interim appointments will be approved by the Chief Executive within the authority delegated by the Executive Nomination and Remuneration Committee.

4.0 Chair and Non Executive Directors

4.1 The Council of Governors has responsibility for setting remuneration, following the recommendations of the Governors' Nomination & Remuneration Committee. This forms part of the review of all terms and conditions, including expenses to be claimed.

4.2 As with Executive remuneration, benchmarking is required against the information published by regulators and NHS Providers.

4.3 The current rates of pay are as set out below, and take account of guidance published by NHS England and NHS Improvement in September 2019. There have been no changes since that time:

Board role	Requirement	Days per month	Salary
Trust Chair	Statutory	10	Lower quartile £44,100 Median £47,100 Upper quartile £50,000
Deputy Chair	Trust Constitution - the Council of Governors may appoint to this role. Agreed November 2017 not to appoint at this stage with time commitment and salary to be reviewed if there is a requirement in future	N/A	N/A
Non Executive Director	Statutory (majority on the Board)	3	£13,000
Additional responsibilities			
Chair, Audit Committee	Statutory – Foundation Trust Code of Governance July 2014 C.3.1	3	£14,000
Chair, Safety and Quality Governance Committee (now Patient Safety and Quality Committee)	Whilst not statutory the Committee has an assurance role in relation to systems of control and governance and specifically for clinical quality and safety; with the Audit Committee instigates action to deal with any risks identified. This role also carries additional Non Executive lead responsibilities for Mortality, End of Life and medical revalidation requiring external representation	3	£14,000
Chair, Executive Nomination & Remuneration Committee	Statutory – Foundation Trust Code of Governance July 2014 D.2.1		Included within Chair's role
Senior Independent Director	Statutory – Foundation Trust Code of Governance July 2014 A.4.1 – in addition to the Non Executive Director role	3	£14,000

4.4 Where the posts of Deputy Chair, Senior Independent Director and Chair of the Safety & Quality Governance (Patient Safety and Quality) or Audit Committees are held by the same person, only one of these posts will be recognised for payment.

Annual Report on remuneration

Further details of each Board member and their term of office can be found within the Directors' Report from page 31.

Induction and performance reviews

Each Board member undertakes a full induction programme. This is reviewed and updated prior to every new appointment to ensure that latest NHS and Trust developments are included. It is supported by a full induction pack. This is in addition to the Trust's corporate induction processes for every member of staff.

During this year, reflecting the challenges of new Non Executive members of the Board not being on site, a full induction section was built on a password protected area of the Trust website. Existing induction films were revised to provide a flavour of the inside of the hospital and latest updates. This did not prove to be a workable substitute for being on site and will not be repeated.

Individual annual performance reviews take place once the Trust objectives have been approved by the Board. This ensures that all Board members and senior managers focus on achieving the strategic ambitions, meeting the longer term strategy aims and the performance requirements expected. This process supports the annual Fit and Proper Person assessment for all Board members.

The Senior Independent Director, with the Lead Governor's support, appraises the Chair, offering the opportunity for all members of the Board, the Council of Governors and external stakeholders to feed in their views. The processes utilised are in line with NHSE/I guidance.

The Chair appraises the Chief Executive on behalf of the Executive N&R Committee. This is based on the objectives set for the organisation for the coming year and includes any development requirements.

The Chief Executive appraises all those directly reporting to them, including all Executive Directors. These reviews, and any changes in portfolio, underpin proposals for remuneration as considered by the Executive N&R Committee.

The Chair appraises the Non Executive Directors.

The pandemic led to a delay in completing the previous year's performance reviews, in line with regulatory guidance. All were completed by the end of December 2020. This has also resulted in a delay to the 2021/22 reviews due to the second wave and significant challenges seen in providing care to increasing numbers of patients testing positive for the virus. These reviews will be completed by the end of summer 2021, with Fit and Proper Person reporting to the Board delayed until the autumn. This process takes account of the revised framework for both Chair and Non Executive Director appraisals received from regulators on 8 April 2021.

The outcome of all Non Executive reviews is considered in detail with the Governors' N&R Committee, together with the proposed objectives, all of which is discussed and approved at the Council of Governors. Succession planning is considered and the outcome of individual reviews forms the basis of any reappointments during the year. The pandemic led to information being presented direct to Council this year.

Individual development and learning requirements are addressed with a Director's line manager.

Any gaps or additional learning for the Board as a whole are delivered through the Board Seminars. An outline Board briefing programme is in place, reviewed annually to ensure it meets the Board's needs and reflects continuing NHS strategic developments. Work is required to fully develop a programme to meet the Board's future development needs in 2021/22. This may reflect the development undertaken in-year within the Executive Team.

The workforce team has implemented electronic and virtual mandatory training where possible through the Electronic Staff Record. Whilst the Board would previously have undertaken elements of their training together, as a Board, this is now done virtually, with compliance overseen by the Trust Secretary.

Governors' Nomination & Remuneration Committee

The Committee led on two Non Executive appointments this year, seeking experience of engaging with diverse social, economic and cultural groups, managing transformational change and the adoption of innovations. John Hennessey and Karen Knight joined the Board on 1 January 2021 to cover the departure of Roger Margand, who agreed to stay for a further six months after the end of his first three year term of office, and an additional Director reflecting the breadth of strategic projects being developed.

Each appointment is made in line with the Council approved selection process. This is initially for a three year term of office. In relation to reappointments for a further three year term, this is presented to the Committee and the Council of Governors for approval. It relies on the latest performance assessment of an individual and an overview of their achievements in their first term of office.

Professor Scott, Senior Independent Director, was reappointed by the previous Council, whilst his second term of office did not begin until 1 September 2020. He was also reappointed in the role of Senior Independent Director.

Removal of the Chair or another Non Executive Director requires the approval of three quarters of the members of the Council of Governors, on the recommendation of its N&R Committee. This action would only be taken in extreme circumstances once all other opportunities had been utilised to resolve issues.

A meeting was due to be held in June 2020, but this did not go ahead due to the impact of the COVID-19 pandemic.

Committee membership and attendance is set out below:

Name	Job Title	14/10/20	Meeting Count	% Attend
Anna Davidson	Chair	Y	1	100.00
Jane Harvey	Lead Governor	Y	1	100.00
Lyn Gibbs	Deputy Lead Governor	Y	1	100.00
Jose Bamonde	Public Governor	Y	1	100.00
Stuart Brooks	Public Governor	Y	1	100.00
Ian Clayton	Public Governor	Y	1	100.00
Michael Field	Public Governor	Y	1	100.00
Devender Khurana	Staff Governor	Y	1	100.00
Neil James	Appointed Governor	N	0	0.00

Executive Nomination & Remuneration Committee

Details of the Executive appointments made this year can be found at pages 33. All changes took place post year-end.

Removal of an Executive Director is led by the Executive N&R Committee in line with Trust policies.

Only one meeting took place on 13 November 2020. Members in attendance at that meeting were:

Ms A Davidson, Chair
Professor D Scott, Senior Independent Director
Mr S Javes, Non Executive Director
Mr R Margand, Non Executive Director

In attendance: Mrs A Hills, Chief Executive; Mr G Armitage, Executive Lead for Workforce
Apologies: Mrs P Kerr and Professor N Spalding, Non Executive Directors; Ms A Filby, Head of Communications & Corporate Affairs (Trust Secretary).

Expenses

Governor and Board expenses during the year are set out below:

Table of disclosure	2020/21	2019/20
Governors		
The total number of governors in office	**23**	23
The number of governors receiving expenses in the reporting period; and	**0**	2
The aggregate sum of expenses paid to governors in the reporting period.	**£0**	£246
Directors		
The total number of directors holding office during the year	**17**	15
The number of directors receiving expenses in the reporting period; and	**7**	13
The aggregate sum of expenses paid to directors in the reporting period.	**£2,754**	£14,673

Senior Managers' salaries and benefits

	Year Ended 31st March 2021	Year Ended 31st March 2021	Year Ended 31st March 2021	Year Ended 31st March 2021	Year Ended 31st March 2021	Year Ended 31st March 2021	Year Ended 31st March 2020	Year Ended 31st March 2020	Year Ended 31st March 2020	Year Ended 31st March 2020	Year Ended 31st March 2020	Year Ended 31st March 2020
	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL	Salary	Expense payments (taxable)	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
	(bands of £5,000) £000	to nearest £100 £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	to nearest £100 £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Mr M Flynn Director of Finance; Deputy Chief Executive from 01/01/21	110 - 115	0	0	0	22.5 - 25.0	135 - 140	105 - 110	0	0	0	22.5 - 25.0	130 - 135
Mrs A Hills Chief Executive	165 - 170	0	0	0	0	165 - 170	155 - 160	200	0	0	100.0 - 102.5	255 - 260
Mrs J Hunt Director of Nursing until 31/03/20							110 - 115	0	0	0	0	110 - 115
Dr WH Stuart Medical Director	190 - 195	0	0	0	0	190 - 195	185 - 190	0	0	0	177.5 - 180.0	360 - 365
Mr A Palmer Director of Transformation and Workforce until 03/11/19							60 - 65	0	0	0	20.0 - 22.5	85 - 90
Mr S Javes Non Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	400	0	0	0	10 - 15
Ms AL Davidson Chair	45 - 50	1,300	0	0	0	45 - 50	45 - 50	3,100	0	0	0	50 - 55
Mrs PR Kerr Non Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	1,300	0	0	0	10 - 15
Mr RP Margand Non Executive Director until 31/01/21	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Professor NJ Spalding Non Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Mr J Barber Director of Strategy and Transformation	115 - 120	0	0	0	37.5 - 40.0	150 - 155	100 - 105	0	0	0	35.0 - 37.5	135 - 140
Professor D Scott Non Executive Director	10 - 15	0	0	0	0	10 - 15	10 - 15	1,700	0	0	0	15 - 20
Mrs K Hansed Director of Governance until 31/03/21	110 - 115	700	0	0	12.5 - 15.0	125 - 130	35 - 40	0	0	0	27.5 - 30.0	65 - 70
Ms J Segasby Chief Operating Officer	120 - 125	0	0	0	47.5 - 50.0	170 - 175	85 - 90	0	0	0	95.0 - 97.5	180 - 185
Mr E Taylor Associate Director of Finance	100 - 105	0	0	0	17.5 - 20.0	115 - 120	70 - 75	100	0	0	65.0 - 67.5	135 - 140
Mr P Morris Director of Nursing from 01/04/20	95 - 100	0	0	0	0	95 - 100						
Mr G Armitage Executive Lead for Workforce from 01/10/20	55 - 60	0	0	0	935.0 - 937.5	990 - 995						
Mrs K Knight Non Executive Director from 01/01/21	00 - 05	0	0	0	0	00 - 05						
Mr J Hennessey Non Executive Director from 01/01/21	00 - 05	0	0	0	0	00 - 05						

None of the senior managers above were in receipt of performance-related bonuses or long-term performance-related bonuses during the reporting period. Eleven employees have been paid more than the highest paid director (2019/20 eight).

Dr WH Stuart's total remuneration paid by the entity as disclosed above, includes £58,430 paid in relation to her clinical duties and not in relation to her managerial role.

The taxable expense payments consist of all expense allowances subject to UK income tax, such as car mileage allowances.

The annual increase in pension related benefits disclosed above represents the increase or (decrease), adjusted for inflation, between the amounts as at 31 March 2020 and the amounts as at 31 March 2021.

The pension related benefit is calculated following a prescribed formula issued by HMRC, derived from s229 of the Finance Act 2004, modified by paragraph 10(1)(e) of schedule 8 of SI 2008/410 (as replaced by SI 2013/1981). The calculated pension benefit figure is representative of the benefits that would be payable to the senior manager if they became entitled to it at the end of the financial year. The calculation is based upon 20 x annual pension income, plus the lump sum payable. Factors determining the variation in the values recorded between individuals include a change in role with a resulting impact on pension benefits.

Ratio of Highest Paid Director to Other Staff

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The mid point of the banded remuneration of the highest-paid director in the James Paget University Hospitals NHS Foundation Trust in the financial year 2020/21 was £192,500 (2019/20 - £187,500). This was 7.73 times (2019/20 - 7.74) the median remuneration of the workforce, which was £24,907 (2019/20 - £24,214). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but it does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The median remuneration is based on an annualised, full-time equivalent basis for all employees at the reporting period date, however this calculation excludes overtime or enhancement payments.

Remuneration ranged from £16,910 to £163,782 (2019/20: £17,652 to £161,770) excluding locum employees. Including locum employees the remuneration ranged from £16,910 to £400,680 (2019/20: £17,652 to £342,720), calculated by annualising the month 12 locum payments made to employees.

Senior Managers' pension entitlements

	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
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 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr M Flynn Director of Finance	0.0 - 2.5	0.0 - 0.0	25 - 30	35 - 40	348	14	385	0
Mr G Armitage Executive Lead for Workforce from 01/10/20	20.0 - 22.5	57.5 - 60.0	40 - 45	120 - 125	0	480	981	0
Mr J Barber Director of Strategy and Transformation	2.5 - 5.0	0.0 - 0.0	15 - 20	0 - 0	185	23	228	0
Mrs J Segasby Chief Operating Officer	2.5 - 5.0	0.0 - 2.5	50 - 55	110 - 115	803	44	879	0
Mr E Taylor Associate Director of Finance	0.0 - 2.5	0.0 - 0.0	25 - 30	50 - 55	391	13	423	0
Mrs K Hansed Director of Governance until 31/03/21	0.0 - 2.5	0.0 - 0.0	10 - 15	0 - 5	164	20	203	0
Mrs A Hills Chief Executive	0.0 - 0.0	0.0 - 0.0	30 - 35	50 - 55	629	0	529	0

As Non-Executive members do not receive pensionable remuneration there will be no entries in respect of pensions for Non-Executive members.

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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

In calculating the actuarial value of the CETV as at 31 March 2021 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010. Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.

Real Increase / (decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design. We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Senior managers' pension entitlement disclosures are subject to external audit.

The policy on payment for loss of office

All senior managers' service contracts are set out with clear notice periods. The Trust may terminate an appointment by notice in writing without compensation, other than payment in lieu of notice as required by the contract.

Anna Hills
Chief Executive and Accounting Officer
15 June 2021

Staff Report

The 5 Year People Strategy

Our Vision

To build a fully engaged, inclusive and high performing workforce that lives our values and behaviours. As part of our 5 Year People Strategy we aim to thrive and succeed in giving our patients the very best care through a workforce that is responsive and adaptable. In order to meet these challenges and continue to deliver high quality services, it is essential that our workforce supports a modern NHS fit for the 21st century.

The People Strategy identifies the workforce priorities required to support delivery of the Trust's vision, strategic ambitions and objectives, whilst demonstrating our values in all that we do. We want to support our staff to deliver care at their best, wherever they work.

We aim to become a leading healthcare organisation, with a compassionate supportive culture that is an attractive place to work, enabling our staff to deliver the highest standard of care. We will continuously improve our culture, ensuring we support our staff with the development they need, identifying talent for the future and making sure we are inclusive.

National and Local Context

We are a leading partner within the Norfolk and Waveney health system, enabling us to benefit from good practice in recruitment, retention and the development of innovative new roles. As such we are contributing to the local 5 year long term delivery plan and drawing upon the National People Plan.

As an organisation we strive to improve the experience of our patients by ensuring staff are appropriately trained, equipped, supported and performing to their best to help improve efficiency and productivity. To achieve this, we believe in robust performance management to provide assurance that all staff are demonstrating our core values and behaviours at all times.

This system strategy sets out our current position, where we are aiming to be and our plans for how to realise our goals.

- The delivery of high-quality patient care depends upon staff being happy in work, being appreciated and having the support they need. The evidence relating to improvements in patient outcomes, where staff feel engaged and valued, is compelling and consequently has gained national recognition
- The NHS has recently published the People Plan which sets out the main themes for workforce development. This has been taken into account in developing our People and Culture Strategy
- We are working with partners across health and care system. This helps ensure our workforce strategy supports plans for integration, innovation, and modernising the delivery of care

- It is clear from national and local data that the gap between those being trained for roles in the NHS and the number of vacancies across all services will not be closed through recruitment and retention alone. Therefore, this strategy sets out the actions we need to take in order to design and develop our future workforce to meet the changing needs of our patients.

The strategy is reviewed annually by the Board's People and Culture Committee and updated to take account of the Trust's strategic direction, ensuring our people can meet the demands and challenges of providing services to our patients and communities.

Recruitment – Attracting Talent

The recruitment of all groups of staff remains a challenging area for the NHS and this Trust is no exception. As such we continue to review innovative ways to consider the skill requirements, role design and development of our services to ensure we can attract the best and most diverse talent into our organisation.

In line with best practice, our recruitment team has implemented an extensive improvement programme to move to digital and streamlined working practices. This is to improve efficiency of our processes and also to provide the best experience for our candidates and new starters. Those who apply for positions with us are required to meet the minimum criteria associated with our person specifications and have valid/current qualifications where appropriate. All candidates will go through a robust employment process followed by a comprehensive corporate induction programme which provides new staff with the knowledge and information needed for them to quickly feel part of our organisation. It also provides assurance that our workforce are competent to be able to deliver services to the level and quality we expect.

We recognise the importance for our managers to have the skills to successfully undertake effective recruitment for roles across the organisation. Therefore we provide all managers with recruitment and selection training to ensure they have the knowledge and competencies required.

Recruiting a diverse workforce is key to ensuring our workforce is inclusive and representative of the community we serve. To support our approach to diversity we have an Equalities Policy and a Policy and Procedure on Recruitment and Selection which explain our commitment to giving full and fair consideration to applications for employment.

We constantly review new and exciting pathways in line with service needs and good practice. We also analyse our workforce data regularly and are developing our workforce planning capability. This enables the workforce team to support managers to build the skilled workforce that we need to continue to provide high quality health care. The types of new roles we have introduced in the last 12 months include:

- **Advanced Clinical Practitioner:** Senior practitioners who specialise in particular areas including ED and Paediatrics. Additional capacity for patient care operating at a higher level than healthcare assistants
- **Nurse Cadets:** Enrolled on a level 2 healthcare support worker 15 month apprenticeship programme which is clinically based

- **Nurse Associates:** Bridging the gap between healthcare assistants and registered nurses and providing a range of skills within our multidisciplinary teams
- **Advanced Clinical Practitioners:** Delivery of advanced clinical practice e.g. within our Emergency Department
- **Nursing Degree Apprenticeships:** 2 year top-up programme once the Foundation Degree is achieved - Enabling people to train to become registered nurses
- **Occupational Therapy (OT) Degree Apprenticeships:** Enabling our Therapy Assistant Practitioners to quality as OTs
- **New - 4 year programme:** Requires entry level GCSE English and Maths and after successful completion becomes a registered nurse.

Different ways of working have been explored and capacity prioritised to ensure best use of resources with increased Physician Associates posts and working with Gateway Doctors which have been used to support our specialties and stabilise rotas and gaps in the medical workforce.

Engagement continue with the Joint Junior Doctors' Forum established for working in partnership with the Local Negotiating and Medical Staff Committees for our medical colleagues.

We apply a range of flexible working practices, including part-time hours, term-time contracts and job sharing arrangements, wherever the particular requests of individuals can be met without compromising our service delivery. The pandemic has created the need for many staff to work more flexibly, whether through changing work patterns or working remotely. We want to build on this to ensure we continue to provide flexibility, allowing staff to better balance their lives at home and work.

With the support of senior leaders, we will look to continue to facilitate different working arrangements. We will continue to offer flexible working where possible, by proactively advertising flexibility in roles and ensuring requests for flexible working are given full consideration. We will utilise our workforce systems, including E-roster, to ensure rotas are planned and communicated in advance so that staff are able to make plans at home.

We are building on our flexible retirement options to ensure we provide an opportunity to support staff while retaining valuable experience within the workforce. This work includes reviewing and designing a series of flexible retirement options including:

- **Step down –** staff can step down to a different role to reduce the level of responsibility while remaining in NHS employment
- **Wind down –** staff can wind down to retirement by remaining in their current post but reducing the number of hours or days they work
- **Retire and return –** members of the NHS Pension Scheme can request to retire, claim their pension benefits and then return to NHS employment
- **Draw down –** members of the NHS Pension Scheme can take part of their pension benefits and continue in NHS employment
- **Late retirement enhancement –** members can retire later than their normal pension age and have their pension benefits increased
- **Early retirement reduction buy out –** members or employers can pay additional contributions to buy out the reduction applied to a member's pension if they retire before their normal pension age.

Recognising our staff

Our staff enable us to provide care to our patients. Earlier in this report we detailed how we focussed on their health and wellbeing during the last year, recognising the challenges of the pandemic. This was in addition to the processes that we usually have in place to celebrate individuals and teams.

The Trust's Remarkable People Awards

This year it didn't seem appropriate to recognise a very small number of staff when everyone – over 4,000 of them – demonstrated outstanding commitment to the provision of services to our patients.

So after eight successful years of celebrating our fantastic staff, the annual staff awards ceremony didn't go ahead this year – an event missed by many.

Planning is underway for the 2021 awards, to take place in November.

Long Service Awards

Long-serving James Paget staff are recognised each year for their dedicated service at an awards ceremony. Staff who have served 25 years or 40 years with the hospital, its predecessors or the wider NHS, are all included. Again this year the awards didn't go ahead due to the pandemic, whilst these are scheduled for the summer of 2021.

Employee of the Month

This staff recognition scheme was implemented as a result of feedback from the 2016 National Staff Survey.

The Chief Executive identifies those who have shown a particular dedication to supporting our services and patients. A member of staff or a team is selected each month by the Chief Executive from all those who have been put forward for recognition - by patients, the public or colleagues. With some planning behind the scenes, the winner is taken by surprise and awarded a certificate by the Chief Executive. Awards weren't confirmed in the early part of the year, but were presented as soon as the pandemic allowed.

Supporting our staff – a few treats

Our staff received a number of treats this year to enable the Board and our Executive Team to offer small tokens of thanks for everything they continued to do – free car parking from early in the year which is continuing into 2021/22, hot cross buns, chocolate, ice creams, healthy snacks, rest room treats, refreshments and hot meals for night staff during the snow.

A day's annual leave was also awarded celebrating our Chief Executive's first full year in her role, along with a Proud of the Paget badge for everyone to wear. An in-house designed Christmas card, each signed by our Chief Executive, went to each member of staff, with some great comments on how these were received.

NHS Charities Together grant

We were granted £50,000 to support staff, patients and volunteers during the pandemic. The money was allocated to two projects within the hospital – to provide outside spaces for patients, visitors and staff to relax in and to develop existing staff learning and 'time out' facilities to enhance staff wellbeing.

This includes development of the Trust's existing learning café and conservatory in the Burrage Centre, with the installation of a new conservatory roof to provide relief from the heat in the summer and to keep the heat in during the winter. The second phase of the project will enhance outdoor areas around the hospital including courtyards and areas around the perimeter will be developed to provide quiet areas to improve physical and mental well-being. The second wave of the pandemic has delayed progress, with work due to begin during the summer of 2021.

Data and policies

Staff Numbers contracted as at 31 March 2021

Workforce 31.03.21	Male (fte)	Female (fte)	Total (fte)
Directors (excluding Non-Executives)	6.00	5.00	11.00
Senior Managers	15.36	15.24	30.6
Employees	724.84	2409.66	3134.5
Total	**746.20**	**2429.90**	**3176.1**

Average Staff Numbers

Staff Group	Total WTE (Whole Time Equivalent)	Permanent WTE	Other WTE
Medical and Dental	388	129	259
Ambulance Staff	0	0	0
Administration and Estates	987	880	108
Healthcare assistants and other support staff	783	536	247
Nursing, midwifery and health visiting staff	953	747	206
Nursing, midwifery and health visiting learners	1	0	1
Scientific, therapeutic and technical staff	272	250	21
Healthcare science staff	28	28	0
Social care staff	0	0	0
Other	6	0	6
Total Average numbers (WTE)	**3419**	**2570**	**850**

Staff Costs Analysis

	Year Ended 31 March 2021			Year Ended 31 March 2020
	Permanent £ 000	Other £ 000	Total £ 000	Total £ 000
Salaries and wages	**127,747**	**2,803**	**130,550**	113,663
Social security costs	**12,365**	**-**	**12,365**	11,005
Apprenticeship levy	**678**	**-**	**678**	562
Employer contributions to NHS Pensions	**14,838**	**-**	**14,838**	12,877
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**6,507**	**-**	**6,507**	5,807
Pension cost - other	**45**	**-**	**45**	37
Agency / contract staff	**-**	**6,506**	**6,506**	7,797
	162,180	**9,309**	**171,489**	151,748
Employee expenses recharged to other organisations	**(361)**	**-**	**(361)**	(493)
Employee expenses capitalised as part of assets	**(262)**	**-**	**(262)**	(201)
	161,557	**9,309**	**170,866**	151,054

Sickness absence data

Sickness is managed in line with the Trust's policy, with the workforce team supporting line managers with all issues that they have. This includes identifying improvements to the way staff are supported when on sick leave and focussing on better sickness management within our divisions.

Reports on the latest position are presented to the monthly Board of Directors' meeting and our information is published by NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff policies and their application

The application of workforce policies is in line with the legal requirements currently in place and also with regard to national guidance such as advice from NHS Employers and NHSE/I. The policies that have been applied through the year include:

- **Recruitment Policy, Equality and Diversity Policy –** for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities

- **Equality and Diversity Policy, Managing Attendance Policy** - continuing the employment and arranging appropriate training for employees who have become disabled persons during the period. In addition, for the training, career development and promotion of disabled employees, with a supporting Equality and Diversity Policy Action Plan taken forward in-year

- **Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy** – providing employees systematically with information on matters of concerns to them as employees. In addition to this policy, active promotion of the Speak Up Guardians continues along with the appointment of a Lead Freedom to Speak up (FTSU) Guardian to support further promotion of this service with direct access to the Board of Directors who receive monthly reports. Here is more detail on this:

Anyone can **Speak up** about anything that gets in the way of high-quality effective care, or that affects their working life. **Speaking up** is something that should happen as 'business as usual'. It can take many forms including a quick discussion with a line manager, an idea of how to make an improvement to the service provided, raising an issue with a Freedom to Speak Up Guardian, or bringing a matter to the attention of a regulator.

Some people may interpret all or some of these actions as 'whistleblowing', others may only connect whistleblowing with something that is 'formal', or a problem that is escalated outside an organisation, or to describe something that may qualify for 'protection' under the Public Interest Disclosure Act. **Speaking up is about all of these things**.

Speak up – we will listen. Speaking up about any concern at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff. When a member of staff speaks up and shares their ideas or concerns it will cause others to be inspired and by voicing an opinion this helps others to feel safe to do so.

Our Board and senior leaders are committed to an open and honest culture. We will look into what a member of staff says and always provide access to the support that they need.

The Lead Guardian has been continuing to visit wards/departments and attends team meetings to raise awareness. Posters and flyers are circulated around the Trust to ensure our staff know who to contact and how. Liaising with other leads in the local area and attending regional networking events supports their knowledge and continued learning. This year has shown an increase in people feeling they can speak up and raise concerns.

The Lead Guardian has ready access to the Chief Executive, the Board and FTSU Non Executive Director lead for advice and support to unblock any barriers. Reporting to the Board in private on the cases continues, with the Lead Guardian attending in person twice a year, in public. The full report details current cases, key themes, updates to national guidance and provides assurance that the FTSU agenda is being met.

In line with Serious Incidents/Never Events the aim is to investigate and provide feedback for all concerns raised within 45 working days.

- **Staff Engagement** - we proactively encourage staff and their representatives to regularly provide their views to ensure these are taken into account in making decisions which are likely to affect their interests. Staff are encouraged to be involved in the Trust's performance and these forums are available for staff:
    - Paget's People – a digital platform which allows feedback to be provided on a range of topics, anonymously
    - The national NHS Staff Survey – anonymous feedback, sent to all of our staff rather than a small sample
    - Focus Groups and Listening Events – regular events are held and are open for all staff to attend and participate
    - Chief Executive's weekly MS Teams briefing – a communication update which presents information in brief. The main focus is the opportunity for staff to ask questions and to receive immediate feedback and responses where possible
    - Joint Partnership Forum – a meeting held between staff side representatives and Trust management

- **Change Management, Redeployment and Redundancy Policy** - consulting all employees and/or their representatives on a regular basis so that their views can be taken into account in making decisions which are likely to affect them. This policy is also applied where changes in the organisation's management structure are made or where services changes are required. Regular formal meetings continue with employee representatives for non-medical employee groups through our Joint Partnership Forum, whilst an established Local Negotiating Committee is in place for medical staff

- **Health and Safety Policy, Occupational Health - Surveillance Policy** – this provides information on our health and safety performance. It also covers our occupational health provider, with the workforce team holding regular contract management meetings with them to address any emerging issues and to improve the level of service available to managers and staff. Significant employee safety issues are reported from the Board's People and Culture Committee to the Patient Safety and Quality Committee which in turn is responsible for monitoring the frequency and trends of all patient and staff safety incidents and other reportable incidents. This includes serious incidents and RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

- **Anti-fraud and Corruption Policy** – this covers important information on policies and procedures with respect to counter fraud and corruption. We are committed to reducing fraud, bribery and corruption in the NHS and will seek to take appropriate disciplinary, regulatory, civil and criminal sanctions against any member of staff found to have committed a fraudulent act. The Trust will also attempt to recover any losses incurred by fraudsters, taking all available and appropriate civil and criminal measures to do so. Procedures are in place that reduce the likelihood of fraud occurring, including standing orders, standing financial instructions, documented procedures, a system of internal control and a system of risk assessment

  The Board aims to ensure that a risk and fraud awareness culture exists in the Trust through our Local Counter Fraud Specialist. To this end a quarterly counter fraud newsletter, publicising the counter fraud team and details of successful cases prosecuted by NHS Protect, is distributed. The fraud risk assessment for the Trust has been updated, based on our knowledge of fraud in the NHS, nationally emerging trends and global and UK experience from counter fraud networks.

Diversity and Inclusion

As a Trust we are committed to diversity and inclusion, ensuring that for all our staff we have in place workforce policies that support the minimisation of discrimination. We have embraced the changes to the Equality Act 2010 that replaced the previous anti-discrimination laws with a single Act. It simplified the law and removed inconsistencies to make it easier for people to understand and comply. It also strengthened the law to help tackle discrimination and inequality.

Within the Act, the Equality Duty ensures that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. In this respect there are three main aims that public bodies have a duty to ensure, they are:

1. Eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it
3. Foster good relations between people who share a protected characteristic and people who do not share it.

We have responded to the provision within the Act by ensuring that equality and diversity issues are considered in our strategic and operational decision making. This includes a robust Clinical Quality Risk Assessment (CQRA) process, maintaining the need for equality and diversity on the agenda of the Board's Patient Safety and Quality and the People and Culture Committees.

In addition, all appointing managers are required to undertake recruitment and selection training which makes specific reference to equality and diversity and the requirement for public bodies to adhere to the Equality Duty.

We continue to incorporate the Workforce Race Equality Standard into our reporting mechanisms and report annually on the gender pay gap, with an associated action plan. Continuous improvements are also made through the use of the staff survey results. Details can be found through the Gender pay gap service or on our website at the following link: https://www.jpaget.nhs.uk/about-us/equality,-diversity-inclusion/

All Trust policies are assessed for equality impact and we work in partnership with Staff Side as appropriate to always best support equality and diversity and human rights in our workforce.

An active Inclusion Network is in place which meets on a monthly basis to take forward our diversity and inclusion agenda. Following significant interest in membership of the network this will shortly evolve into a steering group responsible for establishing networks/groups for each protected characteristics and a separate open forum for all staff join and discuss diversity and inclusion issues. Other initiatives being taken forward include reverse mentoring, listening events and additional inclusion training for key roles including the Recruitment, Workforce and Organisational Development teams.

We are committed to developing an inclusive culture where staff and managers are working in an environment that is fair and equitable for all. This is a long-term objective and through the actions now being taken forward, there will be gradual improvements that can be closely monitored. The work is underpinned by the new leadership and management development programme to ensure we continue to embrace inclusion for the benefit of our staff and patients.

Ethnicity – All Staff at 31 March 2021

Ethnic Group	FTE	%
White British	2177.35	72.88%
All 'White' ethnicity other than 'White British'	264.59	8.86%
All 'Mixed' ethnicity	35.51	1.19%
All 'Asian' groups	348.44	11.66%
All 'Black' ethnicity	41.48	1.39%
All other ethnic groups	63.77	2.14%
Declined to disclose	56.28	1.88%
Grand Total	**2987.42**	**100.00%**

Staff Turnover

The retention of skilled and experienced healthcare professionals is at the heart of the Trust's People strategy. In comparison to many NHS organisations, our turnover rates remain low. However, our strategic aim is to ensure we improve our staff experience across all areas of the employee life cycle and to retain people. We are actively working to deliver tailored solutions which help support staff to stay with our organisation.

Information on staff turnover is provided at this link: NHS workforce statistics - NHS Digital

Trade union facility time disclosures

Working relationships with our trade union colleagues are important to the way we work and in line with our values and behaviours. We therefore provide facilities for those recognised trade unions to be able to carry out the support they provide for our staff. At present we have a full time officer and a part time officer for our Staff Side.

The Chief Executive and Executive Lead for People & Culture meet monthly with all staff side representatives and this is used to raise any concerns they may have and to agree how these are to be addressed. This forum is also used to outline any staff consultations that are required and to discuss future plans.

- **Relevant Union Officials**

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
12	1.71 wte

- **Percentage of time spent on facility time**

Percentage of time	Number of employees
0%	4,341 staff
1-50%	12 staff
51-99%	1 staff
100%	1 staff

- **Percentage of pay bill spent on facility time**

	Figures
Total cost of facility time	£67,900
Total pay bill	£170,866,000
Percentage of the total pay bill spent on facility time	0.04%

- **Paid trade union activities as a percentage of total paid facility time hours**

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0

The national NHS Staff Survey

The staff survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. The survey asks staff about their experiences and provides essential information about our staff's views of working at the James Paget.

The survey was undertaken by Quality Health for a total of 120 organisations between September and December 2020. Organisations were given the option to conduct a paper survey, online or mixed mode survey combining both. We chose a mixed mode. Each staff member could only receive one type of questionnaire. For those selected to participate online, an email invitation was sent directly to their work email address inviting them to securely log into the online questionnaire portal and provide their responses. Staff members selected to complete paper questionnaires received these through the internal post, after they were batch delivered from Quality Health.

Questionnaires were sent to 3,363 staff. From the usable sample, 1,319 questionnaires were returned yielding a response rate of 39.3%. Staff were asked a series of questions regarding their experiences at work under the following headings:

- Equality, Diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of care
- Safe Environment - Bullying and harassment
- Safe Environment - Violence
- Safety culture
- Staff engagement
- Team working

The highest response rate was amongst Wider Healthcare Team (including Admin and Clerical staff group) at 30% and Registered Nursing and Midwifery at 29%. In respect of our other staff groups the responses were: Allied Health Professionals / healthcare scientists / scientific and technical (15%), Medical & Dental (9%), Nursing & Healthcare Assistants (10%), General Management (3%) and Other occupational Groups (4%).

The gender and age split are reflective of our workforce as a whole, with 79% of respondents being female, 19% male and 2% preferring not to disclose. The highest age response was from the 51-65 age category. 35% of respondents are 51-65, 25% of respondents are 41-50, 20% are 31-40, 17% 21-30 and 1% of 16-20 and 66+.

20% of respondents disclosed that they have physical or mental health conditions, disabilities or illnesses, out of which 25% stated that they have not received reasonable adjustments.

Respondents split by ethnicity were 86% White, 11% Asian/Asian British, 1% Black/Black British, 1% Mixed ethnic group and 1% Other ethnic groups. This data is reflective of our current overall workforce.

The survey benchmarking group results are presented below. Like many organisations, our results highlighted areas where we scored similarly or lower than the previous year - 64 of the 78 questions showed no significant difference. There were 12 areas where we scored above the sector average with marked improvement. These included being able to do your job properly, delivering the care you aspire to, your manager taking an interest in your health and wellbeing, receiving feedback about changes made in response to reported errors, near misses and incidents and flexible working patterns.

	2020/2021		2019/2020		2018/2019		2017/2018	
	Trust	Bench marking Group	Trust	Bench marking Group	Trust	Bench marking Group	Trust	Bench marking Group
Staff Engagement	7.01	7.04	6.9	7.0	7.1	7.0	7.1	7.0
Equality, diversity & inclusion	8.81	8.81	8.9	8.9	9.3	9.1	9.0	9.1
Health and wellbeing	5.95	6.07	5.7	5.8	6.1	5.9	6.5	6.0
Immediate managers	6.62	6.81	6.5	6.8	6.7	6.7	6.7	6.7
Morale	6.25	6.23	6.1	6.1	6.3	6.4	6.1	
Quality of appraisals	-	-	5.0	5.5	5.2	5.4	5.4	5.3
Quality of care	7.52	7.50	7.2	7.4	7.5	7.4	7.4	7.5
Safe environment – bullying and harassment	7.57	8.02	7.5	7.9	7.6	7.9	7.7	8.0
Safe environment – violence	9.37	9.49	9.2	9.4	9.2	9.4	9.1	9.4
Safety culture	6.64	6.76	6.5	6.6	6.5	6.6	6.6	6.6
Team Working	6.14	6.51	-	-	-	-	-	-

We have used the results from the survey to shape a number of key areas of work including a new leadership and management development offer, support sessions for staff, a continuing professional development offer and wellbeing events.

Data gathered by the survey is used by the CQC, the DHSC and other NHS bodies for benchmarking and improvement.

Other disclosures

Off Payroll Engagements

All substantive employees are paid through our payroll. Any off payroll engagements are subject to risk based assessments to ensure full compliance with HMRC requirements either by the Trust or external agencies.

No members of the Board of Directors were engaged on an interim and off payroll basis during the year.

For all off payroll engagements as of 31 March 2021 for more than £245 per day and that last for longer than six months	2020/21
	Number of engagements
No of existing engagements as of 31 March 2021	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Exit Packages

There are processes in place for exit packages which take account of national guidance on how these cases will be dealt with and include compliance and approval through NHSE/I as required. There have been 11 staff exit packages during 2020/21.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000
<£10,000	0	0	10	56
£10,000 - £25,000	0	0	1	17
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	0	0	0	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,000	0	0	0	0
Total	**0**	**0**	**11**	**73**

Exit packages: non-compulsory departure payments

	Agreement Numbers 2020/21	Total Value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	11	73
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**11**	**73**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0

Expenditure on consultancy

There were three management consultancy appointments made during 2020/21 which had a contract value greater than £50,000 in relation to advice provided to the Trust.

One was provided by Four Eyes Insight Limited and was for consultancy supporting the theatre diagnostics project (£53,000). Another was provided by Dearden HR for workforce services (£136,000) and the third was provided by SSG Partners Limited for ophthalmology support and advice (£50,000).

Total expenditure on management consultancy during the year was £438,000 (2019/20: £434,000) as shown in note 5 on page 36 of the financial statements.

Modern Slavery Act 2015

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36million per annum, the NHS is obliged to comply with the Act.

1. Summary

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation, defined as a supplier of goods or services with a total turnover of not less than £36million per year, shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Board of Directors.

The aim of the statement is to encourage transparency within organisations, although it is possible to comply with the provision by simply stating that no steps have been taken during the financial year to ensure that the business and supply chain is modern slavery free. It is worth noting that although this may be an acceptable approach initially, there is an expectation that further work will be undertaken to provide these assurances in years to come.

There are potential consequences for those organisations that do not appear to make progress in this area, especially for those that are funded wholly, or in part, by public money.

2. Approval Process

The Board of Directors approved this statement and in so doing will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2021.

Modern Slavery and Human Trafficking Act 2015 Annual Statement

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility lead for overall compliance.

James Paget University Hospitals NHS Foundation Trust provides services from its main hospital site and other sites where it operates services from. The Trust's annual turnover is over £240 million and it employs over 4100 permanent and fixed term contract staff.

We have zero tolerance of slavery and human trafficking and are committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in our supply chain.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

To ensure a high level of understanding of the risks of modern slavery and human trafficking in our supply chains and our business, we will continue to provide training to our procurement staff.

In addition, the Trust is meeting its supply chain commitments on slavery and human trafficking by undertaking the following steps during the year:

- For all Terms and Conditions, including specific clauses that reflect our obligations under the Modern Slavery Act 2015
- Including relevant pass/fail criteria for all Procurement led tender processes and new vendor requests
- Up-skilling the Procurement and Supplies Team on the implications of the Act in order that they can support the wider organisation on its implementation
- Communicating to all high risk suppliers providing an overview of the legislation, stating our intent and future expectations
- For those contracts deemed to be of high risk, including the specific Right to Audit against the obligations of the Modern Slavery Act 2015
- The procurement team will also ensure that, where suppliers outside the normal procurement processes are engaged, they will ensure their compliance with the Modern Slavery Act 2015
- The Trust employs within the UK and overseas too and we treat all our employees consistently across the Trust by the Human Resources Directorate. The Trust pays above the national living wage i.e., the minimum wage set by the Government
- Risks to James Paget University Hospitals NHS Foundation Trust associated with this Act are managed in accordance with the Trust's Risk Management Policy
- The Trust, through the People and Culture Committee, will ensure that any incidence of modern slavery identified will be referred to the appropriate authorities/agencies as required by the Act and as such will also be reported to the Board of Directors.

Approved by the Board of Directors, 26 March 2021

Council of Governors and our membership

Our structure and gaining assurance

The size of the Council was reduced from 28 Governors prior to the summer elections and will remain for 2021/22. The Council now consists of 20 Governors, including the Chair, five appointed, 10 elected by the public membership and four elected by our staff.

Governors standing for the Staff or Public Constituency are elected by the process set out in the Trust's Constitution, using the single transferable vote system, generally for a three year term of office.

The elections were due to take place in the summer of 2020 for a 1 August start, with an independent provider appointed. Due to the pandemic, these were put on hold in late March 2020 as there was concern that this wouldn't represent a sufficiently democratic process with the public and staff focussed on managing and stopping the spread of the virus. The public events planned were also no longer possible. During the summer the Trust Constitution was reviewed and revised to take account of a pandemic situation. In addition to the reduction in the size of the Council, the limit of two, three year terms of office for any Governor, in line with best practice, was relaxed for this year, with elections undertaken for a one year term of office only. The new Council did not begin until 1 September, with the previous Council finishing on 31 July.

Elections will be undertaken once again during 2021/22 for a three year term of office.

The Council role

Governors are responsible for representing the interests of members and partner organisations in the governance of the Trust and holding the Non Executive Directors to account for the performance of the Board of Directors. They give their views on strategic issues, but do not manage the hospital. This is the responsibility of the Board of Directors.

The Council is chaired by the Chair of the Trust, supported by the Senior Independent Director and Trust Secretary. The role of the Council is included within the Trust Constitution, with clear processes in place to ensure information is available to Governors.

Formal Council meetings are scheduled at least five times each year, plus the Annual Members' Meeting/Annual General Meeting. Governor Committees undertake the detailed work and report to Council for decision. In the last year, these have been refined with the Governors' Nomination and Remuneration Committee remaining. Membership discussions take place at a Membership Working Group, with all other elements dealt with at Council. Where necessary, such as the External Auditor appointment, a small group of Governors will be identified to participate to enable them to fully brief the Council when a decision is required.

A Lead and Deputy Lead Governor are in place, confirmed through an internal election process undertaken with the Council in the autumn. These are important roles in representing the views of the Council and ensuring that regulatory requirements for a Lead Governor are met.

The Lead Governor in particular works closely with the Chair and the Trust Secretary to ensure that the Council structure supports Governors to undertake their statutory role and add value. During the pandemic, both the Lead and Deputy met with the Chair on a regular basis.

Members of the Board of Directors attend the Council meetings during the year – the Chief Executive and Non Executive Directors for each meeting. Other members of the Executive Team present as required. The Director of Strategy and Transformation is a regular attendee to ensure that Governors are informed and engaged in ongoing strategic discussion on the future of our services and the developments across Norfolk and Waveney and the wider NHS.

As previously mentioned in this report, Non Executive Directors have been presenting at each Council meeting on their Committee or leadership roles as a Board member for a number of years. This process continues to provide sufficient assurance to Governors.

There is a long standing process for Governors to ask questions or raise issues of concern at any time outside of a Council meeting, supported by the Chair and Trust Secretary.

Supporting the Trust's continuous improvement of services

The Governors' Review, Planning & Membership Committee has previously been the main focus of detailed Governor work and ensuring sufficient training is provided. Due to the pandemic, the Committee has not met this year. Once the new Council is in place later in 2021/22, the structure will be reviewed and refined as required.

Governors are fully involved in the Trust's planning with their views taken into account in forward planning through strategic debate at the Council meetings in private section. This usually includes early discussion on future objectives so that Governor views can feed into management/Board review ahead of approval. This year, due to the pandemic and awaiting the planning guidance to inform objective setting post year-end, this did not take place. Governors were involved in discussion on the Trust's priorities early in the new financial year.

Governor training and development

Providing Governors with the development that they need enables effective discharge of their responsibilities. On election, a full induction programme is implemented. Two development days are generally arranged each year and the Council meeting is utilised for any additional learning required.

The pandemic meant cancellation of meetings towards the end of the previous Council's term of office. Significant work was undertaken with Governors to refine induction and briefing processes prior to the new Council beginning. Governors are encouraged to attend meetings of the Board of Directors in public, with attendance at least annually forming part of their role commitment.

All meetings this year have been virtual, which has posed additional challenges, particularly for those that have struggled with the technology or don't have access to it. Additional support has been implemented where possible to enable all Governors to continue to contribute.

Despite the challenges, a virtual induction took place, including an 'ice breaker' which seemed to go well. As the restrictions are lifted by the Government, and depending on any further waves, a mix of virtual and face to face meetings is being considered for 2021/22.

The support provided to Governors - as well as the Chair and Trust Secretary being available to answer any queries - enables the Board to undertake the annual self-certification previously required by our regulator, NHSE/I, that sufficient training has been provided.

A Council of Governors' Code of Conduct is in place providing support to all Governors on the requirements of the role, and including a Frequently Asked Questions section. All Council members are required to sign up to the Code as part of the election process or when new Appointed Governors join the Council. This is due for review in October 2021.

Our Council of Governors 2017-20

These are members of the previous Council, some of whom were re-elected during the summer.

At the end of a Council, we would generally have a social gathering and lunch to thank each one of our Governors for everything they have done during their term of office. This is a voluntary role and their support to the Trust enables the views of local people to be taken account of.

As face to face events weren't possible in August, we presented each member of the 2017-20 Council with a letter from the Trust Chair and a paperweight.

Our Council from 1 September 2021

Appointed Governors (x5)

Councillor Mary Rudd, East Suffolk Council | Councillor Emma Flaxman-Taylor, Great Yarmouth Borough Council | Councillor James Reeder, Suffolk County Council | Councillor Haydn Thirtle, Norfolk County Council | Dr Neil James, UEA

Public Governors (x10)

José Bamonde | Stuart Brooks | Jim Carter | Ian Clayton | Ben Falat | Lyn Gibbs | Mike Field | Jane Harvey | Sheena McBain | Jan McCarrick

Staff Governors (x4)

Yvonne Hacon | Devender Khurana | Jane Oldman | Carol Tuck

Membership of the Council during the year and attendance at meetings is set out below. With regard to our Staff Governors, they already have a job to do and we know that it isn't always easy for them to attend every meeting. They work together, as a group, to make sure at least one of them is able to attend Council meetings and represent our staff.

Name	Job Title	06/05/2020	15/06/20	24/09/20	11/11/20	13/01/21	10/03/21	Meeting Count	% Attend
Anna Davidson	Chair	Cancelled	Y	Y	Y	Y	Y	5	100.00
Jane Harvey	Lead Governor		Y	Y	Y	Y	Y	5	100.00
Lyn Gibbs	Deputy Lead		Y	Y	Y	Y	Y	5	100.00
Jose Bamonde	Public Governor		N	Y	Y	Y	Y	4	80.00
Stuart Brooks	Public Governor		Y	Y	Y	Y	N	4	80.00
Iain Ferguson	Public Governor		Y					1	100.00
Dr Michael Field	Public Governor		A	Y	A	Y	N	2	40.00
Andrew Gowen	Public Governor		A					0	0.00
Sheena McBain	Public Governor		Y	A	Y	Y	Y	4	80.00
Jim Carter	Public Governor			Y	Y	Y	Y	4	100.00
Jan McCarrick	Public Governor		Y	Y	Y	Y	N	4	80.00
Ian Clayton	Public Governor			Y	Y	Y	Y	4	100.00
Ben Falat	Public Governor			Y	Y	Y	Y	4	100.00
Bryan Watts	Public Governor		A					0	0.00
Leigh Beuttell	Staff Governor		Y					1	100.00
Yvonne Hacon	Staff Governor			A	Y	A	Y	2	50.00
Devender Khurana	Staff Governor		Y	Y	A	A	N	2	40.00
Jane Oldman	Staff Governor			Y	Y	A	Y	3	75.00
Carol Tuck	Staff Governor			Y	Y	Y	Y	4	100.00
Emma Flaxman Taylor	Appointed Governor		Y	A	Y	Y	N	3	60.00
Neil James	Appointed Governor		Y	Y	Y	A	Y	4	80.00
James Reeder	Appointed Governor		Y	Y	Y	Y	Y	5	100.00
Mary Rudd	Appointed Governor		Y	Y	Y	Y	Y	5	100.00
Haydn Thirtle	Appointed Governor		Y	Y	Y	Y	Y	5	100.00

Our members

Anyone living in the catchment area covered by the Trust can become a member of the Public Constituency if they are aged 16 or over; our staff are automatically members unless they choose to opt out. There is a section available on the Trust's website and membership information is displayed in the hospital, with clear contact details. A Governor email address is in place.

The Council of Governors' work on membership is fully integrated with the wider Trust work on engagement with our patients, carers and the general public. Any comments that Governors receive in relation to patient care are submitted to the Head of Patient Experience and Engagement.

Membership data reports have been considered by the Governors' Review, Planning and Membership Committee or Membership Working Group on a six monthly basis to ensure that the figures remain largely representative of the local area and there is limited fluctuation. The Council and the Board usually receive an annual membership update in January.

As at 31 March 2021, the staff membership is 4,175, with the public membership at 6,709, giving a total of 10,884. This is a slight reduction on last year's figure of 10,977.

Membership strategy

With the change in the Council this year, and the impact of the pandemic, the previous membership strategy was finalised and closed. A new, short strategy and refined process for managing it was implemented in December 2020 having been approved by the Council and the Board in November.

2018-20

The previous strategy was approved by the Council and the Board in January 2018. A small number of priorities were agreed with Governor leads for all. Support for implementation was provided through the Corporate Affairs Admin Officer and the Head of Communications and Corporate Affairs (Trust Secretary).

The priorities, and the final update on success or otherwise, is set out below.

1. Enhance engagement with the Trust's membership and the wider public

a. Enhance the Governor presence by encouraging feedback and debate through effective use of the Trust's social media accounts, particularly Facebook

Closed as an action mid-strategy. Inside Story, the Governors' Newsletter, the membership newsletter Your Trust News, and other publications highlighted through Trust social media sites.

b. Maximise effectiveness of existing communication mechanisms by implementing direct e-contact through a Governors' email address governors@jpaget.nhs.uk and reviewing all membership communications and their frequency

Inbox checked daily by Corporate Affairs team Monday-Friday and email address utilised in all Governor publications. Very limited use by local people but proposed, and Committee agreed, that this is retained.

c. Implement a more strategic and consistent approach to engagement with GP Patient Participation Groups and other groups, including Healthwatch

Significant success in ensuring content included in local newsletters – Governor prepared Briefing on Council meetings or content from colourful Inside Story newsletter is generally utilised. Gorleston Community with 3,000 circulation; Village Voice 3,500; Martham Parish magazine; NR29 9,000. Contacts enhanced and information circulated, including parish councils.

Linking with GP surgery Patient Participation Groups has been a long-standing part of our Governor engagement. From initial reluctance in some practices, this link has been largely welcomed. However, engagement is variable, and some practices don't have patient groups that Governors can engage with. With the new virtual approach since the start of the pandemic this has become increasingly challenging.

Only a small number of Governors have seen real success in this engagement with only 8 of the 18 GP groups – some of whom have a number of surgeries – with details of the activity and any issues raised received by the JPUH team. All issues were dealt with, and any answers provided to specific questions or inaccuracies in perception/information clarified.

Links were established with both Suffolk and Norfolk Healthwatch and briefings and Inside Story were sent. Healthwatch is an important stakeholder for the Trust with regular meetings in place at all levels, as described earlier in this report. They are involved in discussions about patient engagement as services develop.

d. Refocus staff governors to ensure effective processes are in place to canvas staff views and support wider staff engagement improvements

Staff Governors undertook monthly sessions in the Aubergine staff restaurant, where a Governor was available to talk to any members of staff – following publication through All staff emails and posters.

This was particularly successful in the last year of the Council. Information received was passed to staff engagement leads for inclusion in planning (some issues raised in Paget's People online conversation) and the wider Norfolk and Waveney system planning where appropriate.

2. Ensure that the public and Trust members have the opportunity to engage in strategic discussion

a. Agree a process for strategic questioning and gathering of feedback

This was agreed in late 2018*: In Norfolk and Waveney we are looking for all organisations to work together much more closely – called an integrated care system – what is most important to you when you think of the healthcare you receive?*

It was used when Governors attended membership events, talked to people at PPGs etc.

This was a real success and enabled a more strategic approach and feedback from local people to be utilised in our/system planning. Sometimes Governors can get involved in personal issues, which isn't their role, and this enabled some focus to any discussion.

The new Council has considered a revised focus on quality ahead of more information being available on the planning for a new hospital and the potential for a question to be used to support this work. It will be essential to gather the views of local people on the services that patients need and this will form part of the Trust communications and engagement programme for this long term strategic project.

3. Monitor the Trust's membership data, focusing on those areas of under-representation

a. Resolve current membership data quality issues

Some improvements made to data, but there remain issues to be resolved with internal teams, which were put on hold due to the COVID-19 pandemic. Data is checked as far as possible prior to any mail out, including the recent elections – such as any Trust members who may have passed away. Data is available on an e-report, whilst work is still needed to enable hard copy reporting to Governors so they can consider it prior to their six monthly review at the membership meetings.

b. Enhance engagement with young people to ensure they have a voice in future service plans

Initial work focussed on local colleges, with events held and a small number of additional young members secured.

Data has underpinned our strategy. A decision was made to focus supermarket Meet the Governor events in three under-represented areas in the 16-35 year old group rather than just the 16-19 years. However, due to the pandemic further visits were put on hold.

Additional younger members have been seen during the summer of 2020 with completion of membership forms online during the Governor Election process. A younger Trust member stood in the Public Constituency in this summer's elections but unfortunately was not successful. It is hoped this has not put them off from standing again in the future.

c. Hold membership engagement events annually to provide opportunities to engage with Governors and to seek member/public views on strategic questions

A number of events were held during this strategy:

- Local fetes and clifftop events – important across the membership area, not just focussed on Great Yarmouth, Gorleston and Lowestoft
- Health events – visits linked to PPG engagement
- A stand in a number of libraries during 2019
- Supermarkets.

An 'aide memoire' was in place and a toolkit, led by the Deputy Lead Governor, distributed to all Governors to support their engagement in the community. All feedback received has been provided to the Head of Patient Experience and Engagement and strategic question feedback was considered at each Governors' membership meeting.

Further events that would normally be held during the summer were put on hold due to COVID-19.

4. Support continuous improvement of the patient experience

a. Undertake regular surveys under the leadership of the patient experience team
b. Bi-monthly Meet the Governor sessions held encouraging engagement and seeking views on agreed strategic questions

Discontinued mid-strategy in favour of other engagement events, mainly outside the hospital. Any concerns in relation to patient experience are dealt with through the Trust Secretary or more formally through the Non Executive Directors at Council meetings.

2020/21
In the previous strategy a more strategic approach had already been confirmed, which we wanted to continue.

A range of ideas were discussed and comments made by Governors. These can be considered as the year progresses, with two areas of focus proposed initially as well as continuing with existing member communications:

- The quality of services at our community's local hospital matters the most to patients
- Revise the strategic question for use
- Maximise individual Governors' existing networks
- Consider the e-mechanisms available to Governors to enable effective engagement – Trust Twitter/Facebook/web Q&As, MS Teams meetings – advertised in advance; video messages published on YouTube with details of how the public could engage
- A visual display in Trust reception area with 'get in touch' details
- Utilise Hospital Radio Yare to get messages out to hospital patients
- Seek support for messages to be displayed on supermarket community notice boards
- Working Group members to encourage other Governors to get involved and revise toolkits for their use – using a buddy system where that would help
- Consider enhancing liaison with Parish Councils – potentially as part of stakeholder engagement on the plans for a new hospital
- Continue to communicate with members on alternate months – with Governors' written e-Governors' News – encouraging other Governors to get involved – and the six monthly membership newsletter in hard copy to member households – recognising that not everyone is on email
- Consider Trust website home page banner and how this is used for the strategic question and feedback mechanisms.

Priorities agreed – and the actions required to achieve these:

1. **Confirm a new strategic question to engage with and gather feedback from Trust members, Governors' networks and local people**

    a. Refine the seven potential survey questions for next year's Quality Priorities and ask one question, focussed on *what good care looks like for individuals*

    b. Review personal details forms and maximise Governors' existing networks

    c. Membership toolkits and support to be revised and a buddy system implemented where required

    d. Agree a process for comments to be logged and feedback to be provided to the Trust Secretary's office.

2. **Enhance virtual engagement through trialling a virtual Q&A/feedback session on the Trust's Facebook**

    a. Once strategic question confirmed, agree participants, focus of first ½ hour event, and publicity - Trust Secretary and a maximum of two Governors

    b. Provide training session on how engagement will operate

    c. Review effectiveness, and plan next steps.

3. **Continue preparation of existing membership communications**

    a. Confirm timing of issues

    b. Widen participation in content preparation to e-Governors' News to all Governors.

Progress on the new strategy is being overseen by the Membership Working Group. It has been challenging this year, with regulatory direction that Governor engagement should be focussed on COVID-19.

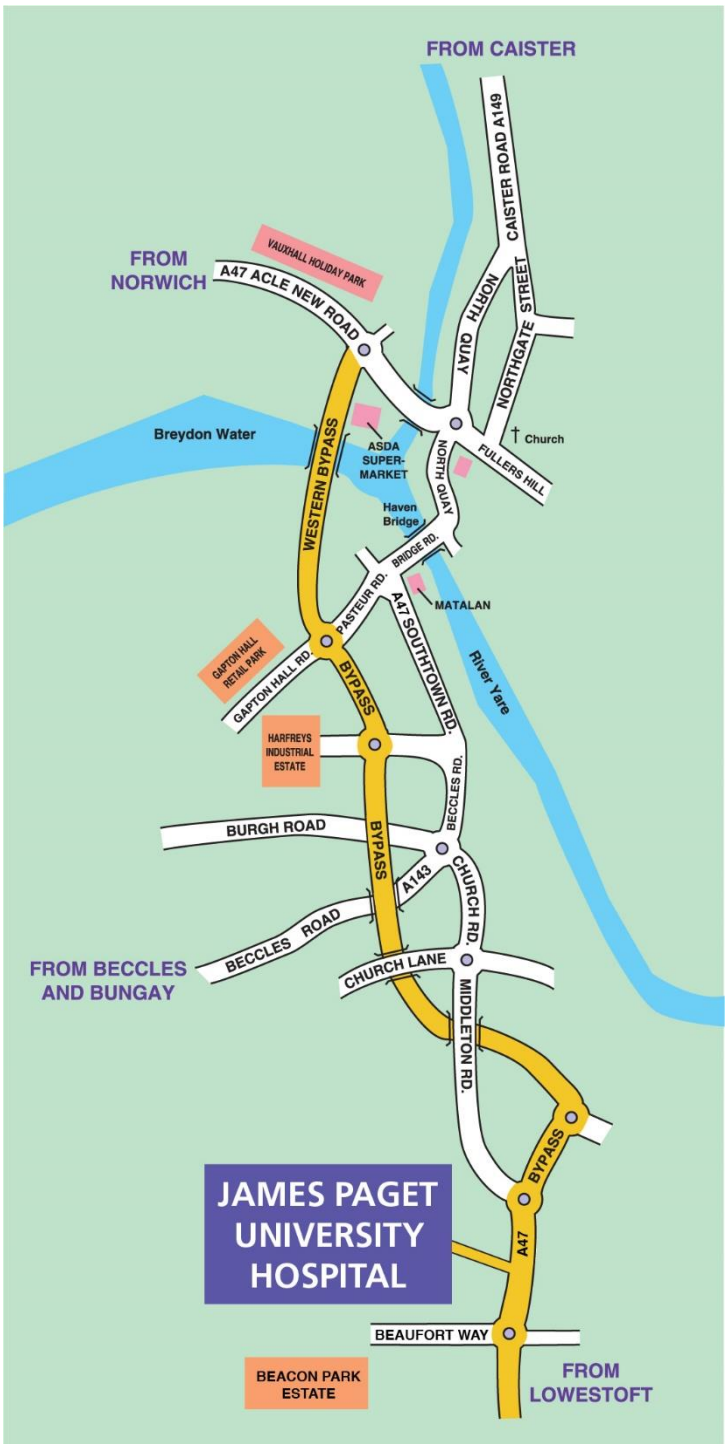
A virtual event was planned for January 2021 but postponed due to the second wave and the pressure that the hospital and the country was facing with increased numbers of patients testing positive for the virus. The country was also in a national lockdown at that time.

Early in April 2021, the priorities were reviewed and a number of actions have been agreed, including planning for a virtual event during May.

Glossary/Abbreviations

A&E	Accident and Emergency, part of the Emergency Department
Acute	Rapid onset, severe symptoms and brief duration
Audit	A continuous process of assessment, evaluation and adjustment
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
CDEL	Capital Departmental Expenditure Limit
CQC	Care Quality Commission
Capital	Spending on land and premises and provision, adaptation, renewal, replacement or demolition of buildings, equipment and vehicles
CiC	Committees in Common
DHSC	Department of Health and Social Care
ED	Emergency Department
EPRR	The NHS Emergency Preparedness Resilience & Response Framework
FTSU	Freedom to Speak Up
GPs	General Practitioners
HMB	Hospital Management Board
HSS	Hospital Services Strategy
Inpatient	A patient admitted to hospital for a period of treatment or to undergo an operation, staying in hospital for 24 hours or more
ICS	Integrated Care System
JCVI	Joint Committee on Vaccination and Immunisation
JPUH	James Paget University Hospitals NHS Foundation Trust
KPIs	Key Performance Indicators
NED	Non Executive Director
N&R	Nomination and Remuneration
N&W	Norfolk and Waveney
NHSE/I	NHS England/NHS Improvement, regulatory oversight of all NHS organisations foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care
NMAHP	Nursing, Midwifery and Allied Health Professions - research
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
Outpatient	Provided on an appointment basis without the need to be admitted to or stay in hospital
PALS	Patient Advice and Liaison Service
PDC	Public Dividend Capital
PPE	Personal protective equipment used during the COVID-19 pandemic
PPG	Patient participation group
PSF	Provider Sustainability Funding
QEH	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT	Referral to Treatment
SOC	Strategic Outline Case
SPTG	ICS N&W Strategic Planning & Transformation Group
STP	Sustainability and Transformation Partnership – the Norfolk and Waveney Health and Care Partnership
UoR	Use of Resources
UEA	University of East Anglia
VSM	Very Senior Manager
WTE/FTE	Whole time/full time equivalent (staffing)

Useful contacts and how to get here



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#PROUD OF THE PAGET

NHS
James Paget University Hospitals
NHS Foundation Trust

Financial Statements

for the year ended 31 March 2021

Contents

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of the James Paget University Hospitals 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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require the James Paget University Hospitals 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 James Paget University Hospitals NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

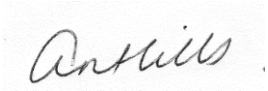
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable 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 NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is 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.



Chief Executive
15 June 2021

Annual Governance Statement

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 James Paget University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has in place a Risk Management and Assurance Strategy which makes it clear that overall leadership and responsibility for risk management is placed with the Chief Executive. The Audit Committee receives reports and assurance from the directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. In addition, responsibility for specific risk management areas has been assigned to the following key Committees and Groups;

- Audit Committee;
- Patient Safety and Quality Committee;
- Finance and Performance Committee;
- People and Culture Committee;
- Hospital Management Board;
- Patient Safety and Effectiveness Committee;
- Health & Safety and Staff Welfare Committee;
- Fraud Risk Group;
- Information Governance Committee;
- Hospital Infection Control Committee;
- Carer and Patient Experience Committee;
- Safeguarding Committee;
- Divisional Boards; and
- Divisional Governance Groups.

The Trust has a Clinical Quality Risk Assessment (CQRA) process in place to ensure that any new change project, whether arising from cost saving initiatives or otherwise, has been rigorously assessed for the impact on the quality of patient services. All CQRAs are signed off by the Director of Nursing and Medical Director before changes are implemented.

The Strategy also identifies individual Executive Directors, Deputy Directors, Divisional Directors, all managers and all employees and clearly defines their role and responsibilities within the risk management framework. The Board of Directors has clearly articulated that it has no appetite to tolerate any extreme risks on the risk register and worked under the following Risk Appetite statement during 2020/21:

> "The Trust has the lowest tolerance for risks that negatively impact on patient safety; this includes risks to achieving national minimum safe staffing levels applicable at any given time. The Trust has a greater appetite to take considered risks in relation to areas that provide potential benefits for patients. The Trust has the greatest appetite to pursue innovation, challenge current working practices and take opportunities where there are anticipated benefits for our local population, whilst operating within appropriate governance arrangements and regulatory constraints, and accepting potential reputational risks."

In addition, the Trust also included the following statement in relation to its strategic ambitions:

> "The Trust will ensure that patients are at the centre of what we do and will not by choice introduce service changes or risks that negatively impact on patient safety. As a minimum, the Trust will always maintain the applicable national safe staffing levels as set by NHS England/NHS Improvement. However, the Trust recognises that in a financially challenged NHS and/or during a national emergency such as the Covid-19 pandemic, the need to work differently and reconfigure services may have a negative impact on patient safety as well as the patient's view of their experience. We will robustly assess risks using our risk assessment processes where local circumstances require deviation from nationally imposed minimum standards".

Monthly reporting to the Board of Directors focusses on any extreme risks and the actions being taken to mitigate them. The Trust's Board Assurance Framework sets out the principal risks to delivery of its strategic objectives. Regular review of the Board Assurance Framework is undertaken which includes an analysis of whether achievement of the strategic objectives is on track and if not, whether the Board has the appetite to refocus priorities in order to ensure compliance. From January 2021 the monthly meeting schedule was amended to enable Board Committees to consider the BAF and make changes prior to its presentation to the Board. The aim is to ensure that this document is more dynamic and supports agenda planning more effectively.

A range of risk management training is provided to staff and there are policies in place to describe their roles and responsibilities in relation to the identification and management of risk. The Trust records and manages incidents using a computer software package called Ulysses. During 2020/21 the Trust also adopted this software to provide a full web-based management system for the corporate risk register, specifically designed to record and track progress of risks electronically in real time. Nominated key staff are responsible for ensuring this system is kept up to date.

An introduction to the Ulysses reporting system is provided for staff at induction together with information on what should be reported and when. This is supplemented by bespoke training sessions for individuals, departments and staff groups upon request or if deemed necessary following incidents. Periodically awareness raising is also undertaken in relation to incident reporting including when new national guidance is issued, such as for Never Events. All incidents are fully investigated and ways to cascade the learning are included in action plans signed off and monitored at Divisional level. During the year, the Trust also provided bespoke training sessions to accompany the launch of Ulysses for full management of the risk register.

All relevant policies are available on the Trust's intranet. Written guidelines are also disseminated, covering all components of risk management.

The risk and control framework

The James Paget University Hospitals NHS Foundation Trust's integrated Risk Management and Assurance Strategy is reviewed by the Audit Committee and the Patient Safety and Quality Committee. The Risk Management and Assurance Strategy and associated policies set out the key responsibilities for managing risk within the organisation, including the ways in which the risk is identified, evaluated, updated and controlled.

All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. Local Clinical Governance and Risk Groups are responsible for identifying and managing local risks and overseeing the management of adverse incidents. Management teams are responsible for reviewing risk mitigation action plans and ensuring they are implemented through business planning and other established routes.

The Board of Directors has delegated responsibility to the Audit Committee for monitoring and reviewing risk processes. Other key features include:

- There is an integrated reporting system for all types of adverse incident;
- There is a requirement for identification within terms of reference of all committees, action groups and other working groups for every type of risk and adverse event to be reported;
- The Audit Committee and all other Board Committees receive reports and instigate action to deal with risks which have been identified; and
- There is a full risk register which is available at each meeting of the Board of Directors, and extreme risks, any Covid-19 specific risks, and any changes to the risks within the register over the previous month are highlighted.

The Trust's Board Assurance Framework sets out the principal risks to delivery of its strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key priorities and objectives. The principal risks to the delivery of these objectives are mapped to key controls. The Board of Directors requires both the assurance that the Board Assurance Framework identifies those actions required to address gaps in control and assurance, and the development and implementation of action plans.

Risk appetite and tolerance of risk is determined via a risk estimation matrix which has been developed for use throughout the Trust for identifying risks, maintaining progress and monitoring the risk register and plans. The Trust's risk management approach establishes the appetite for risk, and also determines whether risks are to be tolerated or not. Where it is determined that risks are to be managed, priorities are assigned with resources and timescales for remedial action. The full risk register is available to the Board of Directors at each meeting. All Board Committees review high and extreme risks at each meeting and approve all additions, closures and amendments to the corporate risk register. The Audit Committee reviews and receives assurance at each meeting from the relevant Executive Director in relation to the key risks to their portfolio annually on a rolling basis.

Issues related to data security and general cyber security are monitored through the IT Security Committee which reports to the Information Governance Committee, which in turn reports to the Finance and Performance Committee. Risks and adverse incidents are reviewed at every meeting of the Information Governance Committee.

In relation to the risks around European Union Exit, the Trust received regular correspondence and advice from co-ordinating national NHS bodies. The Trust completed risk assessments which were subject to regular review by the Board of Directors through the risk register. The Trust complied with all guidance issued by the Department of Health and Social Care on this matter throughout the transition period and subsequently.

The Trust has an overarching People Strategy which looks to the medium and long term workforce planning and supply. This is supported by the Trust's strategic ambitions and objectives. Specifically the Trust has invested in digitising its workforce systems, and 2020/21 has seen the further rollout of e-Roster and e-Job planning systems. In terms of operational assurance, daily dynamic risk assessment reviews are undertaken for nursing and allied health professionals to ensure suitable and safe staffing levels. The Trust undertakes regular establishment reviews underpinned by national guidance, best practice and professional judgement and provides significant assurance to the Board of Directors via dedicated reports which are in the public domain.

Developing Workforce Safeguards (NHSI 2018) sets out a clear accountability framework for NHS organisations in relation to expectations for the delivery of best practice standards for workforce deployment and planning. A gap analysis has taken place at the Trust to ascertain compliance with the recommendations in relation to the nursing workforce. The current position has been highlighted to the Board of Directors in public. The Board of Directors also receives a report from the Medical Director with respect to recruitment challenges and solutions regarding the medical workforce.

The Trust is well represented at its Local Workforce Action Board and is working with local STP partners exploring opportunities for future workforce development. The Digital Workforce Team are also leading system wide projects on bank and agency collaboratives.

The Trust undertakes an active Organisational Development programme to talent map and develop our future leadership.

In 2020/21, the Trust continued with a comprehensive mental health improvement programme for both patients, visitors and staff. The programme covers five work streams across the organisation which include: Staff Mental Wellbeing & Experience, Patient & Staff Safety, Staff Education & Training, Carer & Patient Experience and Patient Pathway. This has now become integrated into the Trusts Wellbeing Programme developed to support staff during and post pandemic.

The Trust also has a Staff Engagement & Wellbeing Manager. This role is an important conduit between staff and the Trust, spending dedicated time engaging, listening and speaking to staff. The role has concentrated in identifying and reaching "hard to reach" staff groups across the Trust. The Board has introduced new staff engagement methods including a new online digital platform called 'Paget's People', where questions can be posted and staff can freely respond to with ideas and comments. Additionally, the Trust is encouraging feedback from all staff through listening events and regular pulse surveys.

The Trust has a Freedom to Speak Up (FTSU) service with a dedicated Lead FTSU Guardian who reports in line with publications from the National FTSU Guardian's office, and presents at public Board meetings on a six monthly basis. A lead Non Executive Director for FTSU is also in place.

The Chief Executive has signed the Time to Change Employer Pledge, a national movement working towards eliminating discrimination and stigma in mental health, demonstrating that the Trust is an organisation which is taking positive action towards improving mental health interventions for staff. The Trust has also put in place during 2020/21, a new Inclusion Network to promote equality, diversity and inclusion. The aim of the network being to encourage diversity and address any areas of discrimination and inequality.

The Trust has recruited and trained 25 Wellbeing Champions located in a wide range of areas across the organisation. The Wellbeing Champions have all received training in Mental Health First Aid and play an important role in providing a listening ear to staff, and signposting them to a range of wellbeing events throughout the year.

The Board of Directors receives a monthly report of Care Hours per Patient Day (CHPPD) actual versus required, which reflects nursing hours only. This is one of many tools utilised by the Board to monitor safe staffing levels across all areas of the Trust.

On 30 January 2020, national NHS leaders declared coronavirus a serious, level 4 incident, and by mid-March 2020 the Trust was responding to COVID-19 as a major incident under the Trust's Emergency Planning, Resilience and Response (EPRR) Strategy. The Trust adapted the ways in which services were provided to patients, and temporarily ceased the provision of service in some cases. This process was replicated to a varying extent as the Trust experienced the second wave of COVID-19 hospital admissions during the winter of 2020/21. Interim governance and assurance arrangements were put in place for the Board of Directors and these were reviewed on a monthly basis throughout 2020/21, ensuring that the Board was fully appraised of the latest national and regulatory position in relation to the pandemic and that assurance processes remained effective. This included moving to virtual meetings rather than face to face, with business critical agenda items only during some parts of the year, and specific focus on how assurances could be most efficiently provided.

A significant operational effort was made by the Trust to recognise, record and mitigate new and emerging risks on a daily basis, responding to local, regional and national issues. Actions were taken to manage the flow of COVID-19 patients through the hospital, including reconfigurations to the Trust's estate. Where possible, homeworking was introduced with the accelerated deployment of IT hardware and software, and where not possible measures taken to implement social distancing for staff. The Trust adapted systems for the testing of patients and staff as priorities and capacity changed. Services to outpatients were transformed by the rapid introduction of virtual outpatient clinics.

During the emergency response phase, COVID-19 risks were dynamic as the pattern of the spread of the disease unfolded regionally and nationally. Therefore the Trust's contingency plans were adapted accordingly, including involved assessment of capacity around ventilators, oxygen supply, ICU capacity, staffing, provision of Personal Protective Equipment (PPE), and the reconfiguration of the Trust's estate to safely care for Covid and Non-Covid patients.

The Trust has an overarching risk assessment relating to the management of the COVID-19 pandemic, and also where the Trust has identified more specific high or extreme risks related to the management of COVID-19, these have been recorded as separate risk register entries. These risks are reviewed weekly and approved monthly by the Board of Directors.

The Board has direct oversight of all extreme risks. As of 31 March 2021 there were two non-COVID-19 extreme risks identified by the Trust on its risk register.

Risk	Mitigation
Patients on Referral to Treatment (RTT) pathways may be at risk of harm due to excessive waiting times due to COVID-19 pandemic.	• Improvement in compliance with Clinical Harm Review Policy to ensure patients on the waiting list have a Clinical Harm Review undertaken; • Shared decision-making as part of clinical prioritisation and e-Reviews; • Regional directive to reduce elective activity to support higher priority patients including clinically urgent and cancer patients; • All patients on admitted waiting list to be allocated new priority code. • Clinical harm Review at key points on pathway. Fortnightly meetings with clinical leads, chaired by the Medical Director; • Clinical Priority scores being reviewed by clinicians; • Clinical harm review program is in place and visible to management and Strategic Risk Group. Divisional Operations Directors (DODs) and Divisional Operational Managers (DOMs) fully engaged with clinical harm process; • Final clinical priority scores being added to inpatient/day case wait lists for booking by clinical need.
Patients, Visitors and Staff may be harmed by falling Reinforced Aerated Autoclaved Concrete (RAAC) roof panels	• Completion of laser level surveys to the underside of each of the RAAC roof plank to establish the deflection profile and therefore risk profile of all areas of the affected roof structure; • Structural Engineer professional advisers have completed a review of the available level survey information and have agreed on a proposed action plan for recording and monitoring the condition of all RAAC planks; • Structural engineers commissioned to provide an assessment of end point failure risks with proactive timber structural supports advised; • Safety props installed where reinforcement was required as a precautionary interim measure until permanent steel support is installed; • Initial remedial works plan completed; • The roof structure has been relieved of excessive plant loads where possible; • Additional signage for roof areas now include laminated signs for contractors and visitors regarding weight restrictions.

The Trust records and manages risks and incidents using the computer software package provided by Ulysses (Safeguard), specifically designed to record and track progress electronically in real time and nominated key staff are responsible for ensuring this system is kept up to date. As described above, there is an extensive training and awareness programme in place which has fostered a culture where incident reporting is encouraged. The Trust reported 85 Serious Incidents (SIs) during 2020/21. Of these SIs, 31 were due to 12-hour emergency department attendance breaches, 12 were related to infection control including COVID-19, and 42 relating to other factors comparable to the total number reported in 2019/20 of 41. All SIs were subject to full root cause analysis investigation and actions have been taken to prevent recurrence. The most recent report from the National Reporting and Learning System shows that for incidents reported between 1st April 2019 and 30th September 2019 that there is no evidence for potential under-reporting at the Trust, which means that the level of reporting is what is expected of a Trust of this type and size.
Public Stakeholders are involved in managing risk which impacts on them, including the following organisations and forums:

- There are Foundation Trust meetings at all levels with members of the Trust's lead Clinical Commissioning Group at which risk is assessed;
- Health Overview and Scrutiny Committees;
- Partnership working with Social Services; and
- Joint working with other Trusts i.e. Norfolk & Norwich University Hospitals NHS Foundation Trust, East of England Ambulance Service NHS Trust, Norfolk and Suffolk NHS Foundation Trust, Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and East Coast Community Health Community Interest Company.

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

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

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

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

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

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

The internal audit work methodology highlights areas as advisory where inefficiencies or good practice have been identified.

The Trust has in place a Local Counter Fraud Specialist whose work plan includes providing information to and engaging with staff, prevention through the work of the Fraud Risk Group, including fraud specific risk assessments, and holding to account through investigations. The Counter Fraud Standards Self Review Toolkit has been replaced in 2020/21 by Government Functional Standard on Counter Fraud. 2020/21 is considered to be a baseline year for the new standards, with improvements expected via implementation of an action plan during 2021/22. Ahead of the submission of the Government Functional Standard on Counter Fraud on 31st May 2021, the draft self-assessment shows two red, eight amber and two green ratings against the twelve standards.

The delivery of efficiency savings was suspended under the interim financial regime put in place during 2020/21 due to the Covid-19 pandemic. The Trust’s usual transformation methodology and approach identifies and highlights any potential for the furtherance of economy, efficiency and effectiveness and is balanced and further assured through the clinical quality risk assessment process.

The Board of Directors receives assurances on the use of resources from agencies outside the Trust including NHSEI. NHSEI requires the Board of Directors to self-assess, and scores the Trust in accordance with the Single Oversight Framework. The Trust has a rating of 'good' following its most recent use of resources CQC inspection during 2019. Whilst the CQC inspection regime and other external assurance frameworks were suspended due to the Covid-19 pandemic, other sources of assurance usually include reviews conducted by Royal Colleges and Getting it Right First Time (GIRFT).

The Trust further obtains assurance of its systems and processes and tests efficiency through benchmarking by membership of NHS Providers and the NHS Benchmarking Network where other bodies share good practice. Also, the Trust continues to participate in the nationally mandated cost collection exercise which, amongst other purposes, provides information on the relative efficiency and assessment of productivity. Whilst some cost data has been published during the year (relating to 2019/20) a National Cost Collection Index (NCCI) score has not yet been released. The Trust's most recent NCCI score of 103 relates to 2018/19 data.

NHS England and NHS Improvement's drive to implement the recommendations from Lord Carter of Coles report on unwarranted variation provides another source of benchmarking assurance through the data published in Model Hospital. The Trust has in place governance arrangements to oversee internal projects to implement recommendations as and when new information is released to the Model Hospital portal.

The Board of Directors receives a monthly report of Care Hours per Patient Day (CHPPD) actual versus required, which reflects nursing hours only. This is one of many tools utilised by the Board to monitor safe staffing levels across all areas of the Trust.

Information Governance

During the year 2020/21 the Trust had no serious incidents relating to information governance, which is in line with 2019/20 and reflects the Trust's continued vigilance.

The General Data Protection Regulations (GDPR) have applied since 25 May 2018 and the Trust has been compliant with these regulations. A detailed review of the Trusts GDPR Programme was performed by the Trust's internal auditors during 2018/19 and they identified areas of good practice and highlighted areas for improvement. The Trust continues to embed good practice.

The Trust has retained its Cyber Essentials Plus certification, and also its DCB1596 secure email standard O365 accreditation.

Data Quality and Governance

The directors take steps to satisfy themselves that:

- the performance information reported is reliable and accurate;
- there are proper internal controls over the collection and reporting of measures of performance, and these controls are subject to review to confirm that they are working effectively in practice; and
- the data underpinning the measures of performance is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The systems in place to collect and report on quality metrics culminate in a detailed performance, quality and safety report which is presented at each public Board meeting. Each key performance indicator (KPI) that the Board monitors is assigned to a Committee of the Board whose work plan is shaped around the key risks and these KPIs. There are monthly performance meetings between the Executive and Divisional Management focussing on quality and performance metrics. Reporting by clinical divisions to Patient Safety and Effectiveness Committee, Health & Safety and Staff Welfare Committee, and the Carer and Patient Experience Committee also maintains oversight of the key priorities for Quality as per the Quality Report throughout the year. Progress on quality priorities is also presented to the Board quarterly.

The Trust developed a Quality Improvement Strategy for 2018–23 which is aligned to the Trust's over-arching five-year strategy. The key priorities for quality each year are designed to deliver the aims of the Quality Improvement Strategy and divisional reporting to the executive committees is designed to demonstrate progress with achievement of these aims and objectives. A suite of policy documents are in place and available to staff via the Trust's intranet to support delivery of the Trust's Quality Strategy.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and the Patient Safety and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed through confirmation by NHS Improvement on the Trust's compliance with its Single Oversight Framework, which aims to set out the amount of support Trusts require from the regulator. Throughout the year the Trust has been classified as being within segment 2, where segment 1 gives Trust's the maximum autonomy and segment 4 the least.

The Board of Directors reviewed the 2020/21 Board Assurance Framework throughout the year, and received regular reports on risk management, performance management and clinical governance. The Trust had 4 strategic ambitions, 22 individual objectives, and 53 indivudually rated measures of success. Whilst good progress has been made with the majority of objectives being either partially or fully achieved, 9 out of the 53 measures remain as 'red' rated at the end of the year, largely due to the second wave of the pandemic having a detrimental effect on delivery. These red rated measures include reducing the number of patients waiting for treatment, compliance with targets on mandatory training and staff appraisal, further developing education and training plans, , the appointment of a group Director of People and Culture, produce a full business case for the system-wide Electronic Patient Record project, and development of a clinical strategy.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance and internal financial control within the Trust. The Committee has received reports from external and internal audit. Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Committee. The work included identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. When scope for improvement was found, recommendations were made and appropriate action plans were agreed with management.

The internal audit programme was developed by the Trust's internal auditors on a risk based approach in consultation with the Trust's Executive Team and Audit Committee. The internal audit programme involved reviews in areas considered by the Trust to be higher risk, including operational areas which had not previously been audited, and from emerging in-year risks from which the Trust would gain the most value from the audit work. This included consideration of new risks associated with the Trust's response to the COVID-19 pandemic.

As well as approving the internal audit plan, the Audit Committee has also received a report detailing the alternative sources of assurance on the risks not covered by the internal audit programme, and a separate independent review of the governance, processes and controls in place for controlled drugs at the Trust. This review followed a number of controlled drugs incidents since April 2020, and the report findings did not specifically identify any actual instances of misuse of controlled drugs within the Trust. There were however a number of recommendations made to enhance the control environment.

A review of Data Protection Security Toolkit commissioned by NHS Digital meant that an internal audit review of the toolkit was not required during 2020/21. The draft independent report produced by MIAA Assurance in April 2021 states that the assurance level in respect of the veracity of the Trust's self-assessment under the toolkit is "substantial".

The internal auditors carried out a review of the Trust's key financial systems during 2020/21 which was rated as low risk overall, containing one medium and two low risk findings. An internal audit review of the Trust's arrangements around Duty of Candour produced an overall report classification of medium risk, with one high, one medium and one low risk audit finding, together with one further advisory point. The high risk finding was to do with compliance with Duty of Candour regulations, where, based on a sample of cases reviewed, both timing delays and other control design weaknesses were identified.

The internal audit programme was directed to review two areas related to the Trust's response to the COVID-19 pandemic: a review into IT Remote Working, and a review of Covid Risk Assessments for Staff. The IT Remote working review produced three medium and one low risk audit findings, and a medium risk rating overall. All of the recommendations from this review will contribute towards the wider security and control environment as well as remote working. The review into Covid Risk Assessments for Staff produced two medium risk audit findings, and an overall low risk rating.

The Trust acknowledges the findings from all internal audit reviews, and continues with the process of implementing the associated recommendations. All agreed action plans are monitored by the Trust's Audit Committee to ensure actions are taken within the agreed timescales.

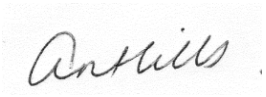
The Trust has a well developed Clinical Audit Forward Plan which is based upon prioritised audits to ensure national recommendations are embedded as well as the learning from significant events. The Clinical Audit Forward Plan has been monitored by the Board of Directors and has remained on track throughout the year.

The CQC's most recent assessment of the Trust was in December 2019 and included a rating of 'good', for Effective, Caring and Well Led domains. The Trust was rated as 'outstanding' under the Responsive domain, and 'requires improvement' under the Safe domain. The Trust also received a Use of Resources assessment in 2019 of 'good', meaning that the Trust's combined rating for quality and use of resources was also assessed as 'good' overall. Whilst this overall rating remained the same as it was previously assessed in December 2018, there were many improvements, and the areas which were previously rated as 'requires improvement' were not re-inspected in 2019.

Internal Audit have completed their program of internal audit work for the year ended 31 March 2021. Their work identified two high risk findings as described, alongside other low and moderate risk findings. Based on the work they have completed, the main opinion of Internal Audit is "Generally satisfactory with some improvements required". Governance arrangements, risk management processes and internal controls in relation to business critical areas are generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

Conclusion

As described throughout the governance statement above, the Trust is aware of its internal control issues and the Board has responded to all the final reports issued and has developed action plans with clear ownership of the issues together with its regular review of governance. This review has identified no significant internal control issues.



Chief Executive
15 June 2021

Independent Auditor's Report to the Council of Governors of James Paget University Hospitals NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of James Paget University Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trusts Statements of Financial Position, Group and Trusts Statement of Changes in Taxpayers Equity and Group and Trusts Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and Trust's ability to continue as a going concern for the going concern period.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the Group and Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group and Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that additional funding was claimed inappropriately through the extra resources made available as a result of Covid-19 and the risk that the Group and Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and provisions.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of Group and Trust-wide fraud risk management controls.

We also performed procedures including Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included:

- Unexpected postings to cash, revenue and expenses codes;
- Journals containing certain words in the description;
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the existence of income recognised with specific emphasis placed on cut-off. This included:
  - Sample testing of year end income accruals;
  - Review and sample testing of income recognised either side of year-end
- Assessing the appropriateness of expenditure recognised with specific emphasis placed on cut-off. This included:
  - Sample testing of year-end accruals and provisions including consideration of year on year movements;
  - Review of year-end journals posted to increase expenditure accounts;
  - Sample testing of invoices and bank payments post year-end;

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Group's and Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group and Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group and Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group and Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities. www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Group and Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Group and Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006;
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Group and Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Group and Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Group and Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Group and Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of James Paget University Hospitals NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

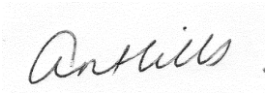
SBeavis

Stephanie Beavis
for and on behalf of KPMG LLP
Chartered Accountants
Dragonfly House
2 Gilders Way
Norwich
NR3 1UB
17 June 2021

Foreword to the Accounts

James Paget University Hospitals NHS Foundation Trust

These accounts for the year ended 31 March 2021 have been prepared by the James Paget University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.



Chief Executive
15 June 2021

Statement of Comprehensive Income

	Note	**Group Year Ended 31 March 2021 £ 000**	Group Year Ended 31 March 2020 £ 000	**Trust Year Ended 31 March 2021 £ 000**	Trust Year Ended 31 March 2020 £ 000
Operating income from continuing operations	4.2	**256,451**	225,729	**255,872**	225,714
Operating expenses of continuing operations	5	**(254,981)**	(230,033)	**(254,783)**	(229,691)
Operating (deficit)		**1,470**	(4,304)	**1,089**	(3,977)
Finance costs					
Finance income	8	**35**	226	**4**	131
Finance expense - financial liabilities	9 & 21.1	**(220)**	(316)	**(220)**	(316)
Public Dividend Capital - dividends payable		**(816)**	(928)	**(816)**	(928)
Net finance costs		**(1,001)**	(1,018)	**(1,032)**	(1,113)
Gains/(losses) of disposal of assets		**(14)**	(22)	**(14)**	(22)
(Deficit) for the year		**455**	(5,344)	**43**	(5,112)
Other comprehensive income					
Impairments		**(321)**	(305)	**(321)**	(305)
Revaluations		**415**	783	**415**	783
Fair Value gains/(losses) on Available-for-sale financial investments		**336**	(258)	**-**	-
Total comprehensive income/(expense) for the year		**885**	(5,123)	**137**	(4,634)

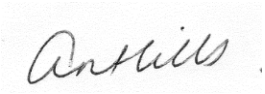
All income and expenditure is derived from continuing operations, and all surplus and comprehensive income / expense is attributable to the owners of the parent.

The accompanying notes on pages 20 to 52 form part of these accounts.

Statement of Financial Position

	Note	Group As at 31 March 2021 £ 000	Group As at 31 March 2020 £ 000	Trust As at 31 March 2021 £ 000	Trust As at 31 March 2020 £ 000
Non-current assets					
Intangible assets	12	**4,068**	2,643	**4,068**	2,643
Property, plant and equipment	13	**67,588**	57,861	**67,588**	57,861
Other investments	13.5	**2,426**	2,330	**-**	-
Trade and other receivables	15.2	**303**	405	**303**	405
Total non-current assets		**74,385**	63,239	**71,959**	60,909
Current assets					
Inventories	14.1	**3,029**	3,087	**3,029**	3,087
Trade and other receivables	15.1	**10,416**	14,835	**10,410**	14,894
Cash and cash equivalents	16	**26,708**	7,678	**25,908**	7,475
Total current assets		**40,153**	25,600	**39,347**	25,456
Current liabilities					
Trade and other payables	17.1	**(30,482)**	(20,091)	**(30,466)**	(20,085)
Borrowings	19.1	**(1,521)**	(8,762)	**(1,521)**	(8,762)
Provisions	21.2	**(603)**	(198)	**(603)**	(198)
Other liabilities	17.3	**(1,912)**	(369)	**(1,912)**	(369)
Total current liabilities		**(34,518)**	(29,420)	**(34,502)**	(29,414)
Total assets less current liabilities		**80,020**	59,419	**76,804**	56,951
Non-current liabilities					
Trade and other payables	17.2	**(3)**	(3)	**(3)**	(3)
Borrowings	19.2	**(5,142)**	(5,948)	**(5,142)**	(5,948)
Provisions	21.3	**(1,311)**	(1,314)	**(1,311)**	(1,314)
Total non-current liabilities		**(6,456)**	(7,265)	**(6,456)**	(7,265)
Total assets employed		**73,564**	52,154	**70,348**	49,686
Financed by taxpayers' and others' equity					
Charitable funds reserves		**3,216**	2,468	**-**	-
Public dividend capital		**71,387**	50,862	**71,387**	50,862
Revaluation reserve	22	**4,323**	4,229	**4,323**	4,229
Income and expenditure reserve		**(5,362)**	(5,405)	**(5,362)**	(5,405)
Total taxpayers' and others' equity		**73,564**	52,154	**70,348**	49,686

The financial statements on pages 16 to 52 were approved by the Board on 15 June 2021 and signed on its behalf by:



Chief Executive

Director of Finance

The accompanying notes form part of these financial statements.

Consolidated Statement of Changes in Taxpayers' Equity

	Public Dividend Capital £ 000	Revaluation Reserve £ 000	Income and Expenditure Reserve £ 000	Trust Total £ 000	Charitable Funds Reserves £ 000	Group Total £ 000
Taxpayers' equity at 1 April 2020 as stated	50,862	4,229	(5,405)	49,686	2,468	52,154
Taxpayers' equity at 1 April 2020	50,862	4,229	(5,405)	**49,686**	2,468	**52,154**
Surplus/(Deficit) for the year	-	-	(535)	**(535)**	990	**455**
Impairments	-	(321)	-	**(321)**	-	**(321)**
Revaluations - property, plant and equipment	-	415	-	**415**	-	**415**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	336	**336**
Other - charitable funds consolidation	-	-	578	**578**	(578)	**-**
Public Dividend Capital received	20,525	-	-	**20,525**	-	**20,525**
Taxpayers' equity at 31 March 2021	**71,387**	**4,323**	**(5,362)**	**70,348**	**3,216**	**73,564**
Taxpayers' equity at 1 April 2019	50,488	3,751	(293)	**53,946**	3,182	**57,128**
Surplus/(Deficit) for the year	-	-	(5,837)	**(5,837)**	269	**(5,568)**
Impairments	-	(305)	-	**(305)**	-	**(305)**
Revaluations - property, plant and equipment	-	783	-	**783**	-	**783**
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	**-**	(258)	**(258)**
Public Dividend Capital received	374	-	-	**374**		**374**
Other - charitable funds consolidation	-	-	725	**725**	(725)	**-**
Taxpayers' equity at 31 March 2020	**50,862**	**4,229**	**(5,405)**	**49,686**	**2,468**	**52,154**

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 and Social Care 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.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 29.

The accompanying notes form part of these financial statements.

Consolidated Statement of Cash Flows

	Group Year Ended 31 March 2021 £ 000	Group Year Ended 31 March 2020 £ 000	Trust Year Ended 31 March 2021 £ 000	Trust Year Ended 31 March 2020 £ 000
Cash flows from operating activities				
Operating surplus/(deficit) from continuing operations	**1,470**	(4,304)	**1,089**	(3,977)
Operating surplus	**1,470**	(4,304)	**1,089**	(3,977)
Non-cash income and expense:				
Depreciation and amortisation	**8,106**	5,248	**8,106**	5,248
Impairments	**2,746**	6,465	**2,746**	6,465
Income recognised in respect of capital donations	**(651)**	-	**(504)**	-
(Increase)/decrease in trade and other receivables	**4,361**	(2,287)	**4,437**	(2,127)
(Increase)/decrease in Inventories	**58**	(145)	**58**	(145)
Increase/(decrease) in trade and other payables	**5,510**	(267)	**5,510**	(267)
Increase/(decrease) in other liabilities	**1,544**	286	**1,544**	286
Increase/(decrease) in provisions	**410**	(19)	**410**	(19)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**293**	233	**-**	-
Other movements in operating cash flows	**-**	128	**-**	128
Net cash generated from operating activities	**23,848**	5,339	**23,396**	5,592
Cash flows from investing activities:				
Interest received	**4**	131	**4**	131
Purchase of intangible assets	**(951)**	(793)	**(951)**	(793)
Purchase of property, plant and equipment	**(15,429)**	(2,404)	**(15,429)**	(2,404)
Receipt of cash donations to purchase capital assets	**325**	-	**180**	-
Net cash (used in) investing activities	**(16,051)**	(3,066)	**(16,196)**	(3,066)
Cash flows from financing activities:				
Public dividend capital received	**20,525**	374	**20,525**	374
Movement in other loans	**(58)**	(129)	**(58)**	(129)
Loans repaid to the Department of Health	**(7,271)**	(961)	**(7,271)**	(961)
Capital element of finance lease rental payments	**(1,046)**	(1,201)	**(1,046)**	(1,201)
Interest paid on Loans	**(32)**	(129)	**(32)**	(129)
Interest element of finance lease	**(219)**	(183)	**(219)**	(183)
PDC Dividend paid	**(667)**	(1,134)	**(667)**	(1,134)
Net cash (used in) financing activities	**11,232**	(3,363)	**11,232**	(3,363)
Increase/(decrease) in cash and cash equivalents	**19,028**	(1,090)	**18,432**	(836)
Cash and cash equivalents at 1 April	**7,679**	8,769	**7,475**	8,312
Cash and cash equivalents at 31 March	**26,708**	7,679	**25,908**	7,475

The accompanying notes form part of these financial statements.

Notes to the Accounts

1 Significant Accounting policies and other information

1.1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trusts 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 DHSC Group Accounting Manual 2020-21, issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation 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.

1.1.2 Accounting convention

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

1.1.3 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. Long term planning and realistic plans for future transformation savings delivery provide the necessary assurance that the Trust is a going concern.

1.1.4 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption.

- IFRS 16 Leases - The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the James Paget University Hospitals NHS Foundation Trust accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.1.6 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's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- The Trust does not have any contractual arrangements that contain material embedded leases that are required to be capitalised under IFRIC 4.
- The Trust has used component lives based on data provided by the Trust's appointed valuer Montagu Evans LLP to depreciate building and dwellings on a component basis.
- The Trust has estimated the provisions for pensions relating to former staff using estimates provided by the NHS Pensions Agency provided at the time of the member's early retirement. These are updated if the member dies or if it becomes apparent that the provision is not sufficient to meet the liability.
- A desktop valuation of land and building assets was carried out by Montagu Evans LLP, and was applied on 31st March 2021 based on an alternate site, modern equivalent asset basis.

1.1.7 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:

In order to calculate the carrying value of the Trust's provisions there are a number of areas which require to be estimated, these are;

- The Trust will need to estimate the amount of its liability. In the case of legal claims, for example, it uses the advice of experts but the actual amount of the liability will not be known until the outcome of the litigation.
- The Trust will need to estimate the probability of a liability existing. The outcome of litigation may be uncertain but the Trust will use the advice of its experts on whether it is probable that it will be found liable.

- In the cases of pension and other benefits payable in the future, an estimate will be made of the length of time that payment will be required to be made, to estimate the present value of the estimated future payments.

1.2 Basis of consolidation

1.2.1 NHS Charitable Funds

The NHS Foundation Trust is the corporate trustee to the James Paget University Hospitals NHS charitable fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Results of the consolidated group and of the Foundation Trust are reported separately in the primary statements, for all other notes to the accounts the results of the consolidated group are reported.

1.2.2 Other Subsidiaries

Entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not coterminous.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as 'held for sale' are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.2.3 Associates

Entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in these financial statements using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the associate's profit or loss and other gains or losses. It is also reduced when any distribution is received by the Trust from the associate.

Associates which are classified as 'held for sale' are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.2.4 Joint arrangements

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

1.2.5 Joint ventures

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.2.6 Joint Operations

Joint operations are arrangements in which the trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The trust includes within its financial statements its share of the assets, liabilities, income and expenses.

1.2.7 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DHSC group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transactions in the period in which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income, and is disclosed separately from operating costs.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).
Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

1.3.1 Revenue from NHS contracts

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

2020/21

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

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

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

For 2020/21 and 2019/20

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

- The Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less.
- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in the Standard that requires The Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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

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

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2 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 employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

1.5 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.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
    - the item has cost of at least £5,000; or
    - collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
    - form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
- Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.
- The latest land and building asset valuation undertaken was carried out by Montagu Evans LLP, and was applied on 31st March 2021.
- Non-property assets are carried at depreciated historic cost as a proxy for fair value.

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

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 they are brought into use.

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

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

1.6.2 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.6.3 Depreciation, amortisation and impairments

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

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

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

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

Buildings	20 to 60 years	Transport Equipment	8 years
Dwellings	3 to 16 years	Information Technology	3 to 16 years
Plant and Machinery	3 to 16 years	Furniture and Fittings	8 to 11 years

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

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.6.4 Donated and grant funded assets

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

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

1.7 Intangible assets

1.7.1 Recognition

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

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

1.7.2 Measurement

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

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

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value, using the First In, First Out (FIFO) method. Inventories are subject to a planned inventory count as at 31 March.
In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.9 Cash and cash equivalents

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

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

1.10 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.

1.10.1 The Trust as lessee

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted 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.

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.

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.

1.10.2 The Trust as lessor

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.

1.11 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 effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.95% (2019-20: negative 0.50%) in real terms.

1.11.1 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 21.4 but is not recognised in the Trust's accounts.

1.11.2 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.

1.12 Financial assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.12.1 Financial assets at amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

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

1.12.2 Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.12.3 Financial assets at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.12.4 Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

The Trust determines expected credit losses based on information about past events, including historical experience, current conditions, and reasonable and supportable forecasts affecting the collectability of the reported amount.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 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 stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care 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 stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.12.5 De-recognition

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

1.13 Financial liabilities

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

1.13.1 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.14 Public Dividend Capital (PDC) and PDC dividend

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

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

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

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

1.15 Value Added Tax

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

1.16 Corporation Tax

Income from commercial activities is subject to corporation tax under section 519A Income and Corporation Taxes Act 1988 (519A ICTA 1988), as amended by section 148 of the Finance Act 2004. However, provision of Healthcare authorised under section 43 of the National Health Service Act 2006 is not treated as commercial income.
The total non-healthcare related activities carried out by the Foundation Trust during the period which are deemed to be commercial activities are not subject to corporation tax because annual taxable profits are below the de minimus limit of £50,000.

1.17 Foreign currencies

The Trust's functional currency and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 24 to the accounts in accordance with the requirements of HM Treasury's FReM.

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.

1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.21 Early adoption of standards, amendments and interpretations

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

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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

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

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

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

The Trust maintains a Lease register to record all operating and finance lease agreements to ensure correct treatment under IAS 17 Leasing. The Trust has implemented a leasing module add-on to the Trusts Fixed Asset register to account for the expected increase in finance leases.

Whilst the overall impact is still being assessed it is expected that upon transition the increased value in fixed assets will be offset by the increased value of the total lease creditor so there will be no overall increased PDC charge.

The increased depreciation charge from 1st April 2022 will be offset by the reduction in charges to operating expenditure from the reclassification of operating leases.

1.22 Building valuation uncertainties

A desktop valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), Covid 19 continues to impact the global economy with some real estate markets having experienced lower levels of transactional activity and liquidity. Nevertheless, as at the valuation date property markets are mostly functioning again, with transaction volumes and other relevant evidence at levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly and for the avoidance of doubt, the valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS3 and VPGA 10 of the RICS valuation – global standards.

Of the £35,643,198 net book value of land and buildings subject to valuation, £30,193,222 relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The DRV valuation method continues to be the appropriate basis of valuation for specialise properties having regard to the requirements of the Government's FReM and GAM.

2 Segmental reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services.

The products and services provided to external customers are identified in notes 4.1 and 4.2 below under the headings “Income from activities analysed by service type” and “Other operating income”.

All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK.

3 Subsidiaries

The James Paget University Hospitals NHS Foundation Trust acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the charity’s declaration of trust, members of the Foundation Trust’s Board of Directors act as ex-officio Trustees of the Charitable Funds.

This Trustee arrangement satisfies the relevant tests of control under IAS 27 and therefore the Charitable Fund is a subsidiary of the Foundation Trust. The Foundation Trust has prepared group accounts for the year ended 31 March 2021.

The James Paget University Hospitals Charitable Fund is a registered charity located in England, and the Foundation Trust as the sole corporate Trustee has 100% of the voting rights. The Foundation Trust does not have any financial investment in the Charitable Fund.

The ability of the subsidiary to transfer funds to the Foundation Trust is significantly restricted by the charitable objects and the legal requirement for the Trustees to act independently and ensure that all funds are spent in accordance with the donors’ wishes.

4 Operating income

4.1 Income from activities analysed by service type

		Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Block contract / system envelope income		**213,631**	173,281
High cost drugs income from commissioners		**1,010**	16,560
Other NHS clinical income		**4,492**	6,531
Private patient income		**242**	762
AfC pay award central funding		**-**	-
Additional pension contribution central funding		**6,507**	5,807
Other clinical income		**675**	904
	Note 4.2	**226,557**	203,846

During 2020/21 the majority of income from Clinical Commissioning Groups and NHS England is included in Block contract / system envelope income and is not split by activity type.

4.2 Analysis of operating income by source

		Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Income from activities			
NHS Foundation Trusts		**4,507**	6,454
NHS Trusts		**(0)**	7
Clinical Commissioning Groups and NHS England		**221,031**	195,624
NHS Other		**105**	51
Non NHS:			
Private patients		**242**	762
Overseas patients	Note 4.4	**82**	0
NHS injury scheme *		**397**	700
Other		**195**	248
Total income from activities		**226,559**	203,846
Other operating income from contracts with customers:			
Research and development		**594**	579
Education and training (excluding notional apprenticeship levy income)		**8,096**	7,419
Non patient care services to other NHS bodies		**159**	191
PSF, MRET and Top-up income**		**12,642**	8,083
Other non-contract operating income:			
Catering		**334**	637
Education and training - notional income from apprenticeship fund		**576**	574
Rental revenue from operating leases	Note 4.3	**325**	338
Accommodation		**749**	772
Car parking		**161**	1,263
Donated Equipment for Covid Response		**325**	-
Charitable and other contributions to expenditure		**(135)**	(234)
Receipt for revenue equipment donated from DHSC		**25**	-
Contributions to expenditure - consumables (inventory) donated from DHSC		**3,699**	-
Miscellaneous		**1,185**	1,521
NHS Charitable Funds: Incoming Resources excluding investment income		**1,157**	740
Total other operating income		**29,892**	21,883
Total operating income		**256,451**	225,729

* NHS Injury Scheme income is subject to a provision for expected credit losses of 22.43% (2019/20 - 21.79%) to reflect expected rates of collection.

** Top-up income of £12,642,000 has been allocated to the Trust during 2020/21 (2019/20 Provider Sustainability Fund income of £4,150,000 and Marginal Rate Emergency Tariff funding income of £3,933,000) to support the financial position of the Trust.

4.3 Operating lease income

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Rents recognised as income in the period	**325**	338
	325	338

4.3 Operating lease income - continued

Future minimum lease receipts due:

	Year Ended 31 March 2021			
	Land	**Buildings**	**Other**	**Total**
Within 1 year	**-**	**261**	**-**	**261**
Between 1 and 5 years	**-**	**988**	**-**	**988**
After 5 years	**-**	**942**	**-**	**942**
	-	**2,191**	**-**	**2,191**

	Year Ended 31 March 2020			
	Land	Buildings	Other	Total
Within 1 year	-	259	-	259
Between 1 and 5 years	-	993	-	993
After 5 years	-	1,139	-	1,139
	-	2,391	-	2,391

4.4 Overseas visitor income

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Income recognised in this year	**82**	0
Cash payments received in-year (relating to invoices raised in current and previous years)	**15**	34
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**24**	121

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

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**117**	83
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**(908)**	553

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

	31 March 2021 £ 000	31 March 2020 £ 000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
Within one year	**712**	117
Total revenue allocated to remaining performance obligations	**712**	117

5 Operating expenses

		Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Services from NHS Bodies		**2,055**	272
Purchase of healthcare from non-NHS bodies		**2,098**	840
Employee expenses - executive directors		**966**	1,147
Employee expenses - non-executive directors		**128**	124
Employee expenses - staff		**169,899**	149,907
Drug costs		**18,850**	20,209
Supplies and services - clinical (excluding drug costs)		**17,491**	17,452
Supplies and services - clinical: utilisation of DHSC consumables donated - Covid		**3,463**	-
Supplies and services - general		**2,952**	2,721
Supplies and services - notional cost of revenue equipment donated from DHSC		**25**	-
Establishment		**1,840**	2,541
Transport		**132**	105
Premises		**7,631**	6,200
Increase / (Decrease) in provision for impairment of receivables		**(341)**	468
Change in provisions discount rate		**55**	89
Inventories write down		**138**	118
Depreciation on property, plant and equipment		**7,457**	4,763
Amortisation on intangible assets		**649**	485
Net Impairments of property, plant and equipment	Note 10 & 13.3	**2,746**	6,144
Net impairments of intangible assets	Note 12.1	**-**	321
Audit fees - statutory audit*		**120**	75
Audit fees - Charitable Fund Accounts		**7**	7
Internal Audit and Local Counter Fraud Services		**85**	97
Clinical negligence		**8,022**	6,769
Legal fees		**261**	321
Consultancy costs		**438**	434
Training, courses and conferences		**1,408**	1,286
Patient travel		**21**	71
Operating lease expenditure (net)		**341**	256
Insurance		**165**	108
Other contracted services		**258**	338
Losses, ex gratia and special payments		**5**	10
Other		**5,425**	6,020
NHS Charitable funds: Other resources expended		**191**	335
		254,981	230,033

* There is a £1,000,000 limitation on auditor's liability.

6 Operating leases

6.1 Lease payments recognised as an expense in the period

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Minimum lease payments	**265**	256
Contingent rents	**-**	-
Sublease payments	**-**	-
	265	256

6.2 Total of future minimum lease payments due:

	Year Ended 31 March 2021			
	Land £ 000	**Buildings £ 000**	**Other £ 000**	**Total £ 000**
Within 1 year	**-**	**-**	**107**	**107**
Between 1 and 5 years	**-**	**-**	**80**	**80**
After 5 years	**-**	**-**	**-**	**-**
	-	**-**	**187**	**187**

	Year Ended 31 March 2020			
	Land £ 000	Buildings £ 000	Other £ 000	Total £ 000
Within 1 year	-	-	206	206
Between 1 and 5 years	-	-	144	144
After 5 years	-	-	-	-
	-	-	350	350

7 Employee expenses and numbers

7.1 Employee expenses

	Permanent £ 000	**Year Ended 31 March 2021 Other £ 000**	**Total £ 000**	Year Ended 31 March 2020 Total £ 000
Salaries and wages	**127,747**	**2,803**	**130,550**	113,663
Social security costs	**12,365**	**-**	**12,365**	11,005
Apprenticeship levy	**678**	**-**	**678**	562
Employer contributions to NHS Pensions	**14,838**	**-**	**14,838**	12,877
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**6,507**	**-**	**6,507**	5,807
Pension cost - other	**45**	**-**	**45**	37
Agency / contract staff	**-**	**6,506**	**6,506**	7,797
	162,180	**9,309**	**171,489**	151,748
Employee expenses recharged to other organisations	**(361)**	**-**	**(361)**	(493)
Employee expenses capitalised as part of assets	**(262)**	**-**	**(262)**	(201)
	161,557	**9,309**	**170,866**	151,054

7.2 Directors' remuneration

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Directors' remuneration	**1,037**	1,037
Employer contributions to NHS Pensions Agency	**111**	100
Benefits in kind	**3**	12
Defined benefit pension schemes	**-**	-

Further details on directors' remuneration are given in the remuneration report from page 53 of the Annual Report.

7.3 Average number of employees

	Year Ended 31 March 2021			Year Ended 31 March 2020
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	**128**	**234**	**362**	334
Ambulance Staff	**-**	**-**	**-**	-
Administration and estates	**537**	**57**	**594**	512
Healthcare assistants and other support staff	**476**	**55**	**531**	464
Nursing, midwifery and health visiting staff	**1,117**	**193**	**1,310**	1,280
Scientific, therapeutic and technical staff	**310**	**18**	**328**	283
Agency Staff	**-**	**69**	**69**	79
Bank Staff	**-**	**227**	**227**	168
	2,568	**853**	**3,421**	3,120
Of which number of employees engaged on capital projects	**2**	**-**	**2**	6

Total nursing, midwifery and health visiting staff numbers for 2020/21, including all nursing, midwifery and health visiting bank and agency staff are 1,497 (2019/20 - 1,459). Total Medical and dental staff numbers for 2018/19, including all Medical and dental agency staff are 382 (2019/20 - 346).

7.4 Staff exit packages

There have been no non contractual staff exit packages during the year ended 31 March 2021 with a value of £nil (Year ended 31 March 2020 two, £22,000).

7.5 Retirements due to ill-health

During the year ending 31 March 2021 there were one (2019/20 - two) early retirements from the Trust agreed on the grounds of ill-health. The additional pension costs of these ill-health retirements (calculated on an average basis and borne by the NHS Pension Scheme) for 2020/21 was £22,000 (2019/20 - £62,000).

7.6 Reporting of other compensation schemes - exit packages

During the year ending 31 March 2021 there were eleven (2019/20 - seventeen) other departures agreed from the Trust. The costs of other departures agreed for 2020/21 was £72,000 (2019/20 - £86,000). Of the other departure costs eleven were for contractual payments in lieu of notice and ten had an individual cost less than £10,000 and one payment of £16,000

7.7 Retirement benefits

Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

8 Finance income

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
Interest on cash deposits	**4**	131
NHS Charitable funds: investment income	**31**	95
	35	226

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

9 Finance expenditure

Interest expense:		
Loans from the Department of Health and Social Care	**-**	107
Other loans	**8**	22
Finance leases	**219**	183
Total interest expense	**227**	312
Unwinding of discount on provisions	**(7)**	4
Total finance costs	**220**	316

10 Impairment of assets recognised as operating expenses

Operating expenses include impairment costs due to:

Abandonment of assets in course of construction	**-**	363
Changes in market price	**2,746**	6,102
	2,746	6,465

There were £2,746,000 of impairments recognised in operating expenses for the period ending 31st March 2021 (2019/20 £6,465,000)

11 Interests in Joint Operations

The James Paget University Hospitals NHS Foundation Trust has a 22% interest in a joint operation for the provision of pathology services in Norfolk known as Eastern Pathology Alliance (EPA). The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

The Trust has recognised its interest in the joint operation using the line-by-line reporting format for proportionate consolidation. This means that included within income from activities in note 4.1 is £3,525,000 (2019/20 £3,886,000) representing a 22% share of EPA revenue, and included within operating expenses in note 5 is £6,430,000 (2019/20 £7,021,000) representing a 22% share of the operating costs of EPA.

	Assets Under Construction £ 000	Software Licences £ 000	Other £ 000	Total £ 000
12 Intangible assets				
12.1 Intangible assets 2020/21				
Cost or valuation at 1 April 2020	904	6,324	30	**7,258**
Additions - purchased	1,609	323	-	**1,932**
Additions - donated	-	6	-	**6**
Reclassifications	(605)	744	-	**139**
Disposals	-	(728)	-	**(728)**
Cost or Valuation at 31 March 2021	**1,908**	**6,669**	**30**	**8,607**
Amortisation at 1 April 2020	-	4,594	25	**4,619**
Provided during the year	-	644	5	**649**
Disposals	-	(728)	-	**(728)**
Amortisation at 31 March 2021	**-**	**4,510**	**30**	**4,539**
Opening net book value at 1 April 2020				
Purchased	699	1,457	5	2,161
Finance leases	-	230	-	230
Donated	205	28	-	233
Government granted	-	19	-	19
Total NBV at 1 April 2020	904	1,734	5	2,643
Closing net book value at 31 March 2021				
Purchased	1,908	1,949	-	**3,857**
Finance leases	-	172	-	**172**
Donated	-	25	-	**25**
Government granted	-	14	-	**14**
Total NBV at 31 March 2021	**1,908**	**2,160**	**-**	**4,068**
12.2 Intangible assets 2019/20				
Cost or valuation at 1 April 2019	586	6,227	30	**6,843**
Additions - purchased	698	39	-	**736**
Reclassifications	(373)	373	-	**-**
Impairments	(7)	(314)	-	**(321)**
Cost or Valuation at 31 March 2020	**904**	**6,324**	**30**	**7,258**
Amortisation at 1 April 2019	-	4,115	19	**4,134**
Provided during the year	-	479	6	**485**
Amortisation at 31 March 2020	**-**	**4,594**	**25**	**4,619**
Opening net book value at 1 April 2019				
Purchased	586	1,787	11	2,383
Finance leases	-	287	-	287
Donated	-	15	-	15
Government granted	-	24	-	24
Total NBV at 1 April 2019	586	2,113	11	2,709
Closing net book value at 31 March 2020				
Purchased	699	1,457	5	**2,161**
Finance leases	-	230	-	**230**
Donated	205	28	-	**233**
Government granted	-	19	-	**19**
Total NBV at 31 March 2020	**904**	**1,734**	**5**	**2,643**

Notes to the Accounts

continued

13 Property, plant and equipment

13.1 Property, plant and equipment 2020/21

	Land	Buildings (excluding dwellings)	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total Trust
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Cost or valuation at 1 April 2020	3,297	33,563	3,067	3,362	26,051	594	14,105	1,519	**85,558**
Additions - purchased*	-	-	-	14,888	3,126	-	1,039	87	**19,140**
Additions - leased	-	-	-	-	-	-	350	-	**350**
Additions - donated DHSC - Covid	-	-	-	-	326	-	-	-	**326**
Additions - donated	-	-	-	6	138	-	29	-	**173**
Reclassifications	-	1,497	700	(3,357)	97	-	890	34	**(139)**
Impairments	-	(6,495)	(325)	-	-	-	-	-	**(6,820)**
Revaluations	194	145	-	-	-	-	-	-	**339**
Disposals	-	-	-	-	(2,201)	(168)	(2,137)	(92)	**(4,598)**
Cost or Valuation at 31 March 2021	**3,491**	**28,710**	**3,442**	**14,899**	**27,537**	**426**	**14,276**	**1,548**	**94,329**
Accumulated depreciation at 1 April 2020	-	-	-	-	16,651	397	9,456	1,193	**27,697**
Provided during the year	-	3,718	111	-	2,208	27	1,328	65	**7,457**
Impairments	-	(3,642)	(111)	-	-	-	-	-	**(3,753)**
Revaluations	-	(76)	-	-	-	-	-	-	**(76)**
Disposals	-	-	-	-	(2,189)	(168)	(2,135)	(92)	**(4,584)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**16,670**	**256**	**8,649**	**1,166**	**26,741**
Opening net book value at 1 April 2020									
Purchased	3,297	31,873	3,067	3,359	3,366	197	2,250	215	47,624
Finance leased	-	-	-	-	4,767	-	2,297	-	7,064
Government granted	-	462	-	-	58	-	2	2	524
Donated	-	1,228	-	3	1,209	-	100	109	2,649
Total NBV at 1 April 2020	3,297	33,563	3,067	3,362	9,400	197	4,649	326	57,861
Closing net book value at 31 March 2021									
Purchased	3,491	27,380	3,442	14,899	5,625	170	3,469	287	**58,763**
Finance leased	-	-	-	-	3,858	-	2,053	-	**5,911**
Owned - donated / granted	-	1,330	-	-	1,059	-	105	95	**2,589**
Owned - donated from DHSC - Covid	-	-	-	-	325	-	-	-	**325**
Total NBV at 31 March 2021	**3,491**	**28,710**	**3,442**	**14,899**	**10,867**	**170**	**5,627**	**382**	**67,588**

* For consolidation

Notes to the Accounts

continued

13.2 Property, plant and equipment 2019/20

	Land	Buildings (excluding dwellings)	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings	Total Trust
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
Cost or valuation at 1 April 2019	3,190	38,803	2,816	3,332	24,226	607	12,188	1,479	**86,641**
Additions - purchased**	-	-	-	3,006	731	11	33	-	**3,781**
Additions - leased	-	-	-	-	1,402	-	1,654	-	**3,056**
Additions - donated	-	-	-	13	40	-	13	-	**66**
Reclassifications	-	2,654	-	(2,987)	26	-	258	49	**-**
Impairments	-	(8,215)	-	(2)	-	-	(41)	-	**(8,258)**
Revaluations	107	321	251	-	-	-	-	-	**679**
Disposals	-	-	-	-	(374)	(24)	-	(9)	**(407)**
Cost or Valuation at 31 March 2020	**3,297**	**33,563**	**3,067**	**3,362**	**26,051**	**594**	**14,105**	**1,519**	**85,558**
Accumulated depreciation at 1 April 2019	-	143	8	-	14,998	394	8,565	1,122	**25,230**
Provided during the year	-	1,666	95	-	2,006	27	891	78	**4,763**
Impairments	-	(1,809)	-	-	-	-	-	-	**(1,809)**
Revaluations	-	-	(103)	-	-	-	-	-	**(103)**
Disposals	-	-	-	-	(353)	(24)	-	(7)	**(384)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**16,651**	**397**	**9,456**	**1,193**	**27,697**
Opening net book value at 1 April 2019									
Purchased	3,190	35,961	2,808	3,281	3,561	213	2,644	209	51,867
Finance leased	-	-	-	-	4,113	-	916	-	5,029
Government granted	-	525	-	-	0	-	3	18	546
Donated	-	2,174	-	51	1,553	-	60	130	3,968
Total NBV at 1 April 2019	3,190	38,660	2,808	3,332	9,227	213	3,623	357	61,410
Closing net book value at 31 March 2020									
Purchased	3,297	31,873	3,067	3,359	3,366	197	2,250	215	**47,624**
Finance leased	-	-	-	-	4,767	-	2,297	-	**7,064**
Government granted	-	462	-	-	58	-	2	2	**524**
Donated	-	1,228	-	3	1,209	-	100	109	**2,649**
Total NBV at 31 March 2020	**3,297**	**33,563**	**3,067**	**3,362**	**9,400**	**197**	**4,649**	**326**	**57,861**

* For consolidation purposes purchased additions includes assets funded from donations of £134,000

13.3 Analysis of property, plant and equipment

Land, building and dwelling assets were subject to a full valuation carried out by the Trust's externally appointed independent valuers on an alternate site basis as at 31st March 2021.

There were £3,067,000 net impairments during 2020/21 (2020/21 - £6,770,000), £2,746,000 (2019/20 - £6,465,000) has been recognised in operating expenses, and £321,000 (2019/20 - £305,000) has been recognised directly in equity during the period.

13.4 Analysis of revalued property, plant and equipment

	Land	Buildings (excluding dwellings)	Dwellings	Total
	£ 000	£ 000	£ 000	£ 000
Net book value of PPE in the revaluation reserve				
As at 1 April 2020	**1,581**	**1,054**	**1,594**	**4,229**
Movement in year	**194**	**(204)**	**104**	**94**
As at 31 March 2021	**1,775**	**850**	**1,698**	**4,323**
As at 1 April 2019	1,474	1,038	1,239	3,751
Movement in year	107	16	355	478
As at 31 March 2020	1,581	1,054	1,594	4,229

13.5 Investments

	Year Ended 31 March 2021 £ 000	Year Ended 31 March 2020 £ 000
NHS Charitable funds: Other investments		
Carrying value at 1 April	**2,330**	2,764
Acquisitions in year - other	**194**	246
Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income	**336**	(258)
Disposals	**(434)**	(422)
Carrying value at 31 March	**2,426**	2,330

14 Inventories

14.1 Inventories recognised in current assets

	Total as at 31 March 2021 £ 000	Total as at 31 March 2020 £ 000
Drugs	**1,067**	1,337
Consumables	**1,740**	1,734
Consumables	**208**	-
Energy	**14**	16
	3,029	3,087

14.2 Inventory Movements

Carrying Value at 1 April	**3,087**	2,942
Additions (purchased)	**26,681**	29,772
Additions (donated) - from DHSC	**3,699**	-
Inventories consumed (recognised in expenses)	**(30,300)**	(29,509)
Write down of inventories recognised as an expense	**(138)**	(118)
	3,029	3,087

At 31st March 2021 the Charitable Funds held inventories of £nil (31st March 2020 £nil)

	Total as at 31 March 2021 £ 000	Total as at 31 March 2020 £ 000
15 Trade and other receivables		
15.1 Current trade and other receivables		
Contract receivables*	**8,856**	13,958
Allowance for impaired contract receivables / assets*	**(353)**	(952)
Prepayments	**1,241**	1,138
PDC dividend receivable	**94**	242
VAT receivable	**318**	278
Other receivables - revenue	**233**	132
NHS Charitable funds: Trade and other receivables	**27**	39
	10,416	14,835

On consolidation balance of receivables from Charity of £22,000 is eliminated and replaced with Charity receivables balance £27,000. Trust Current receivable balance is £10,410,000

15.2 Non-current trade and other receivables		
Contract receivables	**261**	474
Allowance for impaired contract receivables / assets	**(59)**	(103)
Prepayments	**101**	34
	303	405

15.3 Allowances for credit losses		
Allowances as at 1 April - brought forward	**1,055**	1,109
New allowances arising	**435**	383
Changes in existing allowances	**(84)**	191
Reversals of allowances	**(692)**	(106)
Amounts utilised	**(302)**	(522)
Provision at 31 March	**412**	1,055

16 Cash and cash equivalents

	Trust Total 2021 £ 000	Charitable Funds Total 2021 £ 000	Trust Total 2020 £ 000	Charitable Funds Total 2020 £ 000
At 1 April	**7,475**	**203**	8,312	457
Net change in year	**18,433**	**597**	(837)	(254)
At 31 March	**25,908**	**800**	7,475	203
Broken down into:				
Cash at commercial banks and in hand	**49**	**800**	56	203
Cash with the Government Banking Service	**25,859**	**-**	7,419	-
Cash and cash equivalents as in SoFP	**25,908**	**800**	7,475	203
At 31 March	**25,908**	**800**	7,475	203

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. Total cash and cash equivalents for the group as at 31 March 2021 are £25,908,000 (31 March 2020 - £7,679,000).

17 Trade and other payables

17.1 Current trade and other payables

	Total as at 31 March 2021 £ 000	Total as at 31 March 2020 £ 000
NHS payables - revenue	**292**	381
Amounts due to other related parties - revenue	**2,252**	2,122
Trade payables - capital	**7,283**	2,413
Other trade payables	**1,812**	3,457
Receipts in advance	**-**	117
Social security costs payable	**1,824**	1,604
Other taxes payable	**1,471**	1,246
Other payables	**7,351**	3,184
Accruals	**8,181**	5,562
NHS Charitable funds	**16**	5
	30,482	20,091

17.2 Non-current trade and other payables

Other payables	**3**	3
	3	3

17.3 Other liabilities - current

Deferred income: contract liabilities	**1,912**	369
	1,912	369

18 Reconciliation of liabilities arising from financing activities

	Loans From DHSC	Other Loans	Finance Leases	Total
Carrying value at 1 April 2019	7,294	57	7,359	**14,710**
Cash movements:				
Financing cash flows - payments and receipts of principal	(7,271)	(57)	(1,046)	**(8,374)**
Financing cash flows - payments of interest	(23)	(8)	(219)	**(250)**
Non-cash movements:				
Additions	-	-	350	**350**
Interest charge arising in year	-	8	219	**227**
Other changes	-	-	-	**-**
Carrying value at 31 March 2020	**-**	**-**	**6,663**	**6,663**

19 Borrowings

19.1 Current borrowings

		Total as at 31 March 2021 £ 000	Total as at 31 March 2020 £ 000
Loans from DHSC		**-**	7,295
Other loans		**-**	57
Obligations under finance leases	Note 20	**1,521**	1,410
		1,521	8,762

19.2 Non-current borrowings

Obligations under finance leases	Note 20	**5,142**	5,948
		5,142	5,948

20 Finance lease obligations

	Total as at 31 March 2021 £ 000	Total as at 31 March 2020 £ 000
Obligations under finance leases where the trust is the lessee		
Minimum finance lease payments due:		
no later than one year	**1,749**	1,648
later than one year and no later than five years	**5,508**	6,285
later than five years	**51**	215
Gross finance lease liabilities	**7,308**	8,148
Finance charges allocated to future periods	**(639)**	(789)
Net finance lease liabilities	**6,670**	7,359
Net finance lease liabilities are due:		
no later than one year	**1,521**	1,410
later than one year and no later than five years	**5,092**	5,741
later than five years	**50**	208
	6,663	7,359

21 Provisions

21.1 Provision for liabilities and charges

	Pensions - Early Retirement	Pensions - injury benefits*	Other Legal Claims	Other	Total as at 31 March 2021	Total as at 31 March 2020
	£ 000	£ 000	£ 000	£ 000	£ 000	£ 000
At 1 April	674	740	44	54	**1,512**	1,526
Change in the discount rate	20	35	-	-	**55**	89
Arising during the year	33	21	29	472	**555**	133
Utilised during the year	(60)	(42)	(20)	1	**(121)**	(162)
Reversed unused	-	-	(25)	(55)	**(80)**	(78)
Unwinding of discount	(3)	(4)	-	-	**(7)**	4
At 31 March	**664**	**750**	**28**	**472**	**1,914**	1,512
Expected timing of cash flows						
Within 1 year	61	42	28	472	**603**	198
Between 1 and 5 years	241	169	-	-	**410**	401
After 5 years	362	539	-	-	**901**	913
Total	**664**	**750**	**28**	**472**	**1,914**	1,512

21.2 Current provisions

	Total as at 31 March 2021	Total as at 31 March 2020
	£ 000	£ 000
Pensions - other staff	**61**	59
Pensions - injury benefit	**42**	41
Other legal claims	**28**	44
Other	**472**	54
At 31 March	**603**	198

21.3 Non-current provisions

Pensions - other staff	**603**	616
Pensions - injury benefit	**708**	698
At 31 March	**1,311**	1,314

21.4 Clinical negligence liabilities

£90,521,000 is included in the provisions of the NHS Litigation Authority at 31 March 2021 (31 March 2020 - £93,588,000) in respect of clinical negligence liabilities of the Foundation Trust.

21.5 Contingent liabilities

The Trust has £9,000 of contingent liabilities at 31 March 2021 (31 March 2020 - £27,000) in respect of potential excess payments for NHS Litigation Authority claims for Public and Employer Liability claims outstanding where timing is expected to be within the next 12 months.

22 Revaluation reserve

	Property, plant and equipment 2021 £ 000	Total 2021 £ 000	Property, plant and equipment 2020 £ 000	Total 2020 £ 000
At 1 April	**4,229**	**4,229**	3,751	3,751
Impairments	**-**	**-**	(305)	(305)
Revaluations	**-**	**-**	783	783
At 31 March	**4,229**	**4,229**	4,229	4,229

23 Financial instruments

23.1 Analysis of financial assets and liabilities by category

	Held at amortised cost £ 000	Held at fair value through I&E £ 000	Held at fair value through OCI £ 000	Total £ 000
Carrying values of financial assets as at 31 March 2020				
Trade and other receivables excluding non Financial assets	8,936	**-**	**-**	**8,936**
Cash and cash equivalents	25,908	**-**	**-**	**25,908**
Consolidated NHS Charitable fund financial assets	827	2,426	-	**3,253**
Total financial assets as at 31 March 2021	**35,671**	**2,426**	**-**	**38,097**
Carrying values of financial assets as at 31 March 2019				
Trade and other receivables excluding non financial assets	13,509	**-**	**-**	**13,509**
Cash and cash equivalents	7,475	**-**	**-**	**7,475**
Consolidated NHS Charitable fund financial assets	242	2,330	-	**2,572**
Total financial assets as at 31 March 2021	**21,226**	**2,330**	**-**	**23,556**

£341,000 of impairment gain on loans and receivables (31 March 2020 - £468,000 loss) has been recognised within operating expenses during the year under the decrease in provision for impairment of receivables within note 5.

	Held at amortised cost £ 000	Held at fair value through I&E £ 000	Total book value £ 000
Liabilities as per Statement of Financial Position			
Carrying values of financial liabilities as at 31 March 2021			
DHSC loans	**-**	**-**	**-**
Borrowings (excluding finance leases)	**-**	**-**	**-**
Obligations under finance leases	**6,663**	**-**	**6,663**
Trade and other payables excluding non financial liabilities	**23,864**	**-**	**23,864**
IAS 37 provisions which are financial liabilities	**1,414**	**-**	**1,414**
NHS Charitable funds	**15**	**-**	**15**
Total financial liabilities as at 31 March 2021	**31,956**	**-**	**31,956**
Carrying values of financial liabilities as at 31 March 2020			
DHSC loans	7,295	-	7,295
Borrowings (excluding finance leases)	57	-	57
Obligations under finance leases	7,359	-	7,359
Trade and other payables excluding non financial liabilities	14,264	-	14,264
IAS 37 provisions which are financial liabilities	1,414	-	1,414
NHS Charitable funds	6	-	6
Total financial liabilities as at 31 March 2020	30,395	-	30,395

	As at 31 March 2021 £ 000	As at 31 March 2020 £ 000
23.2 Maturity of financial liabilities		
Financial liabilities maturing in		
one year or less	**26,224**	22,695
In more than one year but not more than five years	**5,919**	7,353
more than five years	**844**	346
	32,987	30,394

	Book value as at 31 March 2021 £ 000	Fair value as at 31 March 2021 £ 000
23.3 Fair value of financial assets and liabilities		
Financial assets		
Consolidated NHS Charitable funds	**2,425**	**2,425**
Total	**2,425**	**2,425**
Financial liabilities		
Non-current trade and other payables excluding non financial liabilities	**3**	**3**
Loans	**-**	**-**
Other	**-**	**-**
Total	**3**	**3**

The fair value of financial assets and liabilities for the James Paget University Hospitals NHS Foundation Trust is not significantly different from the book value. The assets of the NHS Charity are held in listed securities and as such the market value can fluctuate causing variances between the book value and the fair value. The carrying values of other short-term receivables and payables are a reasonable approximation of the fair value.

The Trust has limited exposure to interest rate risk, currency risk, credit risk, liquidity risk, and other specific price risks, and therefore does not actively seek to manage risk in these areas.

24 Third party assets

The Foundation Trust held £4,000 cash at bank and in hand at 31 March 2021 (31 March 2020 - £4,000) which relates to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts. Gross inflows and outflows during the reporting period are £nil and £nil respectively (2019/20 - £nil and £nil).

25 Financial commitments

25.1 Capital commitments

The Foundation Trust has £486,000 of contractual capital commitments as at 31 March 2021 mainly related to intangible assets (31 March 2020 - £1,221,000 mainly building schemes in progress).

25.2 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) during 2020/21 as follows, analysed by the period during which the commitment expires:

	2021 £ 000
Expiry in less than one year	**377**
Expiry in more than one year but less than five years	**342**
Expiry in more than five years	**-**
Total	**719**

26 Related party transactions

26.1 Key management personnel compensation

	Year Ended 31st March 2021 £ 000	Year Ended 31st March 2020 £ 000
Salaries and other short term benefits	**1,481**	1,049
Post employment benefits	**111**	100
Total	**1,592**	1,149

Key management personnel has been interpreted as all the executive, non-executive and non-voting directors of the Trust.

26.2 Related party payments, receipts and balances

During the year none of the Board members or members of the key management staff, or parties related to them, have undertaken any material transactions (other than employment benefits) with the James Paget University Hospitals NHS Foundation Trust.

All bodies within the scope of the Whole Government Accounts (WGA), including the James Paget University Hospitals NHS Foundation Trust are considered to be under the common control of the UK government, and are therefore considered to be related parties. Within the group structure of WGA, the immediate parent of the Trust is the Department of Health. The James Paget University Hospitals NHS Foundation Trust also acts as the corporate Trustee of the James Paget University Hospitals Charitable Fund and in accordance with the charity's declaration of trust, members of the Foundation Trust's Board of Directors act as ex-officio Trustees of the Charitable Funds. In accordance with note 1.2 the Charitable Fund has been consolidated into these group accounts and is therefore no longer reported as a related party. The values of transactions with these entities are detailed below:

	Payments 31st March 2021 £ 000	Payments 31st March 2020 £ 000	**Receipts 31st March 2021 £ 000**	Receipts 31st March 2020 £ 000
Value of transactions with other related parties				
Non-consolidated subsidiaries and associates / joint ventures	**36,666**	32,681	**179**	192

	Amounts payable 31st March 2021 £ 000	Amounts payable 31st March 2020 £ 000	**Amounts receivable 31st March 2021 £ 000**	Amounts receivable 31st March 2020 £ 000
Value of balances with other related parties				
Non-consolidated subsidiaries and associates / joint ventures	**-**	-	**22**	318

Paragraph 25 of IAS 24 allows entities which are related parties because they are under the same government control to reduce the volume of the detailed disclosures. The GAM interprets this such that DHSC group bodies must disclose the Department of Health and Social Care as the parent department and provide a note of the main entities within the public sector with which the body has had dealings, but that no information needs to be given about these transactions.
In line with this, these related parties notes only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

27 Losses and special payments

	31 March 2021 Total no of cases Number	31 March 2021 Total value of cases £000's	31 March 2020 Total no of cases Number	31 March 2020 Total value of cases £000's
Losses:				
Theft, fraud etc.	**1**	**1**	-	-
overpayment of salaries etc.	**1**	**1**	6	4
Losses of cash	**2**	**2**	6	4
Fruitless payments and constructive losses	**-**	**-**	1	9
Bad debts and claims abandoned	**149**	**85**	255	302
Damage to buildings, property etc. (including stores losses).	**3**	**23**	3	7
Total Losses	**154**	**110**	265	322
Special Payments:				
Extra contractual to contractors	**1**	**-**	2	30
Ex gratia payments	**17**	**17**	19	37
Total Special Payments	**18**	**17**	21	67
Total losses and special payments	**172**	**127**	286	389

29 Charitable Funds summary statements 2020/21

29.1 Summary Statement of Financial Activities

	IFRS Year Ended 31 March 2021 £ 000	Charity Consolidation Eliminations*	Year Ended 31 March 2021 £ 000
Incoming Resources: excluding investment income	**1,157**	-	**1,157**
Total operating income	**1,157**	-	**1,157**
Employee benefits:			
- expended with the Foundation Trust	**(227)**	227	**-**
Other resources expended			
- with the Foundation Trust	**(351)**	351	**-**
- with bodies outside the NHS	**(191)**	-	**(191)**
- audit fee (payable to the external auditor)	**(7)**	-	**(7)**
Total operating expenditure	**(776)**	578	**(198)**
Incoming Resources: investment income	**31**	-	**31**
Net (outgoing) / incoming resources before other recognised gains and losses	**412**	578	**990**
Fair value gains / (losses) on investment assets	**336**	-	**336**
Net Movement in funds	**748**	578	**1,326**

29.2 Summary Balance Sheet

Non-current assets			
Other Investments	**2,426**	-	**2,426**
Total non-current assets	**2,426**	-	**2,426**
Current assets			
Trade and other receivables	**27**	-	**27**
Cash and cash equivalents	**800**	-	**800**
Total current assets	**827**	-	**827**
Current liabilities			
Trade and other payables	**(37)**	-	**(37)**
Total current liabilities	**(37)**	-	**(37)**
Net assets	**3,216**	-	**3,216**
Funds of the charity			
Restricted funds:	**140**	-	**140**
Unrestricted funds:			
Unrestricted income funds	**2,534**	-	**2,534**
Revaluation reserve	**542**	-	**542**
Total Charitable Funds	**3,216**	-	**3,216**

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £396,000 (2019/20 £548,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of £605,000, and net assets of £2,819,000.

30 Charitable Funds summary statements 2019/20

30.1 Summary Statement of Financial Activities

	IFRS Year Ended 31 March 2020 £ 000	Charity Consolidation Eliminations*	Year Ended 31 March 2020 £ 000
Incoming Resources: excluding investment income	**516**	-	**516**
Total operating income	**516**	-	**516**
Employee benefits:			
- expended with the Foundation Trust	**(216)**	216	**-**
Other resources expended			
- with the Foundation Trust	**(509)**	509	**-**
- with bodies outside the NHS	**(335)**	-	**(335)**
- audit fee (payable to the external auditor)	**(7)**	-	**(7)**
Total operating expenditure	**(1,067)**	725	**(342)**
Incoming Resources: investment income	**95**	-	**95**
Net (outgoing) / incoming resources before other recognised gains and losses	**(456)**	725	**269**
Fair value gains / (losses) on investment assets	**(258)**	-	**(258)**
Net Movement in funds	**(714)**	725	**11**

30.2 Summary Balance Sheet

Non-current assets			
Other Investments	**2,330**	-	**2,330**
Total non-current assets	**2,330**	-	**2,330**
Current assets			
Trade and other receivables	**39**	-	**39**
Cash and cash equivalents	**203**	-	**203**
Total current assets	**242**	-	**242**
Current liabilities			
Trade and other payables	**(104)**	-	**(104)**
Total current liabilities	**(104)**	-	**(104)**
Net assets	**2,468**	-	**2,468**
Funds of the charity			
Restricted funds:	**206**	-	**206**
Unrestricted funds:			
Unrestricted income funds	**2,280**	-	**2,280**
Revaluation reserve	**206**	-	**206**
Total Charitable Funds	**2,692**	-	**2,692**

Charitable Funds are presented under UK GAAP and are consistent with SORP 2015. In restating the charity accounts to be consistent with the IFRS based accounting policies of the Foundation Trust, the commitments accrual of £548,000 (2018/19 £486,000) reported under UK GAAP has been removed. The separate accounts of the Charity can be found on the Charity Commission website.

* Consolidation eliminations illustrate the impact on the balances of the group accounts, and do not impact on the underlying performance of the Charitable Fund which retains a movement in funds of (£787,000), and net assets of £1,909,000.