North Cumbria Integrated Care NHS Foundation Trust

Annual Report and Accounts

2020/21

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

Annual Report and Supplementary Material 2020/21

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CHAIR AND CHIEF EXECUTIVE WELCOME

We absolutely have to introduce this year's report with a big thank you. Thank you to our staff, our partners, our patients, their families, and the communities we serve.
It is a privilege to work alongside a fantastic group of people and we should all be proud of our achievements in this most difficult of years.

It's no understatement to say that this year has been the most challenging that many of us in healthcare have ever faced. We have lost members of our NCIC family, and many people will have lost family and friends. We don't underestimate the sacrifices people have made.

We are incredibly proud of our efforts to manage the latest phase of the pandemic, in which Carlisle was more severely affected than anywhere outside of London. Nevertheless, our teams pulled together, doing remarkable, resilient, and spirited work despite the turmoil they have experienced.

In the last year, our efforts to improve patient flow have paid dividends and resulted in us creating a system-wide transfer of care hub with partners. We have also made great progress in partnership with social care partners on improving our emergency care pathways.

And a £35m investment in our brand-new Northern Centre for Cancer Care, created in partnership with Newcastle Upon Tyne Hospital Trust, will deliver exceptional care to our local communities in state-of-the-art facilities. The centre is due to open in autumn 2021 and will treat many patients each year.

Most of our services have now restarted and our focus for the coming year will be on continuing restoration, with a particular emphasis on culture and becoming a clinically-led organisation in collaboration with management through *Our NCIC Way*. This will put our values of kindness, respect, collaboration, and ambition at the heart of how we behave towards one another. We intend this will also improve engagement with our staff, which has been shown to have a positive effect on patient care and outcomes.

We also want our executive and leadership teams to be more visible to staff and patients during 2021/22 through a programme of visits and other informal events. It's important to us both that our teams know who their leaders are, and can have frank and open discussions with us about the things they consider important.

During the summer of 2020, we were inspected by the CQC twice. Those inspections highlighted a number of significant concerns, with the CQC serving a formal notice that we needed to improve. They also identified 51 'Must Do' and 9 'Should Do' improvement actions. We responded immediately and have worked closely with CQC colleagues to provide assurance that the safety of our services has improved. We are also working

closely with colleagues in NHS Improvement who are providing a bespoke package of support.

We will continue our transformation and improvement plans, which include strengthening our governance and risk management arrangements, and improving how we use data to inform quality and patient safety.

There is still much we need to do to make NCIC the organisation we know it can be – for our patients, our staff, and our communities. We are determined to continue to make improvements to ensure NCIC is a place where patients receive safe, high-quality professional care, and staff feel valued and respected.

Peter Scott
Interim Chair
24th June 2021

Lyn Simpson
Chief Executive
24th June 2021

1. PERFORMANCE REPORT

1.1 Performance Overview

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

North Cumbria was one of the first areas to be under significant pressure from Covid-19 in the first wave in April 2020. It was in the top 20 worst hit locally alongside the London Burroughs initially. Local rates of Covid were also very high in the January 2021 wave of the Covid pandemic which effected services at NCIC. North Cumbria worked closely with partners locally and regionally to ensure the following:

- The Trust has had sufficient PPE supplies. Local PPE stocks were managed effectively ensuring frontline staff had the necessary PPE despite widespread national shortages. The Trust used 2.8 million items of PPE.
- 134,000 coronavirus tests were carried out, 19,000 antibody test and 30,000 lateral flow test.
- NCIC was one of the first Trusts in the country to start administering the Covid vaccine and has now vaccinated more than 20,000 people including staff, partners, and patients.
- The Trust was prepared for a surge with extra beds prepared in the acute setting, ICUs and in the community.
- The Trust has used national capital funding to enable both Acute Hospitals to improve their ability to manage future pandemics effectively and improve infections prevention and control, in the following ways:
    - Improvements to Urgent and Emergency Care; A&E and receiving areas on both sites; improving ventilation and number of isolation rooms, increasing same day emergency care and improving layout to separate Covid and Non-Covid patients.
    - Improvements to inpatient ward areas; increasing the capacity to escalate quickly on both sites, increasing the number of cubicles and improving ventilation at Cumberland Infirmary.

Alongside responding to the Covid Pandemic, where possible work continued in the delivery of healthcare service, with the following notable achievements:

- The Trust are in the process of successfully recruiting circa 200 nurses from overseas
- The Trust launched Our NCIC Way, the model for our culture and how we will do things, following listening to and engagement with staff

- Won a bid to implement a new electronic prescribing and medicines administration (EPMA) system so we can improve our service to patients
- The Trust has received capital funding for a new PCI (primary percutaneous coronary intervention) centre.
- The Endoscopy Decontamination Suite at CIC has been renewed, significantly improving the service for patients
- WebV has been successfully launched as a clinical record and patient safety digital solution, securing a start on our EPR (Electronic Patient Record) journey
- The Trust is developing the final version of West Cumberland Hospital business case Phase 2 which will be a fantastic new development for patient and staff.
- The Northern Centre for Cancer Care North Cumbria is currently under development on the Cumberland infirmary site and will completed in the summer of 2021.
- Radiology – new MRI and CT scanning facilities on the Lower Ground Floor completed mid-December 2020.
- The in-patient unit at Brampton Hospital reopened in the summer of 2020 following a £1m refurbishment programme of the 16 bedded unit.

We are currently looking at the principles of equity and equality of service delivery to different groups and ways in which to collate and report this information. This will form part of the integrated performance report during 2021/22.

During the year the Trust operated within the temporary national financial regime instituted as a response to the pandemic. We achieved our planned financial performance overall with a deficit of £7.4m against a planned deficit of £8.9m. However, on an underlying basis the Trust has a deficit that is unsustainable and so we remain focussed on long term financial recovery. The future financial regime will likely require the Trust to reduce its annual running deficit. During the year the Trust, post merger, embedded its financial controls and budgetary controls to ensure we are well prepared for increased financial performance delivery in future periods. By achieving our financial plan we have demonstrated an overall stronger financial performance than in the previous year. We have maintained a focus on delivering efficiency and have prepared modest efficiency plans in line with national planning requirements to be implemented from April 2021 onward. These will be expanded as the temporary financial regime converts back to a permanent financial planning process. We have engaged fully with our NHS partners in the North East and North Cumbria ICS and have confirmed our financial plan in this context for a modest surplus in the first six months of 2021/22. In considering key issues at the Statement of Financial Position (SoFP) date the Trust undertook a review of its PFI prepayments and amended these to a more appropriate level; we also revisited the approach to fixed asset valuation. Both of these reviews have led to a reduced asset balance on the Trust's SoFP to more appropriately reflect the fair and modern equivalent values of these assets respectively.

During the work to finalise the accounts for 2020/21 an issue affecting valuation of the West Cumberland Hospital site was identified. The site has undergone extensive redevelopment in recent years, however, following a new build and extensive refurbishment of the retained estate there have been changes to floor areas which had not been reflected in the valuations of some of its buildings and dwellings. To address the error the Trust submitted revised floor areas to its valuers who prepared revised valuations for the affected 2018/19 and 2019/20 periods. The Trust's key financial statements for 2019/20 (included in the 2020/21 accounts as the prior year comparator) and a number of the associated notes have been restated to reflect a reduction to the value of Property, Plant & Equipment of £19,053k as at 31 March 2020.

Chief Executive's statement on the performance of the Trust

Since March 2020, the Trust has been dominated by responding to the challenges of the Covid pandemic. The usual NHS England & Improvement planning programme, including elective care recovery, was postponed at a national, regional and local level in the first and final quarters of 2020/21. The immediacy of the emergency response was prioritised and the NHS saw a national mandate to stop all non-urgent elective care procedures in order to release capacity to allow trusts to respond to the challenges of the pandemic.

Non elective performance, including the delivery against the 4-hour standard continues to be challenging, particularly at the Cumberland Infirmary Carlisle site, however the declining trend over winter has reversed, with performance in February and March in 2021 performing better than last year. Cohorting of COVID/non-COVID patients to prevent outbreaks and ensure patient safety has led to periods of bed shortages dependant on the combination of people and cases requiring admission throughout the day. We plan daily for this using a rolling average of the number of people admitted with COVID, and our work with System Partners to discharge to other settings patients who are at or beyond 14 days since they were confirmed as having COVID and who are fit to discharge. The impact of our targeted discharge improvement work has been evident over the course of 2020/21. We have reduced and stabilised numbers of patients' length of stay for both stranded (14+ days) and superstranded (21+ days) and are working with System partners to implement the Hospital Discharge Policy and review daily those patients who are medically optimised and appropriate to discharge.

The Trust delivered Elective care at around 80% of its planned activity levels in March 2021 due to the impact of the third COVID wave. The size of our waiting list has gradually increased since the first COVID wave, however remains well below our projected plan for 2020/21. The number of people waiting over 52 weeks grew at an accelerated rate during the third wave. However, due to the earlier than anticipated restart of elective services in March 2021 we ended the year on plan with 3,109 patients waiting. Patients continue to be prioritised based on clinical urgency. We have worked with partners on the

development of an elective care recovery plan for 2021/22 which will reduce to zero the number of patients waiting 52 or more for treatment.

Our diagnostic performance is gradually improving, achieving 51% waiting over 6 weeks for test, 9% better than the peak in January 2021. Activity returned to pre-third wave levels by the end of the year, however overall recovery is a long term challenge due to the size of the waiting list backlog.

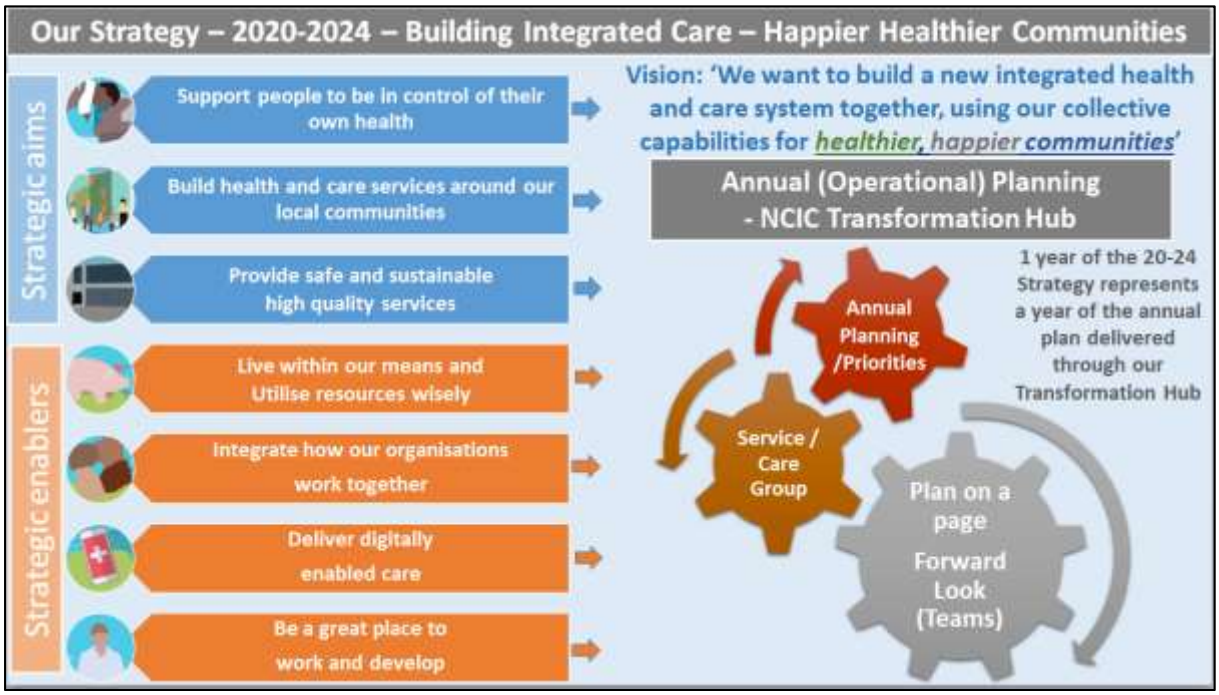
Performance against the 14 day Cancer standard saw a significant improvement in the last half of the year. This declining trend is expected to gradually reverse in Quarter 1 of 2021/22 as patients complete their delayed-treatment pathways across the Cancer Network.

The purpose and activities of the Trust

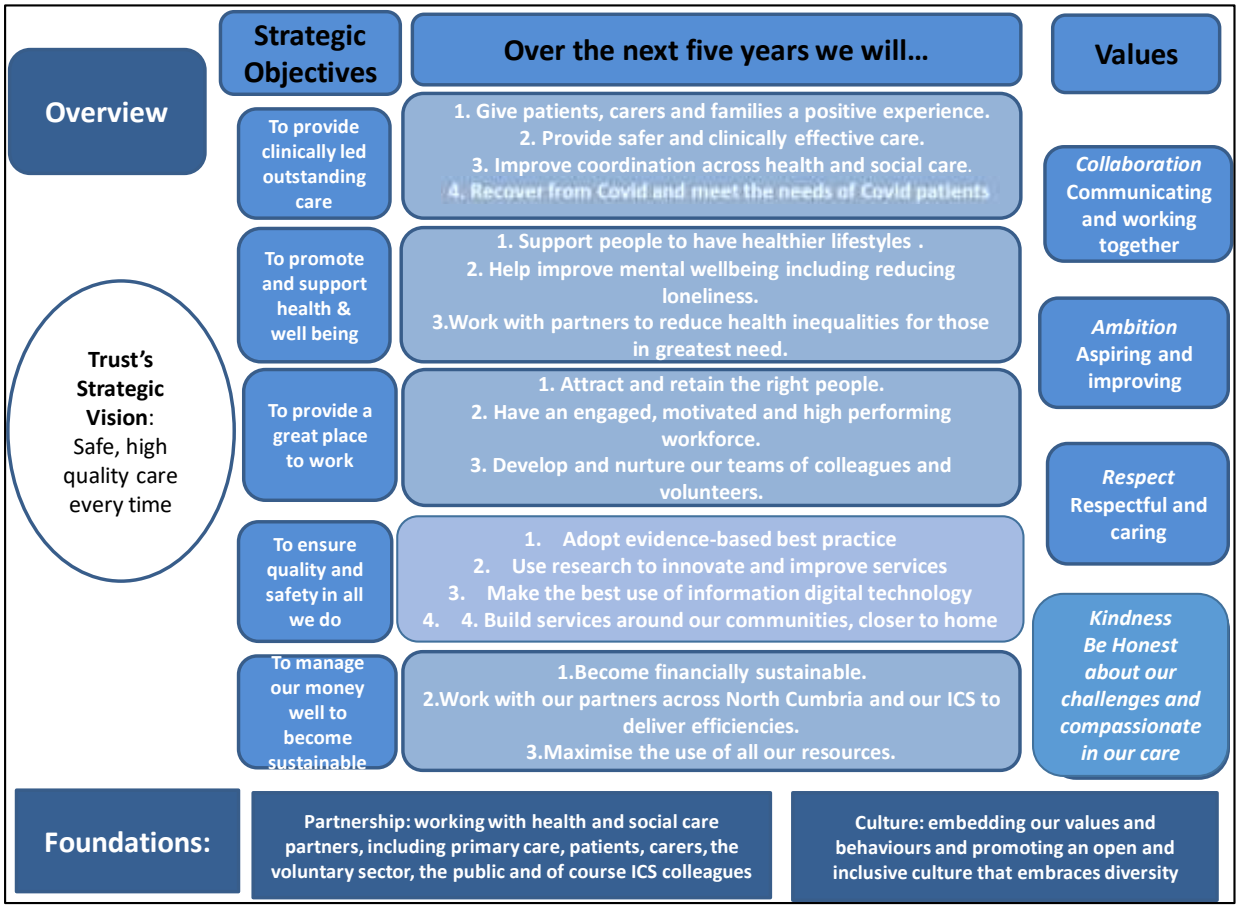
North Cumbria Integrated Care NHS Foundation Trust (NCIC) provides hospital and community health services to a half a million people. We're responsible for delivering over 70 services across 15 main locations and we employ 6,072 whole time equivalent members of staff.

Our vision is shared by our partners in the north Cumbria health and care system **to build a new integrated health and care system to create healthier and happier communities.** The system strategy and trust strategy are outlined below.

North Cumbria Integrated Care Partnership (ICP) Strategy 2020-24



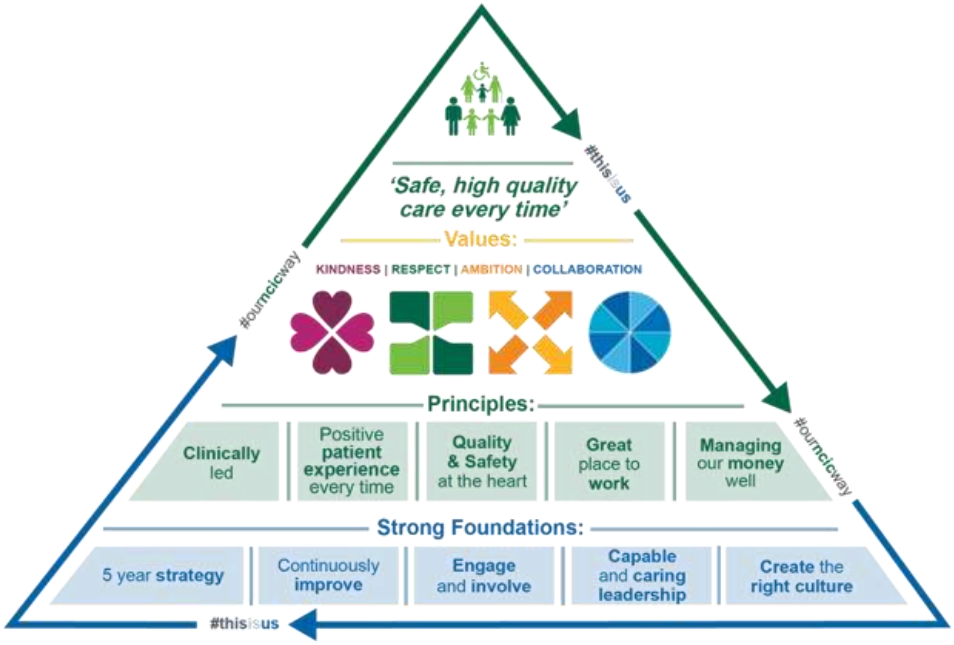
North Cumbria Integrated Care Trust Strategy 2021-2026



Our Core priorities and goals 2021/22

Priority Grouping	11 Core Priorities 2021/22	Priority goals/actions				Success Criteria	
Corporate	**Quality & Safety at the heart (inc CQC)**	Improving use of patient safety information	Increasing patients, staff and partners involvement	Deliver effective and sustainable change in key areas	Positive patient experience every time Clinical Effectiveness	*CQC rating retained and heading for Good*	*Improved patient safety experience*
	Organisational Form and Governance	Organisational Form	Governance			*CQC rating retained and heading for Good*	
	People - Be a great place to work	Align Health & Wellbeing interventions /support to our Trust priorities	Understand key retention issues and devise appropriate solutions	Improve ESR accessibility and applications	Compassionate leadership development	*Improved retention rates*	*Improved: staff satisfaction and recommending NCIC for care*
	Digitally enabled care	Improving digital care for patients	Digitally enabling our workforce	Digital Systems	Strengthening our digital infrastructure	*Meet data protection standards*	*Improve digital maturity scores*
	Managing our money well	Living within our means	Operational Reset (Efficiency, Collaboration, Two site working)			*Reduce our deficit*	*Improve our efficiency and meet CIP targets*
	Transformation Plan	#NCICway	Transformation Programmes			*Improved retention rates*	*Improved: staff satisfaction and recommending NCIC for care*
Service development	**Elective Care Recovery**	Transform Outpatients	Recover waiting times and cancer standards	Theatre Utilisation	Provider Collaboration/ Networks	*Meet of Elective Recovery targets and gateways*	*Meet our agreed trajectories for Elective, Cancer and Diagnostics standards*
	Patient flow, discharge acute/ community	Innovations for Urgent and Emergency Care Pathways	Surge Planning	Reducing the avoidable admissions	Improve discharge effectiveness	*Reduction bed occupancy medically optimised Reduce LOS 14/21 days*	*Meet A&E measures*
	Enhancing services in the community	Developing day units to provide services out of the acute	Patient upstream prevention/ Population Health / Risk Stratification		Enhance ICC working inc: Mental Health	*Meet 2 hour rapid response trajectories* *Increase discharge to assess*	*Reduce admissions and reduced bed days of ICC targeted cohort*
	Children and Families	Enhancing Maternity Services - Better Births - Ockenden Report	Development of Short Stay Paediatric Assessment Units	SEND improvements for children - working with partners	Improved partnership/ pathway working	*Meet Ockenden Report milestones*	*Meet better Births milestones*
	Major Development programmes	Cancer Centre	WCH Phase 2	PCI		*Cancer Centre open and operational*	*WCH - P2 FBC Passed PCI - new labs open /functioning and in budget*

The NCICWay is how we do things around here – the way we deliver safe, high-quality care to patients every time. Our NCIC Way is about how we do things, not what we do.



It is underpinned by key principles and our five-year strategy, but at its heart, Our NCIC Way is about our shared values and how we behave with one another. It's the way we're going to transform NCIC.

Key components of Our NCIC Way are our values kindness, respect, ambition, and collaboration, and the Compact, which was co-created by staff and members of the executive team last year. The Compact is the promises we make to one another about how we'll behave, which clearly link back to our values.

We want to create a culture which values professional behaviours, and which enables people to be the best they can be. NCIC needs to be clinically-led, but we will only be successful if clinicians, managers and all staff work together in partnership to do the right thing for our patients.

We will use Our NCIC Way to help us recover from the demands of the Covid-19 pandemic. It's a framework to help us review and shape policy and procedure, it can be used to help people challenge behaviours which aren't in line with our values, and it will guide the changes we need to make to turn NCIC into the organisation we know it can be.

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

Kindness

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

Respect

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

Ambition

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

Collaboration

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

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

A history of the Trust and its statutory background

NCIC was formed on 1 October 2019 following the merger of the former Cumbria Partnership NHS Foundation Trust (CPFT) and North Cumbria University Hospitals Trust (NCUH). As a single Trust, we want to become more embedded in our local community. Not just caring for people but improving their wellbeing too.

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

Our four care groups are the Emergency Care and Medicine Care Group; Community and ICC Care Group; Surgery, Critical Care and Clinical Support Care Group, and the Women's and Children's Care Group which provide a range of services including acute services in north cumbria at the Cumberland Infirmary and West Cumberland Hospital and a range of community services across our footprint.

Key issues, opportunities, risks and associated controls

Key risks to the delivery of our objectives and associated controls are set out in our Board Assurance Framework (BAF) which is reviewed on a quarterly basis. Risks described within the BAF relate to the themes of workforce, leadership, quality, financial sustainability, our IT and estates infrastructure, dependencies on system partners. A new risk added to the BAF in 2020/21 related to our ability to manage and recover from the significant disruption associated with the Covid-19 pandemic which has had a notable impact on our elective care programme. During quarter 3 of 2020/21 the Board of Directors agreed the elective care recovery strategy which is the framework for how we will recover services to at least pre-pandemic performance by the end of 2021/22.

Operational and clinical risks are identified, managed and monitored through our governance frameworks, in accordance with the Risk Management Policy and performance management framework. Risk reporting and measurement are actioned through our Oversight Framework, quality and safety dashboards, and via the risk management information system (Ulysses) - all of which enables a line of sight to risk management performance at all levels throughout the Trust.

Our BAF will be undergoing a full refresh during quarter 1 of 2021/22 as part of work we are undertaking to improve board effectiveness. Further details about our key strategic, operational and clinical risks, and work to refresh the BAF can be found in the Annual Governance Statement.

Going Concern Disclosure

After making enquiries, the directors have a reasonable expectation that the services provided by the 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.

Summary of Performance

- All healthcare providers across the country are set a range of quality and performance targets by the Government, commissioners and regulators. 2020/21 was dominated by responding to the challenges of the Covid pandemic, with routine and planned appointments stood down from March to July , and then again in January and February 2021.
- Urgent and Emergency Care experienced shifts in attendance and admissions, with reductions in attendances to our Urgent Care Treatment Centres and Emergency Departments alongside reduced non elective admissions from March to July 2020. This was followed in December through to February 2021 with a 3rd wave of extremely high Covid admissions, alongside anticipated winter pressures.

Area	Measure	National Standard	National average	Trust actual performance as reported				20/21 compared to	
				17/18	18/19	19/20	20/21	National standard	National average
A&E	% of patients who wait under 4 hours in A&E	95%	86.3%	90.3%	90.1%	84.9%	85.1%	🔴	🟡
Cancer	% of cancer patients seen within 2 weeks of a GP referral	93%	90.3%	94.6%	91.5%	92.4%	93.7%	🟢	🟢
	% of cancer patients treated within 31 days of a decision to treat	96%	94.7%	97.6%	95.7%	96.0%	86.6%	🔴	🔴
	% of cancer patients treated within 62 days of GP referral	85%	69.7%	85.4%	81.6%	76.6%	61.6%	🔴	🔴
Waiting Times	% of patients waiting less than 18 weeks from Referral to Treatment	92%	64.5%	84.2%	75.3%	72.0%	55.4%	🔴	🔴
	% of patients waiting less than 6 weeks for a diagnostic test	99%	71.5%	98.6%	95.2%	88.6%	49.0%	🔴	🔴
Key:	🟢 **Same or better**	🟡 **Slightly worse (<2%)**				🔴 **Significantly worse (>2%)**			

- Cancer Treatment activity has been steadily increasing post the peak COVID period and is projected to achieve pre-COVID levels in 2021/22.
- 62 day performance has been the area of most challenge at NCIC, with Urology performance being a significant driver. During the Covid lockdown, the Trust followed national guidance for treating cancer patients, leading to large numbers of patients being deferred.
- Covid has also had a significant impact on endoscopy capacity, leading to challenges in the 14 day standard for upper and lower GI.
- Diagnostic performance against the 1% standard had slowly recovered post COVID first wave, maintaining around 50% over 6 weeks, however, performance dropped

to 60% over six weeks in January as staff were redeployed to support ward areas. The total waiting list is roughly double the pre-COVID volume.

Signed:  **Date: 24th June 2021**

Lyn Simpson
Chief Executive

2. ACCOUNTABILITY REPORT

This comprises the following reports:

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

Signed:  **Date: 24th June 2021**

Lyn Simpson
Chief Executive

2.1 Directors' Report

NHS England and NHS Improvement's Well-Led Framework

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

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

The Board of Directors gives specific attention to:

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

The Quality Report (published separately) describes our quality plans in more detail and outlines our achievement of quality over a number of specific areas. You can find out more about our quality governance, the challenges encountered and action taken during 2020/21 in the Annual Governance Statement.

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

There were a number of changes to Board membership during the year which can be found in the Remuneration Report. You can find out more about the background and experience of all individual Board members as at 31 March 2021 later in this report.

All NEDs, the Chief Executive and a maximum of six other Executive Directors were able to exercise one full vote in 2020/21. The Chair has a second, casting vote on occasions where decisions are tied.

The Board meets formally in public every two months and monthly in private. There were two additional meetings of the Board held during the year in addition to scheduled meetings. A summary of decisions made by the Board is provided at each public Board of Directors meeting. The Board is responsible for:

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

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

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

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

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

As a unitary board, all Executive and NEDs have joint responsibility for every decision of the Board and share the same liability. This does not impact upon the particular

responsibilities of the Chief Executive as Accountable Officer to Parliament, for ensuring that the Trust operates consistently within national policy and public service values.

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

All NEDs are considered to be independent in character and judgement and have no other cross directorships or significant links which could materially interfere with the exercise of their independent judgements. Arrangements are in place to manage any potential conflicts. The Chair had no other significant commitment during the year and therefore there was no requirement to report on this issue to the Governors' Council.

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

Table 3.1 shows members of the Board, their roles and attendance at Board and Governors Council general meetings during the year. Regular attendance at meetings of the Governors Council provides the opportunity for members of the Board to gain an understanding of the views of governors and members. The Board and Governors Council undertake a programme of joint visits to Trust services which enables NEDs and governors to listen to the views of staff and observe service delivery. This programme was paused during 2020/21 due to Covid-19. We are seeking to re-start these visits from July 2021 having due regard to Covid-19 restrictions.

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

All NED vacancies are managed by the Governors Council's Nominations Committee to ensure the Board has the necessary skills and experience required and that the Board is well balanced. Terms of office for the Chair and NEDs are reviewed regularly to ensure succession planning is adequate and effective. Peter Scott commenced in the role of interim Chair on 1 April 2020 following Robin Talbot's resignation from the Chair position in January 2020. Recruitment activity to appoint a substantive chair began in March 2020 but was paused due to Covid-19. During 2020/21 the Governors Council agreed Peter Scott's continuance as interim chair until March 2022. Further details of NED and Chair

recruitment processes during the year can be found in the report from the Nominations Committee.

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

Table 3.1 Board of Directors and attendance at Board and Governors' Council General meetings 1 April 2020 – 31 March 2021

Name	**Attendance – Board of Director meetings (max 15) (actual/potential)**	**Attendance* – Governors' Council General meetings (max 8) (actual/potential)**
Current Non-Executive Directors		
Peter Scott	15/15	6/8
Dr Louise Nelson PhD	13/15	5/8
George Liston	15/15	5/8
Jeff O'Neill	15/15	4/8
David Allen	14/15	0/8
Susan Mckenna	15/15	1/8
Philip Kane **	n/a	n/a
Other Non- Executive Directors in post during 2020/21		
Malcolm Cook	11/12	5/6
Current Executive Directors		
Lyn Simpson	15/15	4/8
Dr Rod Harpin	12/15	0/8
Dean Oliver	14/15	1/8
Michael Smillie, BSc (Hons), FCPFA	15/15	0/8
Justine Steele	12/15	0/8
Jill Foster **	n/a	n/a
Other Executive Directors in post during 2020/21		
Prof. John Howarth MBBS, DTM&H, FRCGP, FFPH	1/5	1/3
Ramona Duguid	14/15	3/8
Anna Stabler	13/15	2/8

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

** Not in post during 2020/21.

Director profiles

Details of Directors in post on the date of this annual report are shown below.

NON-EXECUTIVE DIRECTORS

Peter Scott
Interim Chair

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

My previous positions include working at various levels of the NHS locally at North Cumbria Acute Hospital, Cumbria Clinical Commissioning Group and Northumbria and Tyne & Wear Strategic Health Authority together with national roles at the Department of Health.

Louise Nelson PhD
Non-Executive Director

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

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

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

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

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

George Liston
Non-Executive Director / Senior Independent Director

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

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

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

Jeff O'Neill
Non-Executive Director

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

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

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

David Allen
Non-Executive Director

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

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

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

Susan McKenna
Non-Executive Director

I was appointed to the Board in October 2019.

I have spent the last 37 years in the NHS, within clinical care or management and leadership roles, both physical and mental health and hold a current registration.

I retired from my previous full time role as Chief Operating Officer at South West London and St George's University Hospitals NHS Trust in December 2019. Previously Chief Operating Officer at Avon and Wiltshire Mental Health Partnership NHS Trust and Director of Nursing, and before that, an operational Director for many years. Key areas of interest and expertise are performance management, governance and safety, leadership and large scale transformation.

I have recently taken on the role of Chair of the Board Committee Finance, Improvement and Performance. I am an active member of the Quality Improvement and Safety Committee. I have recently also taken on the Non-Executive Director lead for Maternity Services.

Philip Kane
Non-Executive Director

I was appointed to the Board in May 2021.

I retired in December 2020 after 24 years in NHS clinical practice as a consultant neurosurgeon in the South Tees Hospitals NHS Foundation Trust. During that time I held a number of clinical leadership and managerial roles including Neuro-oncology MDT lead, Clinical Director of Neurosurgery & Neuroradiology and Chief of Service, Division of Neurosciences. Several roles reflected my specialist interest in the management of cancer including chair of the NSSG for Brain & CNS tumours, Cancer peer reviewer, member of the National Clinical Reference Group for Brain & CNS tumours and Trust lead clinician for cancer. I enjoyed an active role in undergraduate and postgraduate medical education and was an honorary Professor in the School of Health, Durham University, AFP supervisor, MRCS examiner and an ATLS course director. During the two years preceding my retirement I chaired the senior medical staff forum.

EXECUTIVE DIRECTORS

Lyn Simpson
Chief Executive

I was appointed as Chief Executive of North Cumbria Integrated Care NHS Foundation Trust in January 2020 and have a number of years of clinical and executive director level experience working in the NHS at a local, regional and national level.

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

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

I have previously worked as the regional director for the North at the NHS Trust Development Authority which subsequently became NHS Improvement and I was involved in providing leadership and engagement for 70 NHS organisations across the North East and Yorkshire and North West regions including acute, community, mental health and ambulance trusts as well as NHS foundation trusts.

Prior to joining North Cumbria Integrated Care NHS Foundation Trust, I led, on behalf of the North East and Yorkshire region, the early phases of integration and transformation in the Tees Valley which included designing and executing a clinical services strategy, financial recovery plan and an options appraisal process for organisational form.

Having trained as a nurse, health visitor and midwife, I remain passionate about ensuring the delivery of safe, high-quality care for patients in parallel with developing and supporting

staff and services. I look forward to continuing to work with colleagues to build on the good work in place and improve areas through the engagement of clinicians, staff and partnership working.

Dr Rod Harpin
Interim Executive Medical Director

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

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

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

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

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

Michael Smillie BSc (Hons) FCPFA
Executive Director of Finance, Estates and Digital

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

I have over 27 years' experience working in the NHS and have held posts as a Director of Finance, Director of Commissioning and Director of Business Development in both commissioning and provider organisations in England.

I lead on financial stewardship, digital services and developing our estate for the Trust and do so working closely with our partners to get the most from our limited resources.

Having grown up in Cumbria and returned here following working elsewhere in the NHS I now live with my family in Cumbria and I am a champion for our services achieving the best for our population.

Jill Foster
Interim Executive Chief Nurse

I joined the Trust in April 2021 as Interim Executive Chief Nurse. I am a registered nurse with 35 years' experience and for the last seven years have held the post of Executive Chief Nurse of integrated provider organisations in London and North Yorkshire.

My clinical background is in Acute Medicine, Coronary and medical high dependency and intensive care.

I am passionate about providing exceptional outcomes and care for the people this organisation serves delivered by skilful, respectful and kind colleagues.

Dean Oliver
Executive Director of Performance, Planning & Strategy

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

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

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

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

Justine Steele
Executive Director of People and Organisational Development

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

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

Over the years I have been committed to my personal continuous development and have attained a Masters in Strategic HRM and accredited level 7 in Executive Coaching and Mentoring through the British School of Coaching. I am also a trained mediator.

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

Johanna Reilly
Director of Operations (Programmes)

I joined the Trust as Director of Operations (Programmes) in May 2021. I am a registered nurse with over seven years' experience as a Chief Operating Officer at South Tees Hospitals NHS Foundation Trust and Liverpool Community Health NHS Trust. I also have experience working in NHS England and in commissioning roles.

Income disclosure required by Section 43(2A) of the NHS Act 2006

Provision of goods and services for the purposes of the health service in England
During 2020/21, income from the provision of goods and services for the purpose of health services in England was greater than the income from the provision of goods and services for other purposes.

2.2 Remuneration Report

Section One – Annual statement on remuneration

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

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

Executive team changes

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

Name and Role	Change
Dean Oliver, Executive Director of Performance & Improvement	Dean joined the Trust in April 2020 on secondment from NHS Improvement
Justine Steele, Executive Director of People & OD	Justine joined the Trust as Executive Director of People & OD on 4 May 2020
Anna Stabler, Executive Chief Nurse	Anna was appointed as Executive Chief Nurse on 6 July 2020. Anna had been undertaking this role on an interim basis since 1st January 2020.
Professor John Howarth, Executive Director of Strategy	John left the Trust on 31 August 2020 to focus on the activities of North Cumbria Primary Care
Mandy Nagra, System Executive Chief Operating Officer	Mandy left the trust on 23 January 2021 after a period of secondment elsewhere in the NHS from 1 January 2020.
Ramona Duguid, Executive Director of Operations	Ramona left the Trust on 31 March 2021 to take up the post of Chief Operating Officer with Cumbria, Northumbria Tyne & Wear NHS Foundation Trust

Changes to Executive Directors' Remuneration

In March 2021, the Remuneration Committee approved the very senior manager (VSM) pay award of 1.03% for 2020/21, backdated to April 2020.

Section Two – Senior managers remuneration policy

a. Future Policy Table

Directors:

Element	How this supports the strategic objectives of the Trust	How this operates	Maximum that can be paid
Salary	To attract and retain high calibre individuals and reflect level of responsibility.	All the Executive Directors are remunerated based on a local VSM scale system which is reviewed annually.	£191,957 *
Taxable Benefits	To attract and retain high calibre individuals.	This covers the provision of a lease car.	There is no specific maximum set but costs including fuel and insurance excess in the event of an accident are met by the director.
Pension Related Benefits	To attract and retain high calibre individuals.	Directors are eligible for membership of the NHS pension scheme.	In line with the NHS pension scheme.

** The Medical Director is on the national consultant salary scale with a separate additional responsibility payment for the Executive Director responsibilities. Other allowances may also apply.*

There is no link between individual performance and salary. However should individual performance fall below the expected standard it would be addressed through performance management. All Directors have clear objectives based upon the Trust business priorities No Director received any annual or long term performance-related bonuses in 2020/21.

Non-Executive Directors:

Fees Payable	Additional Fees Payable	How this supports the strategic objectives of the Trust	How this operates	Maximum that can be paid
NEDs: £13,000 per annum	Not applicable	To attract and retain high calibre candidates.	Reviewed by the Nominations Committee and any changes are approved by the	No maximum is specified but market rates are considered.

Chair: £40,000 per annum	Not applicable		Governors Council. Fee in accordance with NHSE/I Guidance Sept 2019	

b. Service contract obligations

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

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

c. Policy on payment for loss of office

All contracts for executive directors during 2020/21 were substantive NHS contracts and are subject to the giving either three or six months' notice by either party. Our normal disciplinary and performance management policies apply to senior managers. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

d. Statement of consideration of employment conditions elsewhere in the Trust

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

e. Diversity and inclusion

Information on the Trust's diversity and inclusion policy can be found in Section 2.8.1 of this report.

Section Three – Annual report on remuneration

a. Service contracts

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

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

Non-Executive Directors and Chair		
	Date Term of Office Commenced	**Date term of Office Ends/Ended**
Peter Scott, Chair	1 April 2020	31 March 2022
Louise Nelson	5 March 2018	30 September 2021
George Liston	1 July 2015	30 September 2021
Jeff O'Neill	9 November 2018	30 September 2021
David Allen	1 October 2019	30 September 2022
Susan McKenna	1 October 2019	31 December 2022
Philip Kane	1 May 2021	30 April 2024

b. Remuneration Committee

Remuneration Committee meetings and attendance details 2020/21

Name	Job Title	15/04/2020	13/07/2020	21/08/2020	17/12/2020	05/02/2021	16/03/2021	Meeting Count = 6 Meetings in total	% Attend
George Liston	NED/Rem Committee Chair	✓	✓	✓	✓	X	✓	5/6	**84**
Peter Scott	Trust Chair	✓	✓	✓	✓	✓	✓	6/6	**100**
David Allen	NED	✓	✓	✓	✓	X	X	4/6	**67**
Louise Nelson	NED	✓	✓	✓	X	✓	✓	5/6	**84**
Jeff O'Neill	NED	✓	✓	✓	✓	✓	✓	6/6	**100**
Malcolm Cook	NED	✓	✓	✓	✓	Malcolm Cook ceased working within the Trust		4/4	**100**
Sue McKenna	NED	X	✓	✓	X	X	✓	3/6	**50**
Executive Directors in Attendance based on Committee Requirements									
Lyn Simpson	Chief Executive	✓						**1**	
Michael Smillie	Director of Finance, Digital and Estates	✓						**1**	
Daniel Scheffer	Company Secretary			✓				**1**	
Justine Steele	Director of People & OD			✓		✓		**2**	
Rod Harpin	Medical Director				✓		✓	**2**	
In Attendance									
Jacky Stockdale	Business Manager Corporate Services	✓	✓	✓	✓	✓	✓	6	
Christine Lightfoot	Principal HR Business Partner						✓	1	

c. Disclosures required by the Health and Social Care Act

Expenses of the Governors and Directors

	Total Number		Number claiming expenses		Value of claims £00s	Value of claims £00s
	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21
Non Executive Directors	9	7	7	4	141	14
Executive Directors	13	9	8	6	90	141
Governors	42	33	21	6	94	9

Remuneration for each senior manager who served during the last financial year

The information below is subject to audit

Single Total Figure Table

Name and Title	2020/21				2019/20			
	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£	£000	£000	£000	£	£000	£000
Mr David Allen, Non Executive Director wef 1 October 2019	10-15			10-15	5-10			5-10
Dr Vincent Connolly, Executive Medical Director wef 1 June 2019 until 31 March 2020					150-155	200	365-367.5	520-525
Mr Malcolm Cook, Non Executive Director until 31 December 2020	10-15	100		10-15	5-10	200		5-10
Mrs Ramona Duguid, Executive Director of Strategy 1 April 2019 - 31 March 2020 and Interim Executive Director of Operations wef 1 April 2020 until 31 March 2021	130-135		40-42.5	170-175	95-100	200	42.5-45	140-145
Mr Stephen Eames, Chief Executive until 5 January 2020					105-110	11,000		120-125
Dr Rod Harpin, Executive Medical Director, Lead for North Cumbria University Hospitals NHS Trust until 31 May 2019 and Interim	205-210		47.5-50	255-260	5-10	100	0-2.5	5-10

Name and Title	2020/21				2019/20			
	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£	£000	£000	£000	£	£000	£000
Executive Medical Director from 1 April 2020								
Mr Brian Hetherington, Non Executive Director until 30 September 2019					5-10	200		5-10
Ms Heike Horsburgh, Non Executive Director until 30 September 2019					5-10	200		5-10
Prof John Howarth, Joint Deputy Chief Executive until 31 March 2020 and Executive Director of Strategy 1 April 2020 - 31 August 2020	115-120	200		115-120	120-125	2,800		125-130
Mr George Liston, Non Executive Director	10-15	100		10-15	5-10	200		5-10
Mrs Susan McKenna, Non Executive Director wef 2 January 2020	10-15			10-15	0-5			0-5
Mr Alan Moore, Non Executive Director until 30 September 2019					5-10	100		5-10
Mrs Mandy Nagra, Chief Operating Officer until 31 December 2019					65-70	300		65-70
Dr Louise Nelson, Non Executive Director	10-15			10-15	5-10	100		5-10
Mr Gary O'Hare, Interim Executive Director of Mental Health & Learning Disabilities wef July 2018 until 30 September 2019					25-30	200	17.5-20	45-50
Mr Dean Oliver, Interim Executive Director of Performance & Improvement wef 1 April 2020	75-80	500	17.5-20	95-100				
Mr Jeffrey O'Neill, Non Executive Director wef 1 October 2019	10-15			10-15	5-10			5-10
Dr Peter Rooney, Interim Executive Director of Service Improvement wef 27 August 2019 until 31 March 2020					n/a	n/a	n/a	n/a

Name and Title	2020/21				2019/20			
	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) total (to nearest £100)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£	£000	£000	£000	£	£000	£000
Mr Daniel Scheffer, Company Secretary until 27 December 2020	75-80		37.5-40	115-120	95-100	900	32.5-35	130-135
Mr Peter Scott, Interim Chair wef 1 April 2020	40-45			40-45				
Mrs Lyn Simpson, Chief Executive wef 6 January 2020	195-200		287.5-290	485-490	45-50		17.5-20	65-70
Mr Michael Smillie, Executive Director of Finance, Estates & Digital and Executive Lead for Workforce and Organisational Development between 17 October 2019 and 3 May 2020	130-135		20-22.5	155-160	95-100		0-2.5	95-100
Mrs Alison Smith, Executive Director of Nursing wef 9 July 2018 until 5 January 2020					65-70	100	82.5-85	150-155
Mrs Anna Stabler, Interim System Executive Chief Nurse 1 January 2020 - 5 July 2020 and Execuive Chief Nurse wef 6 July 2020	95-100		317.5-320	415-420	0-5	100	2.5-5	5-10
Miss Justine Steele, Executive Director of People & Organisational Development wef 4 May 2020	120-125		25-27.5	145-150				
Mr Robin Talbot, Chair until 31 March 2020					35-40	400		35-40
Mrs Judith Toland, Executive Director of Workforce & Organisational Development (wef 5 November 2018) and Digital (wef from 1 April 2019) until 16 October 2019					35-40	200		40-45

Remuneration Notes:

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

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

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

2020/21

The salary range quoted is pro rata to the annual salary and relates to the period that the individual was employed by the Trust.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

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

Dr Harpin's salary was split between his role as a director for the Trust (£85k - £90k) and his clinical duties as a Consultant Anaesthetist (£115k - £120k).

Prof Howarth's remuneration includes contractual payments in lieu of notice of £50k - £55k.

Mr Oliver was on secondment from NHSE/I with effect from 1 April 2020 but recharging arrangements were effective only from 1 June 2020. The figures relating to Mr Oliver in the table above relate only to the period from 1 June.

Mrs Stabler was on secondment from NHS North Cumbria CCG until her substantive appointment to Executive Chief Nurse with effect from 6 July 2020. The CCG met her salary and pension costs in 2020/21 until then and the figures in the table above only relate to the period from 6 July 2020.

Taxable expenses include benefits in kind arising from lease cars.

2019/20

Details of 2019/20 remuneration notes are provided below for ease of reference and comparison with 2020/21.

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

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Taxable expenses include benefits in kind arising from lease cars.

d. Fair Pay multiple

The information below is subject to audit

Median remuneration of staff	Year ended 31 March 2021	Year ended 31 March 2020
Median Total Remuneration £	30,471	29,535
Band of Highest Paid Director's Total Remuneration (£000)	205-210	230-235
Ratio	6.8	7.9

The annualised banded remuneration of the highest paid director in North Cumbria Integrated Care NHS Foundation Trust in the period to 31 March 2021 was £205,000 - £210,000 (2019/20: £230,000 - £235,000). This was 6.8 times (2019/20: 7.9) the median remuneration of the workforce which was £30,471 (2019/20: £29,535).

During the period to 31 March 21 13 Trust-employed members of staff (2019/20: 4) received remuneration in excess of the highest paid director. The equivalent of 30 agency medical staff earned more than the highest paid director (2019/20: 20). Remuneration ranged from £18,005 to £319,197 (2019/20: £17,652 to £300,363).

The reasons the ratio reduced from 7.9 to 6.8 are the reduction in the salary range for the highest paid director and the increase in the median remuneration.

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

e. Total Pension Entitlement

The information below is subject to audit

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2020	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2021
	£000	£000	£000	£000	£000	£000	£000
Mrs Ramona Duguid, Executive Director of Strategy 1 April 2019 - 31 March 2020 and Interim Executive Director of	2.5-5	0-2.5	30-35	65-70	427	20	474

Operations wef 1 April 2020							
Dr Rod Harpin, Executive Medical Director, Lead for North Cumbria University Hospitals NHS Trust until 31 May 2019 and Interim Executive Medical Director from 1 April 2020	2.5-5	n/a	15-20	n/a	260	n/a	n/a
Mr Dean Oliver, Interim Executive Director of Performance & Improvement wef 1 April 2020	0-2.5	0-2.5	15-20	30-35	301	15	337
Mrs Lyn Simpson, Chief Executive wef 6 January 2020	12.5-15	40-42.5	95-100	290-295	n/a	n/a	n/a
Mr Michael Smillie, Executive Director of Finance, Estates & Digital and Executive Lead for Workforce and Organisational Development between 17 October 2019 and 3 May 2020	0-2.5	0-2.5	45-50	105-110	789	20	841
Mrs Anna Stabler, Interim System Executive Chief Nurse 1 January 2020 - 5 July 2020 and Execuive Chief Nurse wef 6 July 2020	12.5-15	42.5-45	60-65	185-190	883	318	1361
Miss Justine Steele, Executive Director of People & Organisational Development wef 4 May 2020	0-2.5	n/a	0-5	n/a	0	12	30
Mr Daniel Scheffer, Company Secretary until 27 December 2020	0-2.5	0-2.5	25-30	40-45	396	31	459

Notes:

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

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

Accrued benefits reflect members' purchase of added years of service and any "transferred in" service where these apply.

As Mrs Simpson is beyond the normal retirement age there are no Cash Equivalent Transfer Value (CETV) values. Dr Harpin passed the normal retirement age during 2020/21 and there is no closing CETV value or real increase in CETV recorded.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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

Signed:  **Date: 24th June 2021**

Lyn Simpson
Chief Executive

2.3 Staff Report

The information in the tables below is subject to audit

2.3.1 Analysis of staff costs

	2020/21			2019/20
	Permanently Employed	Other	Total	Total
Staff Costs - Gross	**£000s**	**£000s**	**£000s**	£000s
Salaries and wages	221,941	14,567	236,508	158,987
Social Security costs	19,449	1,247	20,696	13,973
Apprenticeship Levy	1,040	100	1,140	736
Employer's contributions to NHS Pensions	35,870	2,302	38,172	27,840
Pension cost - other	0	146	146	85
Termination Benefits	174	0	174	40
Temporary staff	0	20,468	20,468	12,453
Total staff costs	**278,474**	**38,830**	**317,304**	214,114
Of which:				
Costs capitalised as part of assets	0	0	0	281

2.3.2 Analysis of average staff numbers

(whole time equivalents – WTE)

	2020/21			2019/20
	Permanently employed	Other	Total	Total
Average Staff Numbers (WTE)				
Medical and dental	551	47	598	365
Administration and estates	1,565	29	1,594	1,347
Healthcare assistants and other support staff	773	167	940	795
Nursing, midwifery and health visiting staff	1,622	124	1,746	1,399
Scientific, therapeutic and technical staff	762	27	789	763
Healthcare Science Staff	350	0	350	217
Other	55	0	55	29
Total	**5,678**	**394**	**6,072**	4,915
Of which:				
Number of employees (WTE) engaged on capital projects	0	0	0	12

2.3.3 Male/female staff numbers as at 31/03/2021

Information below is not subject to audit

	Female	Male
Directors (Executive & Non Executive)	6	7
Other Senior Managers	0	0
All other employees	6,649	1,219
Grand Total	**6,655**	**1,226**

2.3.4 Sickness absence data

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

2.3.5 Staff policies and actions applied during the financial year

Staff Policies are regularly reviewed in partnership with Staff Representatives. We work with subject Specialists to ensure they reflect best practice and current law. Our Local Counter Fraud Specialist input to the review of our Attendance Management policy and our Health and Safety Team worked with us to review our Pregnancy at Work policy.

We continue to work towards ensuring our policies attract and meet the needs of a diverse workforce and are inclusive of people and communities with a protected characteristic. Equality Impact Assessments form part of all policy reviews.

Human Resources and Occupational Health teams work together with line managers to ensure recruitment practices; processes for managing attendance; supporting wellbeing and access to training, career development and opportunities for promotion give full and fair consideration to applicants and staff with disabilities, having regard to their particular aptitudes and abilities.

2.3.6 Staff Turnover

Details of our staff turnover are published by NHS Digital and are available on the link below.
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

2.3.7 Staff Survey Report

Staff Engagement

One of our key objectives is to embed the right culture and make the organisation a great place to work. Staff engagement is essential because we know that when staff are happy and fully engaged they provide the best possible care for our patients. The Trust's People Plan addresses the key employer actions in the National People Plan and we are working with partners in North Cumbria to deliver aspects of the plan and also contribute to the North East & North Cumbria Integrated Care System (NENC ICS) plan. The plan addresses a number of key areas that directly impact on staff engagement which are:

- Workforce Supply
- Health & Wellbeing and Equality, Diversity & Inclusion
- System Development and Leadership
- Workforce Redesign

NHS Staff Survey

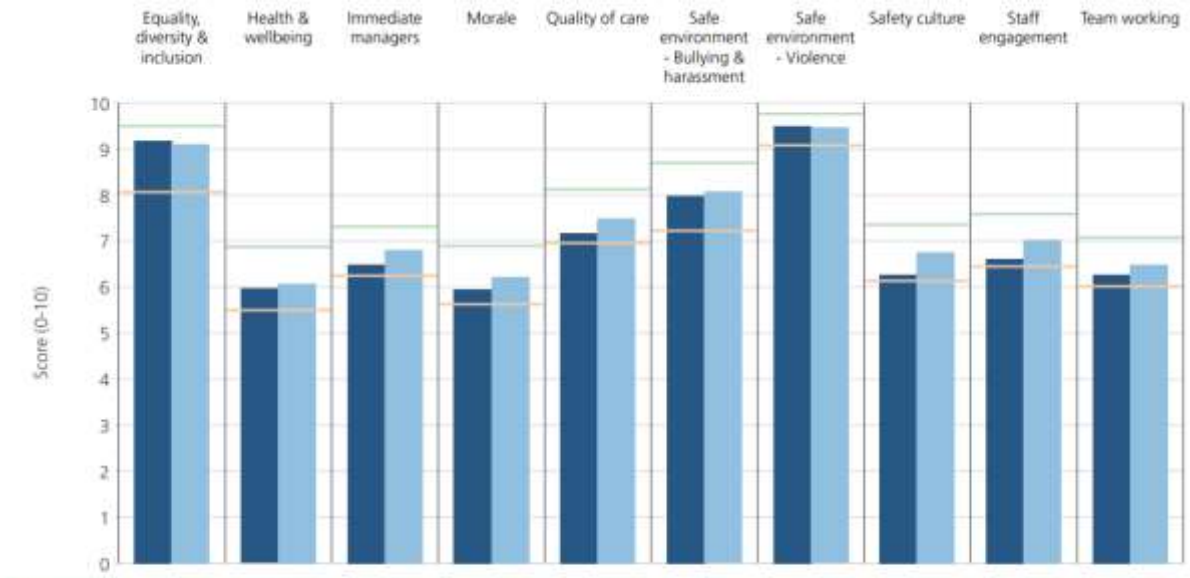
The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020/21 survey among Trust staff was 45%. Scores for each indicator together with that of the survey benchmarking group are presented below.

The NHS Staff Survey 2020 (NSS20) results are the first scores for North Cumbria Integrated Care NHS Foundation Trust (NCIC). Last year the Trust merger took place during the survey, and we received separate results for North Cumbria University Hospitals NHS Trust (NCUH), and Cumbria Partnership NHS Foundation Trust (CPFT). Response rates were 34% and 40% respectively.

NCIC is treated as a completely separate entity by the national survey team, and therefore they will not include any historical comparisons in the national reporting. The Trust results measure how we compare in relation to other 'Acute and Acute and Community Trusts'. For the third year running all staff had the opportunity to complete the NHS Staff Survey. In total 2,855 questionnaires were completed by staff which represented a 45% response rate. This was in line with the national average for our benchmarking group.

A summary of the results are below. Themes are on a 0-10 point scale, where 10 is the best score attainable.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.2	6.0	6.5	6.0	7.2	8.0	9.5	6.3	6.6	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,752	2,770	2,777	2,745	2,381	2,701	2,766	2,757	2,799	2,760

Our approach will be to focus on sharing the results and priorities for improvement internally so that care groups and support services can respond locally to the feedback of staff.

Senior leaders have reviewed the findings identified the following improvement priorities trust wide.

- Staff wellbeing – questions 8F, 11A
- Senior Managers – questions 9 A to D
- Patient quality and safety – questions 16D, 17C, 18 A to D
- Feeling safe to speak up – question 18F
- Focus on free-text comments relating to what staff want to keep / do more of following their experiences of Covid Disabled staff – deeper dive into responses and how the organisation can improve the experience of staff with a disability

Future priorities and targets

We will build the feedback from staff and actions we are taking into our new ncicway approach. In addition we will be completing additional local pulse surveys so we can measure progress against our actions prior to the next staff survey. In addition

There are some bespoke areas the Care Groups/Corporate Services wish to focus on individually, to take account of their own particular results. Each Care Group and Support Services will base their action plans on the key areas outlined above, and will draw together plans which suit local delivery and requirements. A similar framework will be utilised across each area, in order to ensure some consistency across the whole organisation. The initiatives will be linked to the Care Group People Plan metrics, to enable straightforward referencing and triangulation.

The Care Group priorities will be monitored through the local Operational Boards/local well led meetings on a monthly basis, and Service Managers and other heads of service will report activity/progress regularly. This will ensure that very senior teams are cited on progress, and also can have the opportunity for intervention to support any agreed plans which are not on track.

2.3.8 Trade Union (TU) facility time

Table 1: Total number of employees who were relevant union officials during 2020/21

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
8	7.8

Table 2: Percentage of time spent on TU facility time

Percentage of time spent	Number of employees
0%	0
1-50%	5
51%-99%	0
100%	3

Table 3: Percentage of pay bill spent on facility time

The table below provides the percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for TU facility time during 2020/21

Item	Figures
Total cost of TU facility time	£59286.65
Total pay bill	£267,248,098
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.022%

Table 4: Time spent on paid trade union activities

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	14.28%

2.3.9 Expenditure on consultancy

The total consultancy fees for 2020/21 were £942k (2019/20: £308k).

2.3.10 Off-payroll engagements

Table 1: Highly paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater

Number of existing arrangements as at 31 March 2021	Number 39
Of which, the number that have existed:	
for less than one year at the time of reporting	26
for between one year and two years at the time of reporting	3
for between 2 years and 3 years at the time of reporting	3
for between 3 years and 4 years at the time of reporting	5
for 4 or more years at the time of reporting	2

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021	Number 42
Of which:	
Number assessed as caught by IR35	41
Number assessed as not caught by IR35	1
Number engaged directly (via PSC contracted to the entity) and are on the departmental payroll	41
Number of engagements reassessed for consistency / assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	1

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility" during the financial year. This figure must include both on payroll and off-payroll engagements.	16

2.3.11 Exit Packages

The information below is subject to audit

The exit packages within the scope of this disclosure include, but are not limited to, those made under nationally-agreed arrangements or local arrangements for which Treasury approval was required.

The cost of ill-health retirements falls on the relevant pension scheme, not the Trust, and are not included in this disclosure.

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

2020/21:

	Number of compulsory redundancies	**Number of other departures agreed**	**Total number of exit packages**
Exit package cost band (including any special payment element)	**Number**	**Number**	**Number**
<£10,000	-	11	**11**
£10,000 - £25,000	1	9	**10**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	-	1	**1**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**21**	**24**
Total cost (£)	**£180,000**	**£242,000**	**£422,000**

2019/20:

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

Other (non-compulsory) departure payments

This note discloses the number of non-compulsory departures which attracted an exit package in the year, and the values of the associated payment(s) by individual type.

	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	21	242	17	71
Total	**21**	**242**	**18**	**89**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual	-	-	-	-

2.3.12 Gender Pay Gap

North Cumbria Integrated Care NHS Foundation Trust undertakes the gender pay gap publication annually, calculated to the pay period snapshot for 31 March the previous year, for all employees who are employed under a contract of employment, apprenticeship or personally. It includes those under Agenda for Change terms and conditions, medical staff and very senior managers. This information is published on the Cabinet Office website https://gender-pay-gap.service.gov.uk/ it is also published alongside the Trust action plan on the Trust website and can be found on the Freedom of Information page.

2.4 NHS Foundation Trust Code of Governance – disclosures

North Cumbria Integrated Care NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance (CoG), most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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

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

Relating to	CoG reference	Summary of requirement	Location in Annual Report
Governors' Council	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governors' Council Report
Governors' Council	FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Governors' Council Report
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its Committees, and its directors, including the chairperson, has been conducted.	Directors Report Performance Report
Board	B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Directors Report

Relating to	CoG reference	Summary of requirement	Location in Annual Report
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors Report Annual Governance Statement (AGS)
Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement (AGS)
Audit Committee / control environment	C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Audit & Risk Committee
Audit Committee Governors' Council	C.3.5	If the council of governors does not accept the audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit Committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Audit & Risk Committee
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the	Audit & Risk Committee

Relating to	CoG reference	Summary of requirement	Location in Annual Report
		committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded	
Board Rem Com	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Remuneration Report
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the NEDs, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Directors Report Governors' Council Report
Board Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership Report

Relating to	CoG reference	Summary of requirement	Location in Annual Report
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Governors' Council Report
Membership	FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Membership Report
Board / Governors' Council	FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Directors Report and Governors' Council Report signpost to Register of Interests

2.4.1 Audit and Risk Committee Report

Composition

The Audit and Risk Committee consists of Non-Executive Directors and is chaired by Mr Jeff O'Neill, non-Executive Director. The other members of the committee during this year are Mr George Liston and Mr David Allen (reserve member).

Meetings

The committee met on seven occasions during 2020/21. The following table gives details of attendance by individual committee members at the meetings and includes details of attendance by Executive Directors.

Although not members of this committee, Executive Directors (or their nominated deputy) are invited to attend for some or all of the meeting, particularly where specific risk discussions fall under the remit of that Director. This is shown in the table below. Agenda papers for the Audit and Risk Committee are issued to all Executive Directors to ensure they are sighted on the issues under discussion and so they are able to provide input where appropriate. The Terms of Reference for this committee includes a requirement for the Chief Executive to attend at least one meeting during each reporting year. The Chief Executive attended 2 meetings of the Audit and Risk Committee in 2020/21.

Table: Meetings of the Audit and Risk Committee 1 April 2020 to 31 March 2021

Name	**Position**	**Attendance - (total of 7 meetings held during 2020/21)**
Committee members – NCIC		
Mr Jeff O'Neill	Non-Executive Director	7/7
Mr George Liston	Non-Executive Director	7/7
Mr David Allen (reserve member)	Non-Executive Director	0/7 (attendance not required due to availability of the two regular members)
In attendance (Executive Directors)		**Audit and Risk Committee Attendance (partial or full attendance based on requirement)**
Michael Smillie	Director of Finance, Estates & Digital	7/7
Anna Stabler	Executive Chief Nurse	1/7
Justine Steele	Executive Director of People and OD	1/7
Ramona Duguid	Interim Executive Director of Operations	2/7
Dean Oliver	Executive Director of Performance	1/7

Role and responsibilities

The work of the Audit and Risk Committee is to:

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

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

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

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

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

- **Counter Fraud**
  The committee received the Local Counter Fraud Specialist Annual Report 2019/20 and approved the Local Counter Fraud Specialist Plan 2020/21.

- **Raising Concerns**

  The committee received the annual report on Raising Concerns.

- **CQC registration**

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

- **Governance statements and declarations process**

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

- **Litigation and claims management**

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

- **Trust Annual Report**
  The committee reviewed the 2019 annual report and accounts and agreed to recommend to the Board that they be adopted.

- **Financial Reporting**
  During 2020/21, the committee considered key accounting issues and judgements relating to the accounts. The significant areas of judgement considered, in relation to the financial statements for the year ended 31 March 2021, were as follows:

- **Valuation of land and buildings** – The Committee discussed a change in the modern equivalent valuation approach proposed by management which switches away from valuing the existing assets in their existing locations to hypothetical modern equivalent assets capable of the same productive capacity. This represents a change in the application of the Trust's accounting policy rather than a change in the policy itself. The hypothetical model would see two main hospital sites retained, one in the east of the county and one in the west. The number of beds and the current model of providing services such as A&E and Maternity on both sites would remain the same.
- **Plant, equipment & intangible assets –** We agreed that, as these assets are not valued, depreciated replacement cost was a reasonable approximation to fair value.
- **Provisions** – The Trust has a number of provisions as set out in note 26 to the financial statements. We reviewed and accepted the judgements made by management in assessing provisions.
- **PFI** – The Trust includes estimates for future RPI in order to populate its PFI Models and provide analysis of future costs. We accepted the estimation approach used by management.
- **PFI Lifecycle Prepayment** – The Committee considered and supported the Trust's assessment that prepayments made for future estates costs that are not likely to be expended should be charged to operating expenditure.
- **Inventory** – The Committee discussed the practical difficulties of the auditors observing an inventory count for 31 March 2021 and alternative options such as virtual attendance in March followed by a physical check in May. We agreed with the Trust's view that, given there was no risk of material misstatement, Trust and auditor resources would be better focussed on the remainder of the audit. We accepted that this means a limitation of scope with respect to inventory again in 2020/21 which will carry forward to the opening inventory position in 2021/22.
- **Going Concern** – The Committee were advised of an update to the guidance around going concern which clarified that the decision to prepare the accounts of public sector organisations on a going concern basis should be based solely on the anticipated future provision of services. Therefore, the Committee supported the Trust's assessment that its accounts should be produced on a going concern basis.

- **Quality accounts**

  As the Quality Accounts were not required as part of the annual report submission for 2019/20 the committee did not consider this report.

- **Standing Orders and Standing Financial Instructions (SFIs)**

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

- **Data quality**

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

- **Board Assurance Framework**

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

- **Risk management**

  The committee reviewed the workplan and now undertake two deep dive meetings per year into risk management. This allows the Committee an opportunity to seek assurance that the strategies in place are sufficient to manage risks faced by the Trust. This Committee reviewed the Trust's arrangements for monitoring and managing risk. The Risk Management Strategy and policy were considered and the committee noted ongoing work and embed the risk appetite statement.

- **Charitable Trust Fund**

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

- **External audit**

  The audit of the 2019/20 financial statements was undertaken by Grant Thornton. The Governors approved a revised external audit fee, in September 2020, due to changes in audit requirements outside the control of the provider. The increase was across the sector and not just with Grant Thornton. Grant Thornton were awarded a contract for 3 years commencing with the 2019/20 audit. The value of the contract for 2020/21 is £78,000 including VAT. At least one representative from the external auditor in contract was in attendance at all meetings through the year.

  The Committee approved the External Audit Strategy Memorandum.

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

- **Internal Audit – role and structure**

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

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

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

2.4.2 Governors Council Report

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

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

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

Roles and responsibilities

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

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

The GC met 8 times during 2020/21 and was quorate on each occasion. Due to the Covid-19 pandemic, all GC meetings took place virtually by Cisco Webex. The GC is chaired by the Trust Chair, Peter Scott, and consists of up to 38 elected and appointed governors who represent our Public and Staff constituencies and our Local Authority and Partner Organisations as identified by the Trust's Constitution. We have 22 Public Governors; 7 Staff Governors and up to 9 Appointed Governors. There are currently 10 vacancies on the GC.

Information on governors who held office during 2020/21 is shown in the table below which includes details of their constituencies or organisations represented; whether they are elected or appointed; their term of office and attendance at meetings. In accordance with the Trust's Constitution and NHS Provider Licence, all governors are required to meet the 'Fit and Proper Persons Test' on appointment and on reappointment.

Lead Governor and Deputy Lead Governor

The Lead and Deputy Lead Governors are elected by their peers for a term of 3 years or until their term ends, whichever is the sooner. During 2020/21 there was a change in post holder for both the Lead and Deputy Lead governor roles.

Our current Lead and Deputy Lead governor are:

- Lead Governor – Carole Woodman, Public Governor Copeland (Feb 2021 – Jan 2024)
- Deputy Lead Governor – Linda Radcliffe, Public Governor Allerdale (Feb 2021 – Jan 2024)

Our former Lead and Deputy lead Governors were:

- Lead Governor - Jane Smith, Staff Governor Allerdale and Copeland (Jan 2017 – Sept 2020 when Staff Governor term ended)
- Deputy Lead Governor – Keith Amey, Public Governor Copeland (July 2017 – June 2020. Keith's term as Deputy Lead Governor was extended until the new Lead and Deputy Lead Governors took up post on 1 February 2021)

Governors' Council – composition and meeting attendance record from 1 April 2020 to 31 March 2021

Constituency	*** No. of Governor positions**	**Name**	**Appointment**	**** No. of meetings**
Public constituency (elected)				
Allerdale	4	Linda Radcliffe	Oct 2016 – Sep 2023	8 of 8
		Leslie Blacklock	Jan 2020 – Sep 2022	7 of 8
		William Miskelly	Jan 2020 – Sep 2022	8 of 8
		Alison McCourt	Oct 2017 – Jul 2020	0 of 1
Carlisle	4	Elizabeth Freeman	Oct 2016 – Sep 2021	6 of 8
		Derrick Bates	Jan 2020 – Sep 2023	7 of 8
		Rebecca Mullins	Jan 2020 – Sep 2023	4 of 7
		Janet Blair	Jan 2020 – Sep 2022	4 of 8
Copeland	4	Keith Amey	Oct 2015 – Sep 2023	7 of 8
		Carole Woodman	Jan 2019 – Sep 2021	7 of 8
		Les Hanley	Jan 2020 – Sep 2023	3 of 8
		Kerry-Ann Lister	Oct 2016 – Sep 2021	0 of 8
Eden	4	Mike Taylor	Jan 2019 – Sep 2023	8 of 8
		Jacqueline Nicol	Oct 2017 – Sep 2023	7 of 8
		David Pollitt	Oct 2017 – Sep 2022	0 of 8
		Christopher Kenn	Dec 2020 – Sep 2022	2 of 2
		Hilary Carrick	Oct 2017 – Nov 2020	4 of 6
Furness	2	Stephen Newton	Sep 2016 – Sep 2022	0 of 8
		Shahnaz Asghar	Jan 2019 – Jul 2020	0 of 1
		Vacant	Aug 2020 to date	Not applicable
Lancashire	1	Derek Seber	Oct 2017 – Sep 2023	1 of 8

Constituency	* No. of Governor positions	Name	Appointment	** No. of meetings
North East England	1	Christopher Mason	Jan 2020 – Sep 2023	6 of 8
South Lakeland	2	George Butler	Jan 2020 – Sep 2022	5 of 8
		David Crouchley	Dec 2020 – Sep 2023	1 of 2
Staff constituency (elected)				
Allerdale and Copeland	3	Chris Fleming	Jan 2020 – Sep 2023	2 of 8
		Clare France	Jan 2020 – Sep 2022	3 of 8
		Rachael Marrs	Dec 2020 – Sep 2023	1 of 2
		Jane Smith	July 2011 – Nov 2020	5 of 6
Carlisle and Eden	3	Deborah Berg	Jan 2020 – Sep 2023	2 of 8
		Neil Racher	Jan 2020 – Sep 2022	6 of 8
		Madhusudhan Varma	Dec 2020 – Sep 2023	1 of 2
		Rob Donlevy	Oct 2017 – Nov 2020	3 of 6
Furness and South Lakeland	1	Vacant	Not applicable	Not applicable
Cumbria County Council	2	Vacant	Not applicable	Not applicable
University of Cumbria	1	Alison Hampson	Apr 2017 – Apr 2023	5 of 8
Cumbria CVS	2	Vacant	Not applicable	Not applicable
Leagues of Friends	1	James Porter	May 2018 – Apr 2022	6 of 8
Other	Up to 3	Not applicable	Not applicable	Not applicable
Total	38			

***** Number of governor positions per constituency. Elections are held annually. The table shows governors that held a position at some point during 2020/21.

****** Number of Governors' Council meetings that each governor attended, out of the total number of meetings held during the year which they were eligible to attend, based on their Term of Office. Due to the pandemic governors who do not have access to virtual meetings were unable to attend.

Details of company directorships of Governors

The register of interests for members of the GC is available on the Trust's website on our 'meet the governors' page or from the Corporate Governance Team on 01228 603761.

Supporting the role of governor

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

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

Communications between the Board of Directors, Governors' Council and members

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

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

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

At Board meetings the Lead Governor is able to ask questions and seek assurances/share best practice on behalf of the GC. Board meetings held in public (Public Board meetings) include a standing item on the activities and views of the GC. Public Board meetings are open to anyone to ask questions on notice or about the agenda items. The Chair also hosts virtual monthly Board debrief sessions for governors.

The GC would normally meet in public with meetings advertised on our website, however, due to the Covid-19 pandemic GC meetings have been held virtually and not open for public attendance. Meeting papers continue to be published on the Trust's website and the public can still ask questions or send in their views on the agenda via email or phone. NEDs attend GC meetings to feedback on progress of issues from the Board Committees to help governors fulfil their role in holding Non-Executive Directors to account for the performance of the Board.

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

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

Joint Non-Executive Director (NED) and Governor Visiting programme - due to the impact of the pandemic all service visits and face to face meetings ceased in March 2020 and will not resume until we receive national guidance to the contrary.

Governors Special Interest Groups (SIGs) – these groups focus on the interests of governors and involvement of members and the local community and partners where appropriate.

- The Learning Disability and Autism SIG focuses on the work of the Trust in establishing the Learning Disability & Autism improvement standards across all care groups.
- The Engagement SIG focuses on engaging with members and the public in line with the approved Member Engagement Strategy. This group restarted in February 2021 and the first virtual event was held for members with an agreed programme for the remainder of the year.
- These groups report to the GC through the Governors Advisory Committee.

Annual Members meeting – a live virtual event took place on 22 October 2020 jointly with North Cumbria Clinical Commissioning Group.

Patient Led Assessment of the Care Environment – This is a national annual programme of assessment of all inpatient areas which governors would normally take part in, however, due to the pandemic the national programme was cancelled in 2020.

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

Dispute between the Governors' Council and the Board of Directors

There were no disputes during 2020/21. In the event of any unresolved dispute between the GC and the Board, the Chair will:

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

2.4.3 Nominations Committee Report

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

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

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

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

The Committee consider Non-Executive Director appointments and re-appointments of the NEDs, including the Chair, in line with the approved process.

The Chair of the Nominations Committee is the Trust Chair who is Peter Scott, Interim Chair since 1 April 2020. The Senior Independent Director (SID) is George Liston, Non-Executive Director who was appointed to this role in November 2019. The SID is invited to attend when considering the Chair's appraisal and chairs the meeting when considering the Chair's appointment.

The Committee membership includes five governors. The following changes in Committee membership have taken place during 2020/21:
Current members

- Linda Radcliffe (Public Governor Allerdale);
- Jacqueline Nicol (Public Governor Eden);
- Elizabeth Freeman (Public Governor Carlisle);
- Carole Woodman (Public Governor Copeland/Lead Governor) joined as new Lead Governor on 1 February 2021;
- George Butler (Public Governor South Lakeland) voted onto Committee on 22 February 2021.

Former members

- Jane Smith (Staff Governor Allerdale and Copeland/Lead Governor) term ended November 2020;
- Keith Amey (Public Governor Copeland/Deputy Lead Governor) stepped down from the Committee when his role as Deputy Lead role ended 31 January 2021;

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

- Board succession planning
- NED appointments
- Chair appointment
- Chair appraisal framework

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

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

The Committee undertook an external recruitment process during Quarter 1 of 2020/21 in line with the agreed procedure to fill the vacancy for a NED which had arisen following the end of Malcolm Cook's term of office on 31 December 2020. The approved recruitment process was carried out during February and March 2021. The Committee recommended Philip Kane to the GC meeting held on 23 March 2021. Philip Kane was approved by the GC with a three year term of office starting on 1 May 2021.

Chair Appointment

The appointment of the Trust Chair is the responsibility of the Governors Council (GC) through the Nominations Committee (NC). The Committee undertook the Chair appointment process in line with the agreed procedure early in 2020 following the early departure of the previous Chair. The Chair appointment process could not be completed in March 2020 due to COVID-19 restrictions when it had been agreed to postpone the process until meetings could go ahead in person. The GC acknowledged that the role was now different to that anticipated earlier in the year and approved the recommendation of the Committee to cancel the recruitment process and stand down the shortlisted candidates.

An Interim Chair was identified and appointed, with the agreement of the Committee; Peter Scott was appointed Interim Chair on 1 April 2020 for a period of up to 6 months. The GC met on 23 July 2020 and approved a further extension to Peter's term to end on 31 March 2021 due to the CQC inspection and well-led review being carried out in the Trust.

Following feedback on the CQC Report, the recommendation of NHS England/NHS Improvement (NHSE/I) was to encourage the continuation of the current arrangements on the Chair for continuity. The regulator's view was for the Chair to have strong links with North Cumbria and with national/regional finance. The GC held an Extraordinary meeting on 30 November 2020 and approved an extension to Peter Scott's term of office to end on 31 March 2022.

2.4.4 Membership Report

What is membership?

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

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

- Public membership – divided into eight constituencies
- Staff membership – divided into three joint constituencies

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

Public membership

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

Staff membership

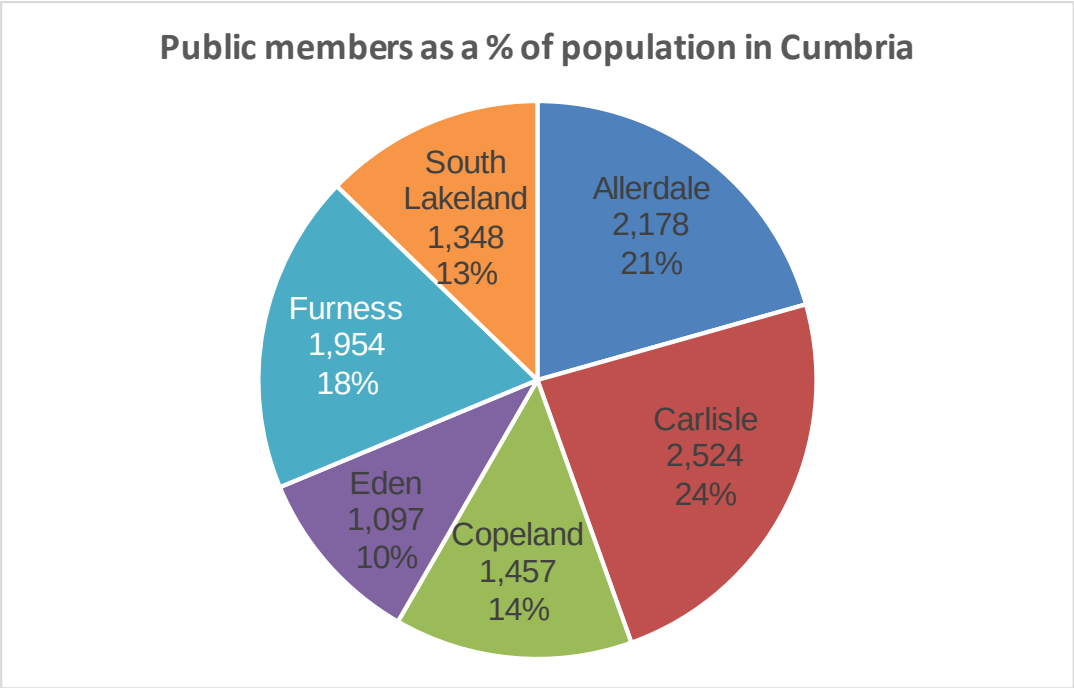
The staff constituency is divided into three classes that are geographically based according to where the member of staff works:

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

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

Membership profile

Information on the total number of Members and the number of Members in each constituency at 31 March 2021 is shown in the chart below.



There are 9 Public members in North East England and 49 members in Lancashire which have been attracted through our general communications channels, primarily our website. The total public membership figure at 31 March 2021 is 10,616, a reduction of 186 from the previous year following the annual data cleanse exercise, plus 27 new public members.

Membership Engagement Strategy 2019 - 2022

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

The Governors' Council (GC) has a duty to represent the interests of the members of the Trust as a whole and the interests of the public and feed back to their communities. Our engagement strategy, which sets out the ways in which the GC and the Trust should engage with our membership, was refreshed in 2019 to support governors engaging with members and the public to contribute to coproduction in our developing integration health and care system. The GC has devolved the work of reviewing this strategy during 2021 to the Membership and Engagement Special Interest Group who will bring their recommendations to the GC mid-year during 2021/22.

Our objectives for 2019 - 2022 are:

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

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

Membership monitoring

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

Contact a Director or Governor

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

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

You are welcome to attend our Annual Members meeting or Governors' Council meetings which are held throughout the year – find out more on our website under 'how we are run' pages.

2.5 NHS England and NHS Improvement's Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs.
The framework looks at five themes:

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

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

Segmentation

This segmentation information is the Trust's position as at 31 March 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. North Cumbria Integrated Care NHS Foundation Trust was rated as being placed in Segment 2 under NHSI's Single Oversight Framework (SOF) at 11th April 2021.

2.6 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of North Cumbria Integrated Care NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

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

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's 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*.

Signed:  **Date: 24th June 2021**

Lyn Simpson
Chief Executive

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

Capacity to handle risk

The Chief Executive has overall accountability for risk management and discharges that duty through the Executive Team who have responsibility for the effective management of risk within their own area of direct management responsibility, and corporate and joint responsibility for the management of risk across the organisation.

Structures and systems are in place to support the delivery of integrated risk management across the organisation. Committees of the Board of Directors are in place both to ensure effective governance for the Trust's major operational and strategic processes and systems and also to provide assurance that risk is effectively managed. Operationally, the Trust is managed through a Care Group structure and centrally managed support service functions reporting up to the Executive Management Team. In May 2021, we introduced a Risk Management Committee into our governance structures to further strengthen our risk management arrangements. The Committee is chaired by the Chief Executive and meets monthly.

Following feedback from our Care Group leadership teams, in July 2020 we updated our governance structures and moved from three Care Groups to four which are the Emergency Care and Medicine Care Group; Community and ICC Care Group; Surgery, Critical Care and Clinical Support Care Group, and the Women's and Children's Care Group.

A programme of risk management training is in place. Staff are supported to attend essential, mandatory training, subject-specific and core skills training which make up the overall training programme. Delivery of training against targets is monitored by the Board of Directors, and managed through devolved management structures. Following the appointment of the Quality Governance Director in quarter 3 of 2020/21, our risk management training, tools and resources have been refreshed, taking into consideration good practice adopted in other trusts, and in 2021/22 we will be rolling out a refreshed risk management training programme.

Care Groups leadership teams are responsible for the management of risk within their Care Groups, supported by staff within Corporate and Support Service teams who are specialists in various aspects of risk management, and who are a central resource for training, advice and guidance. Risk registers are maintained and reviewed by each Group and support services and are reviewed through the Trust's governance structures. Senior clinical leaders have responsibility for driving improvements to quality and safety, and to actively support our staff in the identification and management of identified risks.

We endeavour to learn from incidents, complaints and other events to continuously improve our services, although recognise this is an aspect of governance we need to improve. We also endeavour to benefit from good practice identified through a range of learning and improvement mechanisms including peer review, clinical audits, quality improvement tools, professional and personal development, and application of evidence based practice. During 2020/21 we adopted the systems engineering initiative for patient safety (SEIPS) model for the investigation of serious incidents which has notably improved the quality of investigations undertaken and gives greater insight into the opportunities for learning and improvement. Investigation of complaints is overseen directly by the Chief Executive. Oversight of incidents and near misses is overseen by our Executive Chief Nurse supported by our Quality Governance Director.

The Board of Directors (the Board) has line of sight to the management of significant operational and strategic risks through the Board Assurance Framework and through the functioning of its Committee and governance arrangements. Our Board Committees and their roles are described below.

- Audit & Risk Committee (A&R) – an independent committee and senior Board Committee, with all members NEDs. The A&R Committee has responsibility for overseeing risk management and internal control. The A&R Committee agrees audit

plans with our internal and external auditors and receives progress updates and audit opinions throughout the year. The Committee meets bimonthly.

- Quality Improvement & Safety Committee (QIS) – the designated Board Committee which oversees quality and safety issues. It is chaired by a Non-Executive Director (NED) and has Executive and NED membership. The QIS Committee monitors clinical risk management performance throughout the year and makes recommendations to the Board as appropriate. The Committee meets monthly.
- Finance Investment and Performance Committee (FIP) - the designated Board Committee which oversees financial, corporate performance and investment issues. It is chaired by a NED and has Executive and NED membership. The FIP Committee monitors risks to operational and financial performance throughout the year and makes recommendations to the Board as appropriate. The Committee meetings monthly.
- Charitable Funds Committee – this designated Board Committee which oversees the management of Charitable Funds held by the Trust. The Committee meetings quarterly.
- Remuneration Committee – wholly NED membership. The Committee meets when required.

Our governance manual includes details of sub-Groups of Board Committees, other high level meetings within the governance framework and ward to board governance arrangements. The executive team have collective accountability for the implementation of the Trust's governance framework and delivery of priorities.

The Risk and Control Framework

Board Membership

2020/21 has seen a period of relative stability on the Board of Directors compared with recent years. The transitional Executive leadership team established by the Chief Executive in April 2020 continued largely unchanged throughout 2020/21. Dean Oliver joined the Board in April 2020 as Executive Director of Performance & Improvement, Justine Steele, Executive Director of People & OD joined the Trust in May 2020, John Howarth, Executive Director of Strategy left the Trust in August 2020 to focus on the activities of North Cumbria Primary Care and Ramona Duguid, interim Chief Operating officer left the trust on 31st March 2021 to take up post of Chief Operating Officer at Cumbria Northumbria Tyne & Wear NHS Foundation Trust. The Chief Operating Officer role continues to be covered by interim arrangements whilst a substantive appointment is made. Anna Stabler was confirmed in post as Executive Chief Nurse in June 2020, after undertaking this role on an interim basis since January 2020. In March 2021, Anna Stabler, Executive Chief Nurse announced her retirement and will be leaving the Trust in May 2021. Jill Foster will be covering the role on an interim basis until a substantive appointment is made early in 2021/22.

In November 2020 the Governors' Council agreed to extend Peter Scott's term as interim Chair until 31st March 2022 with the aim that recruitment to a substantive Chair takes place sooner with agreement of NHS Improvement. Malcolm Cooke's term of office as Non-Executive Director ended on 31st March 2020 after six continuous years on the Board of Directors of NCIC and its predecessor Trusts. Following a recruitment process Philip Kane was appointed as Non-Executive Director and will commence in post on 1 May 2021. There were no other changes within Board of Directors during the year.

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

Risk Management

Our Board-approved Risk Management Strategy describes an integrated approach to risk management, which incorporates strategic and operational planning, quality governance, performance management, our accountability framework and our the Board Assurance Framework. The Executive Chief Nurse is accountable for ensuring appropriate systems and processes are in place to enable the implementation of our Risk Management Strategy and is also accountable for delivery of effective clinical governance.

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

Our Risk Management Strategy is implemented through the Risk Management Policy which sets out the framework for how risks are identified, evaluated, controlled and escalated through the governance framework. Operational risks are managed on a day-to-day basis by staff through our governance structures. The Chief Executive chairs the Risk Management Committee as part of the Trust's commitment to strengthen risk management arrangements. The Risk Management Strategy is also delivered through

- policies and procedures available to all staff on our intranet site, including policies on specific risk areas, such as infection prevention and control
- countering fraud and corruption
- investigation of incidents, complaints, concerns, and claims

- risk-based, targeted and tailored training programmes delivered by a combination of in-house experts and external partners
- Induction programmes for our staff and governors
- The Board Assurance framework including reports to the Board and Committees on quality governance matters, including performance against constitutional and locally agreed standards and other regulatory and compliance requirements
- Tutorials and guidance on the Trust's staff web, for example how to record and update risks on the risk register, and responsibilities under health and safety law

We are continually seeking ways in which to enhance the quality of information available to frontline services to support their decision making around risk management. Quality and Safety dashboards have been developed over recent years in liaison with our clinical leads enable our leaders to actively identify and respond to quality and safety risks within their services. A continuous improvement approach is taken to enhance how we use and report risk management information to enable us to meet our statutory obligations with accuracy. An example of this is the use of Statistical Process Control (SPC) charts which were introduced within performance reports during quarter 4 of 2020/21.

Risks, which are identified through a variety of means, are assessed using the risk assessment methodology set out within our risk management policy and recorded within our Ulysses risk management system. Risks are managed on a day-to-day basis through the Trust's governance structures and in accordance with responsibilities for risk management set out within our Risk Management Policy. Risks that are complex in nature and which require senior management attention are escalated through our governance frameworks (ultimately to the Board of Directors) for decisions on how the risk will be managed.

Our corporate risk register is comprised of risks scored at 15 or higher. Risks which have strategic impacts are recorded in our Board Assurance Framework (BAF). Our Board routinely reflects on whether the top strategic risks, upon which our BAF is structured, need to be refreshed. This usually takes place during Quarter 3 or 4 each year. This was most recently reviewed in December 2019 which identified the top strategic risks impacting the trust as:

A. Our leaders are not enabled or empowered to deliver high quality care in a safe and supportive organisational culture
B. Our workforce model is not suitable or sustainable to meet the needs of the trust and its patients.
C. The quality of our services, as experienced by our patients and staff, does not improve
D. We are unable to make the necessary changes and improvements to our services at the pace needed due to dependencies on system partners who are not sufficiently ready or able to support our plans

E. We are unable to reach and maintain a position of financial sustainability
F. Our property and digital infrastructure is unable to effectively meet current operational requirements or enable improvements to service quality
G. We are unable to deliver all of our services and/or meet the needs of our patients during period of prolonged significant disruption such as COVID-19

Balancing high quality care with long term financial sustainability and delivering integrated care are significant and challenging strategic risks integral to our BAF. We are working collaboratively with our system partners within our integrated care partnership and wider integrated care system, and with our communities to find workable solutions to these very challenging strategic risks and to deliver the ambitions of the NHS long term plan.

Activities of the Board and Board Committees, including assurances they receive, aligned to the BAF. The BAF is subject to formal review quarterly by the Board, QIS Committee and FIP Committee. The A&R Committee considers the BAF at each of its meetings and conducts deep dives into risk management and the BAF twice per year. We have recognised that our BAF needs to undergo a refresh to make it simpler and to more effectively support board effectiveness, and to be more outcomes-focussed underpinned by performance metrics where appropriate. This will be undertaken during Quarter 1 of 2021/22, with support from colleagues in NHS Improvement.

The management of identified risks is routinely discussed within Care Groups' clinical governance forums and forms part of Well Led reviews with the Executive team. The QIS Committee receive updates each meeting on 'Well Led' discussions which highlight any notable clinical governance risks or issues impacting Care Quality Commission (CQC) compliance. The Clinical Governance team within the Quality and Nursing Directorate coordinate arrangements for monitoring and overseeing CQC registration and compliance requirements. The greatest risks facing the trust, both operationally and strategically, are in relation to workforce, quality, and estates / IMT infrastructure. These are reflected with the corporate risk register and the BAF. Details of mitigating actions are reflected within the Trust's risk register and within reports to Board of Directors, Board Committees and other governance forums.

The Trust involves public stakeholders in identifying and managing risks to its objectives in a number of ways. These include through the Governors' Council, who are a conduit with Trust members and the public, and through other engagement events for stakeholders and the wider public. The Governors' Council receive regular updates on strategic developments and delivery of trust objectives, and their input is sought as part of the annual planning process.

The Trust has a framework for managing change to services agreed as part of its contracts with its commissioners and also has good relationships with the Overview and Scrutiny Committee. All service users, carers and visitors are encouraged to provide feedback on the service received and offer suggestions for improvement.

Quality governance

Quality governance arrangements are delivered through the governance structures outlined above which enable information flows from ward to Board and oversight through Board Committees. The driving principles of our quality governance arrangements are improving the quality of care we deliver and the safety of our services. Our governance frameworks and structures are used to cascade and escalate quality, safety and performance matters.

We take assurance that our quality governance arrangements are effective from a range of internal and external sources including patient feedback, clinical audits, staff surveys, audits by our Internal Auditors, and reviews by external bodies such as the CQC. These assurances are recognised within our BAF. Following the CQC's inspection of the Trust in September 2020, we have been working closely with colleagues in NHS Improvement who is supporting the Board with activity to improve board effectiveness.

Our Internal Auditors provide independent, objective assurance on the robustness and effectiveness of the Trust's systems and processes and add value by identifying opportunities for improvement. The annual internal audit plan is developed taking into consideration our BAF and significant risks identified within the Trust's risk register. Our External Auditors perform their audit function on the Trust's financial statements in accordance with specific laws or rules and are independent of the Trust.

We anticipate undertaking an externally facilitated review of our quality governance arrangements against the NHSI and CQC's Well Led Framework during late 2021/22 or early 2022/2. This will allow time for the governance improvements we are implementing with support from colleagues within NHS Improvement to embed.

We completed a self-assessment against NHSI's Well Led Framework during quarter 3 of 2020/21. This was originally planned for Quarter 4 of 2019/20 but was deferred due to pandemic disruption. The self-assessment was independently facilitated and involved participation of senior clinical and operational leaders across the Trust. Recommendations from that self-assessment were incorporated into our improvement and transformation plan for 2020/21 and 2021/22. Our improvement plan is structured around deliverables on seven key themes, each of which have defined improvement objectives and measurable outcomes:

1. CQC
2. Governance
3. Operational Form
4. Transformation
5. Finance and Digital (Two separate OGIMs)
6. Quality and Safety
7. People

The Governance improvement work stream includes repurposing of Board Committees, supporting board members individually and collectively to operate as a unitary board, refreshing the Board Assurance Framework (process and content), reviewing and updating the risk management policy, training and awareness programmes, and evaluating how risk management is embedded into operational practice. These, together with improved methods of reporting upon performance and restyling of the integrated performance report to recognise unwarranted variations on the agreed safety and quality performance indicators, should collectively improve board effectiveness.

An assessment of compliance with the NHS provider licence condition 4 was conducted during quarter 4 of 2020/21 which determined that no material risks had been identified during 2020/21 and that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of directors and Committees
- Reporting lines and accountabilities between the board, its Committees and the executive team;
- The submission of timely and accurate information to assess risks to compliance with the trust's licence; and
- The degree and rigour of oversight the board has over the trust's performance.

These conditions are detailed within the Corporate Governance Statement. The Corporate Governance Statement relating to 2019/20 was presented to the Board of Directors for formal acceptance in June 2020. The Statement for 2020/21 is expected to be approved by the Board in June 2021. The Chief Executive has overall responsibility for ensuring compliance with the Trust's Provider Licence conditions, which she discharges through the Executive Team.

The Trust complied with all of the Provider Licence conditions during 2020/21 with no exception reports being required. We expect to comply with all of the Provider Licence conditions in 2021/22. Should there be any indications to the contrary we will ensure NHSI are notified as soon as they become apparent. NHSI is regularly appraised of our financial position. Further information on our quality governance arrangements can be found in the Quality Report (published separately).

Incident reporting

A positive approach to incident reporting is communicated through our policies and procedures. Every six months NHS Improvement publishes reports on reported patient safety incidents that help trusts understand how they benchmark with trusts who provide similar services. Benchmarking data is also provided in CQC insights data. The CQC insights report published on 25 March 2021, relating to January 2021, shows the Trust in

the top quartile of trusts in terms of number of reported incidents, which is seen as a positive indicator of safety culture.

We encourage the reporting of incidents or concerns and use them as a tool to learn and improve. We have a clear focus on open and honest reporting of incidents, with investigation into an incident proportional to the level of harm or potential harm, as detailed in the Trust's Being Open/Duty of Candour and Serious Incident policies.

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

Incidents meeting the guidance contained within the Serious Incident Framework (2015) are declared internally as a serious incident then reported externally to the Trust's Commissioners and the CQC. An incident review is undertaken for each incident report and appropriate immediate actions are taken. The Trust has adopted a Systems Engineering Initiative for Patient Safety (SEIPS 2.0) approach to support the review of these incidents. SEIPS 2.0 is one of the most widely used healthcare human factors systems models for studying and improving the work of healthcare professionals and to improve patient safety. Within the context of a serious incident it provides a structured approach to achieve a better understanding of the "Work System" as to what contributed to the incident and, as a result, what effective actions are required to prevent a similar incident arising in the future.

The report into the incident investigation, which includes an action plan, is reviewed by the relevant Care Group in their governance forums, and the approved by the Trust Patient Safety Panel which is chaired by the Medical Director. Once approved, the report is submitted to the Commissioners and shared with the patient/family. Actions arising from the investigation are monitored within the care groups and on completion details are shared with the Commissioners.

The Trust declared a total of 78 serious incidents between 1 April 2020 and 31 March 2021. An analysis of themes and trends from serious incidents during the year is undertaken to ensure that the wider contributory factors are informing learning across the organisation.

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

Policy Management

Policy review activity continued during 2020/21 with all policies having undergone a fitness for purpose review for NCIC following merger. Arrangements are in place to ensure reviews are undertaken in a timely manner. Focus is now on policy compliance. A task group was established during quarter 4 of 2020/21 to review and refresh our approach to the monitoring of policy compliance with revised arrangements being implemented from quarter 1 of 2021/22. Audit & Risk Committee continues to have oversight of policy management performance on behalf of the Board of Directors.

Quality Impact Assessments

We take a holistic approach to assessing the impacts of major change schemes, including those proposed within our efficiency programme. The impact assessment approach enables decisions to be made based upon a balance of risks to quality, equality and the clinical and financial sustainability of services. The process is jointly led by the Executive Chief Nurse and Executive Medical Director and overseen by the QIS Committee. It is also integrated into the Trust's business planning process.

Board level assurance on the timely undertaking of impact assessments and post-change evaluation of impacts, is provided through the QIS Committee who also have a role in the Equality and Quality Impact Assessment (EQIA) approvals process.

Workforce strategies

The QIS Committee receive routine 'hard truths' nurse staffing reports throughout the year, including fill rates, red flags and care hours per patient day (CHPPD). The Trust has also invested in the 'Insights' package which provides each e-rostered area with detailed information on nursing and HCA safe staffing utilisation. A monthly workforce dashboard also provides the Board and sub committees with regular oversight of workforce performance. In addition a monthly deep dive on medical and nursing vacancies and absence is provided to the Medical Director and Chief Nurse. A quarterly absence and sickness report covering all staff groups which reviews hot spots and sickness trends is now in place and will assist with informing interventions.

The People Plan for the North Cumbria Integrated Health and Care System, approved by the Board in March 2019, sets out the strategic delivery approach to ensure a sustainable workforce. Some significant improvements have been delivered since then including an increase in compliance for mandatory training for contracted staff across the Trust. The investment in international nurse recruitment will contribute to reducing nurse vacancies and the first cohort of nurses from India arrived in February 2021. Quarterly reports on progress are presented to the Trust's QIS Committee.

There is a continued focus on reducing the cost of temporary staffing in line with national targets through good rota management and monitoring. On a weekly basis the Executive Director team receives reports on agency spend, this includes any individuals whose hours have exceeded 48 hours worked and/or (un)paid breaks not taken as well - this is to ensure safe working and manage spend. In addition the Executive Directors team is updated on agency spend for the previous week and a forecast for the following week. Strict processes are in place to ensure substantive/NHS recruitment is prioritised where agency workers are being deployed. Weekly executive reports now include a vacancy review so that oversight of recruitment activity (and associated payroll spend), at-risk deployment and workforce 'hot-spots' can be monitored.

Through the activity described above, and through ongoing collaboration with our system partners on workforce planning, recruitment and retention strategies, we are applying the principles set out by NHS Improvement in their publication 'Developing Workforce Safeguards'. Our plans and priorities for 20201/22, which include how we will support and develop our workforce, are described within our annual operating plan for 2021/22.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. The CQC conducted an unannounced inspection of our Emergency Departments (EDs) in July 2020 which resulted in the CQC serving a warning notice on the Trust to improve safety within our EDs. CQC also undertook a formal Well Led inspection of the Trust in September 2020, their report on which was published in November 2020. In that report the CQC rated the Trust as 'Requires Improvement, and identified 51 'must do' and 9 'should do' actions needed to improve safety, quality governance and board effectiveness. We have worked closely with colleagues from NHSE/I's Intensive Support Team to review and improve our arrangements, and the Emergency care service has been supported on their improvement journey by peer colleagues in South Tees Hospitals NHS Foundation Trust. Details of how we have responded to the CQC's concerns can be found within the Quality Report (published separately).

Business conduct / conflicts of interest

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff *(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: https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/.

The Trust's Standards of Business Conduct policy reflects statutory requirements. Oversight of its implementation is through the A&R Committee. The position reported to the A&R Committee in March 2021 recognised that progress with the policy implementation plan had been disrupted due to the Covid 19 pandemic but will continue

into 2021/22. During 2021/22 the intention is to fully utilise the functionality of the ESR system for the recording and refresh of declarations required under the Business conduct policy.

NHS Pension Scheme

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

Equality, Diversity and Human Rights

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

Environmental Issues

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

Emergency preparedness

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

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

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

Under NHS England & Improvement (NHSE/I) Emergency Preparedness Resilience and Response (EPRR) guidance, we must:

- have a suitable and up-to-date incident response plan which sets out how the organisation would respond to and recover from a major incident/emergency affecting local communities or the delivery of its services; and

- adopt business continuity plans to enable the organisation to maintain or recover the delivery of its critical services in the event of significant disruption.

We comply with NHSE/I requirements by providing an EPRR structure and implementing business continuity management processes through which we plan for and respond to critical incidents and emergencies whilst maintaining the organisation's critical functions, its ordinary functions and contractual obligations as far as reasonably practicable.

COVID-19

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

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

In March and April 2020 large parts of routine elective activity was paused or reduced to divert capacity and resource to the COVID-response, however, with support of system partners, urgent cancer and trauma care continued to be provided. We experienced our first peak of COVID-related admissions and deaths early to mid-April 2020 and a second smaller peak in October 2020. During January and February 2021 we experienced our third and largest peak. During the largest peak periods a substantial proportion (around 20%) of the workforce were also absent due to covid- or non-covid related absence. Redeployment of some of our workforce enabled essential services to continue at this exceptionally challenging time. Further details on how COVID impacted our performance can be found in the Performance Section of this annual report. Look ahead, the Trust has adopted learning from the ongoing incident management approach and has commenced long term recovery planning for services to be fully restored.

The Trust successfully commenced the national vaccination programme for all our staff and some partner organisations in late November 2020. This has continued through until April 2021. All staff who wished to do so have now had both their first and second vaccines and we continue to support our staff with weekly lateral flow testing so that all colleagues are aware of the COVID status and can keep themselves, their families and their colleagues safe.

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

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

During the year the NHS has benefitted from a national temporary financial regime. We have received top-up income to cover the cost impact of COVID on our services during the year. For the first six months this was based on full reimbursement of costs and for the latter 6 months was based upon a planned level of expenditure agreed by our Board of Directors. The regime continues into the first six months of 2021 and beyond then the national NHS funding regime will move forward in a way yet to be announced. The Trust has successfully worked within these parameters over the last year meeting the overall plan set by the Board and required by NHS regulators. This has included significant investment in services (Cancer Centre, Urgent Care Services, Critical Infrastructure, Diagnostics and development at the West Cumberland Hospital Site ahead of future planned rebuilding plans (awaiting Final Business Case approval expected in 21/22).

We closely monitor budgetary control and expenditure through governance forums up to Board level with the Finance Investment & Performance Committee reviewing the financial and performance reports in detail on behalf of the Board of Directors. When required, the Board receives further assurance provided by its internal and external auditors.

The Trust's underlying financial position is unsustainable and so the Board, having focussed on meeting the requirements of the temporary financial regime, is looking ahead to longer term financial recovery. A dedicated programme management team support the identification and delivery of schemes which safely improve the Trust's efficiency and positively impact our overall financial performance. Our Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Delegation set out delegated authority levels across the Trust. Executive Directors and managers have responsibility for the effective management and deployment of their staff and other resources to optimise the efficiency of each area of our operations.

Despite the difficult operational situation caused by the pandemic, the Trust has successfully implemented Same Day Emergency Care services with a view to reducing average lengths of stay and also reduced the number of people inappropriately awaiting transfer from hospital to more appropriate settings. These developments remain a core issue for the ongoing more sustainable improvement of both quality of care and effective use of our resources. During the year the Trust released enhanced digital systems to support clinicians record their assessment of patients and commenced implementation of a longer term Digital Strategy.

The Trust reviewed its organisational culture and identified that increased clinical engagement and communication would support further positive delivery of service improvements in future. On this basis the Trust has embraced revised approaches to secure more cohesive momentum in its quality and resource improvements over time so that these secure more sustainable and lasting impact than has been the case in the past.

NCIC was rated as being placed in Segment 2 under NHSI's SOF at 11th April 2021. You can find further details about ratings in the NHS Improvements Single Oversight Framework Report.

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

Information governance and data security

We use the national Incident Reporting Tool within the Data Security and Protection Toolkit. Incidents are coded in line with the SIRI guide "*Guide to the Notification of data security and protection incidents*" – reporting incidents post the adoption of the General Data Protection Regulations (25 May 2018) and the NIS Directive (10 May 2018). Any incident must be graded according to the significance of the breach and the likelihood of those serious consequences occurring. The incident must be graded according to the impact on the individual or groups of individuals and not the organisation.

The Trust reported three serious untoward incidents (SUI) for the period 1 April 2020 to 31 March 2021 via the Data Security and Protection Toolkit to the Regulator.

Date of Incident	Reference number	Summary of Incident	Outcome	Status
10/02/2021	22980	Member of staff (as a patient) attended Accident & Emergency via North West Ambulance Service (NWAS). NWAS raised safeguarding concerns due to nature of attendance. Safeguarding hub was contacted by the nurse in charge. It is documented in the notes that the advice from safeguarding hub and registrar following this was	Serious untoward incident	Written letter of apology to be sent to data subject. Duty of Candour implications to be considered. Investigation to take place.

Date of Incident	Reference number	Summary of Incident	Outcome	Status
		that the patient's work place should be advised of safeguarding concerns due to nature of individual's profession.		
18/01/2021	22730	Via a complaint, an allegation was made that a Health Care Assistant had accessed the notes of a patient and was subsequently using this information against the patient (who also was a member of staff).	Serious untoward incident	Disciplinary investigation has concluded there is sufficient evidence to take two members of staff to disciplinary panel.
14/08/2020	20887	Member of staff has been suspended for allegedly accessing unnecessary results within the maternity department of a non-pregnant woman. The information is a sensitive nature and allegedly then communicating these results outside of the Trust.	Serious untoward incident	Suspension, as a neutral act, of member of staff has taken place. Serious untoward incident has commenced which will look into the audit trails to confirm whether inappropriate access occurred and will make a judgement whether other action (i.e. disciplinary) is warranted. Duty of candour correspondence progressed

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

Data Quality and governance

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

A governance framework is in place which oversees data quality performance from operational services through to Board level. Data quality performance is overseen by the Information Governance department. Key performance indicators (KPI) are subject to data quality and data validation processes. Performance is routinely reported and regularly reviewed at all levels within the governance structure in accordance with our performance and governance frameworks. This includes oversight through care groups' monthly Well Led and performance review meetings, and review of monthly performance assurance reports by the Finance Investment & Performance Committee and Board. Governors are encouraged to review the finance, workforce and performance reports published on the Trust's website.

A balanced view of our data quality is obtained through comparing and analysing data accuracy from checks undertaken by front line staff and service managers, and through independent audits undertaken by our internal and external auditors. The Audit & Risk Committee received updates on progress against the Data Quality strategy throughout 2020/21 and the internal audit programme included audits on data quality which demonstrated positive improvements. Data quality reviews undertaken by our internal auditors in 2020/21 were re-audits undertaken at the request of the Trust, on waiting times in A&E and referral to treatment (RTT) waiting times. These did not identify any significant issues of concern. Details of the steps we have taken to address data quality are provided in the Quality Report (published separately)

We currently use a number of separate electronic and paper patient record systems to record clinical information and produce reports. This includes EMIS and RiO electronic patient record systems which are used in our Care Groups. Checks are in place to provide assurance that the data from these systems is accurate.

Our suite of policies and procedural documents are reviewed as part of an ongoing review programme to reflect changes to legislation and best practice. A&R Committee oversee policy management arrangements and seek assurance on behalf of the Board of Directors that policies are reviewed in a timely manner.

Our governance framework sets out responsibilities and accountabilities for performance and governance at all levels within the Trust. Our performance management framework, which was refreshed during quarter 4 of 2020/21 and which will be formally launched in

early 2021/22 comprises performance indicators and metrics by which we measure and monitor our performance with local, regional and national standards and targets.

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

Our service improvement, organisational development and programme management functions, support our leadership teams with implementing quality improvements and delivering programmes to support business plan objectives. A suite of tools and training on quality improvement methodologies is also available to all staff.

We achieved a number of quality improvements during the year, including expanded capacity within the Renal Dialysis service at West Cumberland Hospital and the services' home therapies team enabling patients to have dialysis closer to and within their own home. This means home haemodialysis is now routinely available for appropriate patients for the first time which results in better outcomes and increased quality of life for patients. Other examples include collaborative working between Cumbria Health on Call (CHOC) and the Respiratory Home Oxygen Service who developed new ways to prevent admission and support early discharge through the oximetry@home service and virtual ward. These enable patients to be involved in their own treatment and care whilst at home with confidence that comes from having support and regular contact from clinical staff. Due to Covid-19, the Cardiology team quickly adopted to remote consultation to minimise the risks to patients and staff from attending hospital for appointments. This has now become established as a way of delivering outpatient care for the majority of patients and has allowed services to continue despite the challenges of Covid. The Cancer Centre, which underwent construction during 2020/21, was formerly transferred to Newcastle Hospitals Foundation Trust on 1 April 2021 for them to run. Our staff transferred to them under TUPE arrangements. Further details about these and other quality highlights, and also details about our performance and achievement of key performance indicators can be found in the Quality Report (published separately).

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn 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 and Risk Committee (A&R), Quality Improvement and Safety Committee (QIS), and

Finance Investment and Performance Committee (FIP) and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The QIS Committee, FIP Committee, Charitable Funds Committee and A&R Committee each have activity schedules framed around enabling the Board of Directors to have line of sight to any significant risks to internal control. An annual evaluation of committee effectiveness is undertaken for each of these Board committees. For 2020/21, this evaluation was informed by the findings of the CQC from their inspection in September 2020, supportive observations of the Board and Board Committees undertaken by NHS Improvement as part of their supportive work to improve board effectiveness, and internal reviews of Committee arrangements held with the Non-Executive Chair and Executive Director management lead for each of the Board Committees. The outcome of that review was reported to the Board of Directors in March 2021.

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

The internal audit plan for 2020/21 was agreed by the Audit & Risk Committee in July 2020. Our internal auditors awarded substantial, good or reasonable assurance on all audits they undertook during the year, with the exception of an audit into medical staff rotas which was awarded Limited Assurance due to issues relating to standardisation of processes, staffing arrangements and leadership arrangements, which we recognise require improvement. Work is underway, with programme management support, to fully scope and implement remedial actions, progress on which will be reported to the Audit & Risk Committee in due course.

Areas awarded Limited Assurance in 2019/20 have been re-audited during 2020/21 with improved outcomes. These include fire safety and non-medical prescribing. The outcome of the re-audit of health and safety arrangements was awarded Reasonable assurance, as was the re-audit of elective endoscopy waiting list.

An internal audit to evaluate the systems and controls in place within Medical care Groups' governance arrangements was paused during the year due to Covid-19. In the intervening period between then and when the fieldwork recommenced, the Trust's governance arrangements underwent a root and branch review with support from NHS Improvement in recognition that it was not providing the intended supportive framework. Audit fieldwork was halted in light of that review activity. Audit recommendations provided on an advisory basis have been incorporated into our governance improvement plans.

The Head of Internal Audit has given an overall opinion of reasonable assurance that there is a sound system of internal control, designed to meet the organisation's objectives, but that controls are not generally applied in a consistent manner.

The Head of Internal Audit opinion provides assurances in relation to areas covered by the Trust's internal audit plan. It does not take into account assurances from third parties relating to outsourced functions such as payroll and ESR, although these are reviewed by the Head of internal audit for any significant items of control. Contracts for outsourced services are managed and overseen through operational management structures with some oversight by Board Committees. For example the Finance Investment and Performance Committee oversee procurement arrangements provided through University Hospitals of Morecambe Bay NHS Foundation Trust. Reviews of service auditor reports are also undertaken for example for payroll and the general ledger. The auditor opinion for the general ledger for the period 1 April 2020 to 31 March 2021 was that system controls are suitably designed and operated effectively. The auditor opinion relating to the payroll function from June 2021 was substantial assurance.

Conclusion

As Accounting Officer and based on the review process outlined above, I conclude that no significant internal control issues have been identified during the year with the exception of our arrangements for urgent and emergency care and medical staff rotas. We have improved our arrangements for urgent and emergency care, and are implementing remedial actions relating to medical staffing rotas. During 2021/22 we will continue on our improvement journey to address concerns raised by the CQC in their inspections of the Trust during the summer of 2020, and to ensure our patients receive high quality, safe, sustainable care underpinned by refreshed and strengthened governance arrangements.

Signed: L. Simpson **Date: 24th June 2021**

Lyn Simpson
Chief Executive

2.8 Voluntary Disclosure

2.8.1 Equality Reporting

Equal Opportunities, Equality & Diversity and Disability

The Trust's Equality, Diversity and Human Rights annual report, which is available on the Trust website (Freedom of Information pages), provides information on how the Trusts is meeting its legal duties set out in the Equality Act 2010, the Public Sector Equality Duty 2011 and the Human Rights Act 1998 which aim to:

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

Gender Pay Gap Analysis

Following government consultation, it became mandatory from 31 March 2017 for public sectors organisations with over 250 employees to report annually on their gender pay gap.

The Trust meets the mandatory requirements of the gender pay gap analysis by publishing the report on our website and submitting data on to the government website along with action plan.

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

2.8.2 Modern Slavery Act

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

3. QUALITY REPORT

(published separately)

4. AUDITORS' REPORTS

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

Report on the Audit of the Financial Statements

Qualified opinion on the financial statements

We have audited the financial statements of North Cumbria Integrated Care NHS Foundation Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

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

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £6,852,000. .

Due to Trust imposed restrictions on visitors to its premises to manage the impact of the Covid-19 pandemic in March 2021, we were not able to observe the counting of the physical inventories at 31 March 2021 or satisfy ourselves by alternative means concerning the inventory quantities held at that date,

which have a carrying amount in the Statement of Financial Position of £7,202,000.

Consequently, we were unable to determine whether any adjustments to these amounts at 31 March 2020 or 31 March 2021 were necessary or whether there was any consequential effect on the drug costs and supplies and services for the years ended 31 March 2020 and 31 March 2021. We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may

cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.
In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.
The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.
In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities, which have a carrying amount in the Statement of Financial Position of £6,852,000 at 31 March 2020 and £7,202,000 at 31 March 2021, and whether there was any consequential effect on the drug costs and supplies and services for the years ended 31 March 2020 and 31 March 2021. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 or is misleading or inconsistent with the

information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and
- except for the possible effects of the matter described in the basis for qualified opinion section of our report, based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report and accounts for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

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

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

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the

basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2020/21, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.
In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.
The Audit and Risk Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect
of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit and Risk Committee concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, improper revenue recognition, improper expenditure recognition and management bias in making significant accounting estimates relating to the valuation of land and buildings and the PFI lifecycle prepayment. We determined that the principal risks were in relation to:
  - journal entries posted during the annual accounts preparation process;
  - the occurrence of expenditure;
  - the completeness of income; and
  - management's estimate of the Trust's PFI lifecycle prepayment and the valuation of land and buildings.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large value journals posted after year end impacting on the Trust's financial performance;

- challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations and the PFI lifecycle prepayment;
- evaluating the Trust's accounting policy for income recognition for appropriateness and compliance with the DHSC group accounting manual 2020/21;
- updating our understanding of the Trust's system for accounting for income from patient care activities and other operating revenue, and evaluating the design of the associated controls;
- investigating unmatched revenue and receivable balances over £0.3 million in the DHSC mismatch report, corroborating the unmatched balances used by the Trust to supporting evidence;
- evaluating estimates and the judgments made by management in respect of income accruals;
- testing substantively a sample of income and agreeing to supporting documentation to confirm correct accounting treatment;
- documenting the goods received not invoiced accrual process and the processes management have put in place, challenging any key assumptions, the appropriateness of the source data used and the basis for calculations;
- testing substantively a sample of expenditure and agreeing to supporting documentation to confirm correct accounting treatment;
- obtaining a listing from the cash book of non-pay payments made in March to May to ensure they have been charged to the appropriate year;
- testing substantively a sample of year end payable balances; and
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- Team communications in respect of potential non-compliance with laws and regulations and fraud included the potential for fraud in revenue recognition through manipulation of deferred income, the potential for fraud in expenditure recognition through manipulation of accrued expenditure and possible management bias in the making of estimates in relation to the valuation of land and buildings and the PFI lifecycle prepayment.
- The Engagement Partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement; and
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

Matter on which we are required to report by exception – 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 to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.
Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accounting Officer

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

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

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.
We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In

undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for North Cumbria Integrated Care NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

Andrew Smith, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor
Manchester
28 June 2021

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

In our auditor's report issued on 28 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 28 June 2021, we reported that, in our opinion, except for the possible effects of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The Basis for qualified opinion section of our opinion was as follows:

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £6,852,000.

Due to Trust imposed restrictions on visitors to its premises to manage the impact of the Covid-19 pandemic in March 2021, we were not able to observe the counting of the physical inventories at 31 March 2021 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which have a carrying amount in the Statement of Financial Position of £7,202,000.

Consequently, we were unable to determine whether any adjustments to these amounts at 31 March 2020 or 31 March 2021 were necessary or whether there was any consequential effect on the drug costs and supplies and services for the years ended 31 March 2020 and 31 March 2021.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Matter on which we are required to report by exception – 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 to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except:

- On 6 September 2021, we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the Trust's failure during 2020/21, to develop robust plans to address its underlying deficit and to bring it back into financial balance in the medium term. We recommended that the Trust continue the work that is ongoing to accurately identify the extent of its underlying deficit, to allow it to develop a realistic medium term financial plan to return itself towards financial balance. The Trust will need to continue to develop robust arrangements to ensure delivery of planned efficiency savings..
- On 6 September 2021, we identified a significant weakness in how the Trust ensures that it makes informed decisions and properly manages its risks and how the Trust uses information about its costs and performance to improve the way it manages and delivers its services. This was in relation to the serious concerns around the quality and effectiveness of services raised by the Trust's November 2020 Care Quality Commission (CQC) Report. We recommended that slippages in addressing CQC actions should be addressed and progress against key actions should continue to be monitored so that changes become embedded and deliver the desired improvements.

Responsibilities of the Accounting Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have

considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of North Cumbria Integrated Care NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

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

Andrew Smith, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
Manchester
20 September 2021

5. FORWARD TO THE ACCOUNTS

North Cumbria Integrated Care NHS Foundation Trust

Thees accounts, for the year ended 31 March 2021, have been prepared by North Cumbria Integrated Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Lyn Simpson**
Job Title **Chief Executive**
Date **24 June 2021**

6. ANNUAL ACCOUNTS FOR YEAR END 31ST MARCH 2021

Statement of Comprehensive Income

	Note	**2020/21** **£000**	2019/20 restated* £000	2019/20 £000
Operating income from patient care activities	3	405,024	240,031	240,031
Other operating income	4	99,349	34,614	34,614
Operating expenses	6, 7	(538,659)	(324,283)	(328,782)
Operating surplus/(deficit) from continuing operations		**(34,286)**	(49,638)	(54,137)
Finance income	10	(9)	192	192
Finance expenses	11	(7,430)	(4,714)	(4,714)
PDC dividends payable		(4,403)	0	0
Net finance costs		**(11,842)**	(4,522)	(4,522)
Other gains / (losses)	12	254	(95)	(95)
Gains / (losses) arising from transfers by absorption	34	0	(108,621)	(89,040)
Surplus / (deficit) for the year		**(45,874)**	(162,876)	(147,794)
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	16	(3,645)	(6,416)	(6,304)
Revaluations	14.1	2,002	2,490	6,349
Total comprehensive income / (expense) for the period		**(47,517)**	(166,802)	(147,749)

* Please refer to Note 37 for details

Statement of Financial Position

	Note	**31 March 2021**	31 March 2020 restated*	31 March 2020
		£000	£000	£000
Non-current assets				
Intangible assets	13	5,538	4,219	4,219
Property, plant and equipment	14	205,065	210,974	230,027
Investments in associates and joint ventures	18	35	35	35
Receivables	20	2,815	15,709	15,709
Total non-current assets		**213,453**	230,937	249,990
Current assets				
Inventories	19	7,202	6,852	6,852
Receivables	20	21,317	47,837	47,837
Non-current assets for sale and assets in disposal groups	21	0	617	617
Cash and cash equivalents	22.1	77,972	24,585	24,585
Total current assets		**106,491**	79,891	79,891
Current liabilities				
Trade and other payables	23	(57,378)	(48,548)	(48,548)
Borrowings	25	(4,031)	(303,174)	(303,174)
Provisions	26	(1,220)	(1,163)	(1,163)
Other liabilities	24	(5,270)	(3,895)	(3,895)
Total current liabilities		**(67,899)**	(356,780)	(356,780)
Total assets less current liabilities		**252,045**	(45,952)	(26,899)
Non-current liabilities				
Borrowings	25	(44,968)	(49,878)	(49,878)
Provisions	26	(4,290)	(4,186)	(4,186)
Total non-current liabilities		**(49,258)**	(54,064)	(54,064)
Total assets employed		**202,787**	(100,016)	(80,963)
Financed by				
Public dividend capital		402,710	52,390	52,390
Revaluation reserve		11,740	13,383	16,068
Income and expenditure reserve		(211,663)	(165,789)	(149,421)
Total taxpayers' equity		**202,787**	(100,016)	(80,963)

* Please refer to Note 37 for details

The financial statements on pages 1 to 40 were approved by the Board on 24 June 2021 and signed on its behalf by:

Chief Executive:…… **Date: 24 June 2021**

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**52,390**	**13,383**	**(165,789)**	**(100,016)**
Surplus/(deficit) for the year	0	0	(45,874)	**(45,874)**
Impairments	0	(3,645)	0	**(3,645)**
Revaluations	0	2,002	0	**2,002**
Public dividend capital received	351,320	0	0	**351,320**
Public dividend capital repaid	(1,000)	0	0	**(1,000)**
Taxpayers' and others' equity at 31 March 2021	**402,710**	**11,740**	**(211,663)**	**202,787**

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	37,023	9,400	4,996	51,419
Surplus/(deficit) for the year	0	0	(162,876)	(162,876)
Transfers by absorption: transfers between	0	7,956	(7,956)	0
Impairments	0	(6,416)	0	(6,416)
Revaluations	0	2,490	0	2,490
Public dividend capital received	15,367	0	0	15,367
Other reserve movements	0	(47)	47	0
Taxpayers' and others' equity at 31 March 2020	52,390	13,383	(165,789)	(100,016)

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

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

* Please refer to Note 37 for details

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend. The Trust recieved £351,320k of PDC during 2020/21, of which £301,033k related to the refinacing of capital and revenue loans, £43,229k to finance capital schemes and £7,058k to support its revenue position. The Trust also repaid £1,000k

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

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 restated* £000	2019/20 £000
Cash flows from operating activities				
Operating surplus / (deficit)		(34,286)	(49,638)	(54,137)
Non-cash income and expense:				
Depreciation and amortisation	6.1	13,643	8,251	8,430
Net impairments	16	40,396	16,626	20,946
Income recognised in respect of capital donations	4	(1,379)	(65)	(65)
(Increase) / decrease in receivables and other assets		42,084	12,753	12,753
(Increase) / decrease in inventories		(350)	(753)	(753)
Increase / (decrease) in payables and other liabilities		1,704	(7,013)	(7,013)
Increase / (decrease) in provisions		178	652	652
Other movements in operating cash flows		(21)	21	21
Net cash flows from / (used in) operating activities		**61,969**	(19,166)	(19,166)
Cash flows from investing activities				
Interest received		7	183	183
Purchase of intangible assets		(2,797)	(808)	(808)
Purchase of PPE and investment property		(38,590)	(16,193)	(16,193)
Sales of PPE and investment property		1,046	0	0
Receipt of cash donations to purchase assets		0	32	32
Net cash flows from / (used in) investing activities		**(40,334)**	(16,786)	(16,786)
Cash flows from financing activities				
Public dividend capital received		351,320	15,367	15,367
Public dividend capital repaid		(1,000)	0	0
Movement on loans from DHSC		(301,033)	41,205	41,205
Capital element of finance lease rental payments		(59)	(77)	(77)
Capital element of PFI, LIFT and other service concession payments		(2,041)	(476)	(476)
Interest on loans		(899)	(2,079)	(2,079)
Other interest		(3)	(8)	(8)
Interest paid on finance lease liabilities		(11)	(14)	(14)
Interest paid on PFI, LIFT and other service concession obligations		(7,433)	(2,544)	(2,544)
PDC dividend (paid) / refunded		(7,089)	72	72
Net cash flows from / (used in) financing activities		**31,752**	51,446	51,446
Increase / (decrease) in cash and cash equivalents		**53,387**	15,494	15,494
Cash and cash equivalents at 1 April - brought forward		**24,585**	7,239	7,239
Cash and cash equivalents transferred under absorption accounting	34	0	1,852	1,852
Cash and cash equivalents at 31 March	22.1	**77,972**	24,585	24,585

During 2020/21 the Trust received £301,033k of Public Dividend Capital (PDC) to refinance all capital and revenue interim loans. It also accessed a further £7,058k of PDC to support its revenue position.

During 2020/21 the Trust also received PDC of £43,229k (2019/20: £15,367k) to finance a number of capital schemes including £16,082k for the new cancer centre and its CT & MRI scanners. It repaid £1,000k of PDC.

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 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 GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern
The Trust's annual report and accounts have been prepared on a going concern basis. Non trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Note 1.3 Interests in other entities

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

Joint Ventures
Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The Trust entered into a joint venture with the partners of Waterloo House Surgery and University Hospital of Morecambe Bay NHS Foundation Trust with each organisation having one third control over the GP Practice. Joint ventures are accounted for using the equity method (Note 18).

Note 1.4 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.

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.

Note 1.4 Revenue from contracts with customers (cont'd)

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.

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

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

The contract baseline was adjusted to take into account that the Trust did not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This was considered an additional performance obligation to be satisfied under the original transaction price.

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

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

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

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

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

Note 1.5 Other forms of income

Grants and donations

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

Throughout 2020/21 the Department of Health & Social Care (DHSC) issued centrally procured inventory such as personal protective equipment and donated these to NHS providers free of charge. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in other operating income (Note 4).

Apprenticeship service income

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

Note 1.5 Other forms of income (cont'd)

Education & Training (>95% from contracts with Health Education England for the delivery of training to junior medical staff, medical students and a range of other staff) and **non patient services to other bodies** (eg provision of Pathology and Radiology services to non-Trust patients)

Revenue in respect of education and training and non patient services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement 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.

Pension costs

NHS Pension Scheme

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

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.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

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.

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

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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 values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

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 meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

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

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

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

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

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

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

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

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

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

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

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

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

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

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI)

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

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

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	74
Dwellings	2	35
Plant & machinery	1	17
Transport equipment	1	7
Information technology	1	7
Furniture & fittings	1	15

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

Note 1.9 Intangible assets

Recognition

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

Software

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

Measurement

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

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

Amortisation

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

Note 1.10 Inventories

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

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.

In 2019/20 a small number of the Trust's inventory counts were unable to proceed due to COVID-19 priorities. The Trust reviewed previous inventory counts and used this information to estimate inventory values for 31 March 2020 for the affected areas. All inventory counts were able to proceed as normal in March 2021.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

Note 1.12 Financial assets and financial liabilities (cont'd)

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

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

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

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

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

Note 1.13 Leases

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

The Trust as a lessee

Finance leases

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

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

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

Operating leases

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

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

Note 1.13 Leases (cont'd)

The Trust as a lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

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

Note 1.14 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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

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

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

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

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

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

Using information from the Government's Actuary Department (GAD) and NHS Business Services Authority (NHS BSA) a national average discounted value per nomination of £3,345 was calculated to be used to calculate a Trust provision. Where the number of staff likely to take up the offer is unknown it was recommended that the Trust's consultant headcount from NHS Digital's NHS Workforce Statistics - November 2019 was used in order to ensure that the national position is not understated. This figure was 216 for the Trust giving a total provision of £723k for 2019/20. Changes arising mainly from a change in the discount rate meant that for 31 March 2021 the average discounted value per nomination is now £3,927 and the Trust increased its provision and receivable accordingly. (See Note 26.1 and also Note 20.1 for the offsetting asset).

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

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Note 1.15 Contingencies (cont'd)

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public Dividend Capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined 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 (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.17 Value Added Tax

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

Note 1.18 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.19 Losses and special payments

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

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

Note 1.20 Transfers of functions to other NHS bodies (applies to 2019/20 only)

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

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

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

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 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 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. 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 implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

IFRS 17 Insurance Contracts

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

Note 1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see Note 1.24) 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 Cumberland Infirmary and Workington Hospital were constructed under the Private Finance Initiative (PFI) and it is the Trust's judgement that they fall within the scope of IFRIC 12 Service Concession Arrangement. It reaches this judgement for the following reasons:

- the private sector providers provide services to the NHS body;
- the contracts involve the use of assets that are dedicated to the arrangement in providing those services;
- the assets concerned are hospitals which are on the list of infrastructure assets within IFRIC 12;
- the Trust controls/regulates the services being provided by the assets, to whom the services are provided and the price charged for the services;
- the Trust controls the residual interest in the assets at the end of the concessions.

The Trust's judgement that it has controls/regulates the services being provided, to whom the services are provided and the price charged for the services is based on the following:

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

Where a PFI scheme meets the criteria of IFRIC 12 the grantor must recognise an asset and a corresponding finance lease liability in accordance with IAS 17 Leases. See Note 30 for additional information.

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

The Trust has made critical judgements in relation to the modern equivalent asset revaluation as at 31 March 2021. The Trust's valuers, Cushman & Wakefield, carried out a professional valuation of the modern equivalent asset required to have the same productive capacity and service potential as existing Trust assets. This was based on judgements which have been made by the Trust in relation to location with a site based in West Cumbria and one in East Cumbria being the basis for the overall approach. The current model of services for critical care, A&E, theatres, paediatrics and maternity services based on both sites is maintained. The overall number of beds is maintained, however the basis includes more modern design with 6 storeys assumed in line with modern hospital designs and associated grounds and car parking areas and all areas associated with the capacity required to deliver the Trust's services as at 31 March 2021. The land areas assumed in this more efficient valuation are 27.7 acres compared to the current 73.2 acres.

The Trust has made a critical judgement that the cost of replacing the service potential of its operational buildings would exclude VAT. The Trust is a signatory of the Strategic Partnering Agreement with the local eLIFT scheme. The Trust's buildings have been valued on a modern equivalent asset basis and net of recoverable VAT based on the Trust's assessment that if its buildings required replacement the only viable route to facilitate this would be through the eLIFT arrangement. The Trust's judgement is based on the reduced availability of public funding for major capital projects in the NHS currently. There are tax advantages to using the eLIFT route, particularly around construction costs of buildings and their respective lifecycle replacements. Under current VAT regulations input tax would be recoverable and, therefore, the asset value should be stated net of recoverable VAT. See Note 14 Property, Plant and Equipment.

Note 1.24 Sources of estimation uncertainty

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

Uncertainty	Consequences if actual results differ from assumption
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows: • Land and non-specialised buildings – market value for existing use • Specialised buildings – depreciated replacement cost on a modern equivalent asset basis. The Trust seeks professional advice from its valuers' annually in determining the value of its land and buildings. The values in the valuer's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer exercised his professional judgement in providing the valuation and it remains the best information available to the Trust. However, the valuer uses informed assumptions regarding obsolescence, rebuild rates and the area of the sites required to accommodate modern equivalent assets with the same service potential which could change and have a material impact on the valuation. Whilst the pandemic and measures taken to tackle COVID-19 continue to affect economies and real estate markets globally, at the valuation date property markets are mostly functioning again. The March 2021 valuation is not reported as being subject to material valuation uncertainty as defined by VPS and VPGA 10 of the RICS Valuation - Global Standards.	The net book value at 31 March 2021 of the Trust's Property Plant & Equipment valued by professional valuers and reflected in these financial statements is £135.6m. A reduction in the estimated values would result in reductions to the Revaluation Reserve and / or a loss recorded as appropriate in the Statement of Comprehensive Income. If the value of land and buildings were to reduce by 10% this would result in a charge to the Statement of Comprehensive Income of approximately £10.6m and a reduction in the Revaluation Reserve of £2.8m. Depreciation of the assets in 2021/22 would be £0.3m lower. An increase in estimated valuations would result in an increase to the Revaluation Reserve of approximately £2.9m and reversals of previous negative revaluations to the Statement of Comprehensive Income of approximately £10.6m. Depreciation of the assets in 2021/22 would be £0.3m higher.

Note 1.24 Sources of estimation uncertainty (cont'd)

Uncertainty	Consequences if actual results differ from assumption
The Cumberland Infirmary PFI scheme uses a financial model which has been in place since a refinancing in 2010. The model is updated annually to reflect actual charges and RPI. Future years' service costs are estimated based on the latest actual charges and forecast RPI rates. The RPI rate for the next 5 years is taken from the Office for Budget Responsibility's latest 'Economic and fiscal outlook' report whilst any remaining years in the model use an annual RPI rate of 2.5%. Interest and finance lease liability charges are unaffected by changes in RPI. The smaller Workington PFI scheme's financial model is also updated annually and uses a fixed 2.5% RPI rate each year to calculate future years' service costs. Interest and finance lease liability charges are unaffected by changes in RPI.	The total future unitary charge commitment included in table 30.2 of these accounts is £259.5m. A reduction in the forecast RPI rates of 0.5% per annum used in each of the two models would reduce the future unitary charge commitments by £6.2m over the 9 years of the contracts remaining - i.e. operating expenditure would reduce by £6.2m over the remaining 9 years. An increase in the forecast RPI rate of 0.5% per annum used in each of the two models would increase the future unitary charge commitments by £6.3m over the 9 years of the contracts remaining - i.e. operating expenditure would increase by £6.3m over the remaining 9 years.
The Trust has identified that there is a risk relating to the PFI lifecycle prepayment which has been building up on the Statement of Financial Position since 2011/12. The unitary payment made by the Trust to its PFI partner, Health Management (Carlisle), includes an element for the capital expenditure determined at the outset of the contract to be required to maintain the building during the period of the contract. Information on actual lifecycle expenditure is provided by Health Management (Carlisle) with underspends against the payment made by the Trust for lifecycle each year being held as a prepayment against catch up in a future year. Whilst assessment in prior years has been that the level of prepayment was reasonable the level of prepayment has continued to increase and it is the Trust's view that it is unlikely to be recovered in full given the level of actual expenditure by Health Management (Carlisle) and the fact that there are only 9 years of the contract remaining.	The Trust has reduced the total PFI lifecycle prepayment to £1.2m and charged £16.2m to operating expenses. Scheduled lifecycle expenditure over the remainder of the contract is £11.2m. Including the prepayment of £1.2m this would give total fixed asset additions in respect of lifecycle of £12.4m up until March 2030 with a £nil prepayment remaining at 31 March 2030. If actual lifecycle expenditure is 20% (£2.5m) higher than this then £2.5m of the 2020/21 PFI lifecycle prepayment write off would need reversed. Between 1 April 2021 and 31 March 2030 the following changes to the Statement of Financial Position and Statement of Comprehensive Income would be noted: Fixed assets additions £2.5m higher Operating expenses £2.5m lower If actual lifecycle expenditure is 20% (£2.5m) lower then the remaining PFI lifecycle prepayment of £1.2m would need to be written off along with an additional charge of £1.3m for further underspends which will have arisen against the lifecycle element of the unitary charge. Between 1 April 2021 and 31 March 2030 the following changes to the Statement of Financial Position and Statement of Comprehensive Income would be noted: Fixed assets additions £2.5m lower Operating expenses £2.5m higher

Note 2 Operating Segments

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

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

The Trust received income from external organisations for patient care activities amounting to £405,024k (2019/20: £240,031k) as shown in notes 3.1 and 3.2.

£396,343k of the income comes from Clinical Commissioning Groups in England and NHS England which is 98% of the total patient care income (2019/20: £228,346k which was 95% of the total).

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

		restated
	2020/21	2019/20
Acute services	**£000**	£000
Block contract / system envelope income (a)	282,634	106,322
High cost drugs income from commissioners (excluding pass-through costs)	27,476	12,732
Other NHS clinical income	213	154
Mental health services		
Block contract / system envelope income (b)	2,583	35,892
Clinical income for the secondary commissioning of mandatory services	0	23
Other clinical income from mandatory services	0	474
Community services		
Block contract / system envelope income (a)	71,967	62,910
Income from other sources (e.g. local authorities)	5,687	8,937
All services		
Private patient income	382	396
Additional pension contribution central funding (c)	11,656	8,679
Other clinical income	2,426	3,512
Total income from activities	**405,024**	240,031

(a) As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

(b) The reduction in Mental Health Services income is due to the transfer of services to both Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and Lancashire Care NHS Foundation Trust on 1 October 2019.

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

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	£000
NHS England	63,734	40,557
Clinical commissioning groups	332,609	187,789
Other NHS providers	355	973
Local authorities	5,279	7,602
Non-NHS: private patients	382	340
Non-NHS: overseas patients (chargeable to patient)	0	56
Injury cost recovery scheme	589	357
Non NHS: other	2,076	2,357
Total income from activities	**405,024**	240,031
Of which:		
Related to continuing operations	405,024	240,031

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	**Non-contract income**	**Total**	Contract income	Non-contract income	Total
	£000	**£000**	**£000**	£000	£000	£000
Research and development	1,205	0	**1,205**	511	0	511
Education and training	8,165	930	**9,095**	4,017	578	4,595
Non-patient care services to other bodies	7,753	0	**7,753**	5,045	0	5,045
Provider sustainability fund (2019/20 only) (a)	0	0	**0**	340	0	340
Financial recovery fund (2019/20 only) (a)	0	0	**0**	17,147	0	17,147
Marginal rate emergency tariff funding (2019/20 only)	0	0	**0**	994	0	994
Reimbursement and top up funding	65,048	0	**65,048**	0	0	0
Receipt of capital grants and donations (b)	0	1,379	**1,379**	0	65	65
Charitable and other contributions to expenditure (c)	0	8,547	**8,547**	0	89	89
Rental revenue from operating leases	0	74	**74**	0	568	568
Other income (d)	6,248	0	**6,248**	5,260	0	5,260
Total other operating income	**88,419**	**10,930**	**99,349**	33,314	1,300	34,614
Of which:						
Related to continuing operations			99,349			34,614

Note a: The Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) were established in 2016/17 and 2019/20 respectively to support recovery across the NHS. In 2019/20 the Trust accessed £603k of its share of allocated funds (£340k PSF and £263k FRF) and received £16,884k of FRF incentive funding. Due to changes in funding mechanisms during 2020/21, this source of income was not available.

Note b: To support the Trust's response to the ongoing pandemic, the Department of Health and Social Care (DHSC) donated equipment with a value of £1,227k. This charge was offset with corresponding income.

Note c: During 2020/21 the DHSC continued to centrally procure inventory such as personal protective equipment for the organisation. The Trust has recognised £8,004k of income to offset this charge.

Note d: Other income includes £6,300k (2019/20: £3,150k) in support for the PFI scheme at the Cumberland Infirmary, Carlisle. This funding was agreed by the Department of Health during 2012/13 and is received on an on-going basis. Other income also includes £764k (2019/20: £1,177k) for car parking, catering and accommodation income.

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	3,215	525

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	392,397	228,921
Income from services not designated as commissioner requested services	12,627	11,110
Total	**405,024**	240,031

Note 6.1 Operating expenses

	2020/21	2019/20 restated*	2019/20
	£000	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	2,244	2,420	2,420
Staff and executive directors costs	317,130	213,793	213,793
Remuneration of non-executive directors	126	113	113
Supplies and services - clinical (excluding drugs costs) (a)	39,756	19,442	19,442
Supplies and services - general	4,405	3,137	3,137
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	38,456	22,797	22,797
Inventories written down (a)	375	67	67
Consultancy costs	942	308	308
Establishment	5,177	3,206	3,206
Premises	23,019	12,496	12,496
Transport (including patient travel)	3,458	3,840	3,840
Depreciation on property, plant and equipment	12,165	7,251	7,430
Amortisation on intangible assets	1,478	1,000	1,000
Net impairments	40,396	16,626	20,946
Movement in credit loss allowance: contract receivables / contract assets	(67)	(385)	(385)
Increase/(decrease) in other provisions	80	20	20
Change in provisions discount rate(s) (b)	112	304	304
Audit fees payable to the external auditor (c)			
audit services- statutory audit	110	78	78
Internal audit costs	228	202	202
Clinical negligence	10,938	5,483	5,483
Legal fees	948	521	521
Insurance	392	234	234
Education and training (d)	2,539	1,319	1,319
Rentals under operating leases	2,904	2,442	2,442
Redundancy	174	40	40
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	13,577	6,072	6,072
Car parking & security	200	54	54
Hospitality	2	11	11
Losses, ex gratia & special payments	23	45	45
Other services, eg external payroll	983	584	584
Other (e)	16,389	763	763
Total	**538,659**	324,283	328,782
Of which:			
Related to continuing operations	538,659	324,283	328,782

* Please refer to Note 37 for details

Note a: During 2020/21 the DHSC continued to procure centrally inventory such as personal protective equipment for the organisation. The Trust has recognised cost of £7,305k within its accounts including £200k of impairment relating to the difference between purchase price and market value.

Note b: The 2020/21 HM Treasury discount rates were used to calculate the present value of the cashflows associated with provisions see note 26

Note c: Audit fees are inclusive of VAT and in 2020/21 include £5k relating to the 2019/20 audit. Other auditor remuneration was £nil (2019/20: £nil). The Trust's auditors for 2019/20 and 2020/21 were Grant Thornton UK LLP.

Note d: Education & Training includes notional expenditure to match the notional income from the apprenticeship fund (see Note 4).

Note e: Mainly relates to prepayments made for future lifecycle estates' costs that the Trust has assessed as not likely to be expended.

Operating expenditure includes £22,409k (2019/20: £2,232k) of costs relating to COVID-19 of which £2,204k (2019/20: £1,017k) relates to annual leave owing due to the pandemic.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2019/20: £2m).

Note 7 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	236,508	158,987
Social security costs	20,696	13,973
Apprenticeship levy	1,140	736
Employer's contributions to NHS pensions (a)	38,172	27,840
Pension cost - other	146	85
Termination benefits	174	40
Temporary staff (including agency)	20,468	12,453
Total staff costs	**317,304**	214,114
Of which		
Costs capitalised as part of assets	0	281

Note a: The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. In 2019/20 and 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 7.1 Retirements due to ill-health

During 2020/21 there were 6 early retirements from the Trust agreed on the grounds of ill-health (2019/20:3). The estimated additional pension liabilities of these ill-health retirements is £258k (2019/20: £228k).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 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.

The Pensions Act 2008 introduced new duties on employers to provide access to a workplace pension that meets certain legal requirements. As from 1 April 2013 the Trust choose the National Employment Savings Trust (NEST) to fulfil this role for employees who are unable to join the NHS Pension Scheme due to its restrictions. It is a defined contribution pension scheme where the retirement income a member gets depends on how much has been contributed, investment returns and the amount of charges over time. Current combined employee and employer contributions were £341k to 31 March 2021 (31 March 2020: £198k).

Note 9 Operating leases

Note 9.1 North Cumbria Integrated Care NHS Foundation Trust as a lessor

The Trust has a number of small operating leases including lease arrangements for the use of clinic rooms at several of its community hospitals and also the hospital shop at West Cumberland Hospital.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	74	568
Total	**74**	568

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	5	6
- later than one year and not later than five years;	26	22
- later than five years.	0	5
Total	**31**	33

Note 9.2 North Cumbria Integrated Care NHS Foundation Trust as a lessee

The Trust has a number of lease arrangements for both clinical and non clinical spaces, with the higher value leases having lease terms of over 15 years.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	2,904	2,442
Total	**2,904**	2,442

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,737	2,571
- later than one year and not later than five years;	6,611	5,664
- later than five years.	16,825	15,100
Total	**26,173**	23,335

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21	2019/20
	£000	£000
Interest on bank accounts (a)	(9)	100
Other finance income	0	92
Total finance income	**(9)**	192

Note a: The interest rate on Government Banking Service (GBS) accounts has been 0% since March 2020.

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	0	2,137
Finance leases	11	14
Interest on late payment of commercial debt	3	8
Main finance costs on PFI and LIFT schemes obligations	4,910	1,523
Contingent finance costs on PFI and LIFT scheme obligations	2,523	1,021
Total interest expense	**7,447**	4,703
Unwinding of discount on provisions	(17)	11
Total finance costs	**7,430**	4,714

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

During 2020/21 the Trust paid interest totally £3k (2019/20: £8k).

Note 12 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	428	0
Losses on disposal of assets	(174)	(95)
Total gains / (losses) on disposal of assets	**254**	(95)

Note 13 Intangible assets

	Software licences		Software licences
	£000		£000
Valuation / gross cost at 1 April 2020 - brought forward	**9,863**	Valuation / gross cost at 1 April 2019 - as previously stated	4,510
Transfers by absorption	0	Transfers by absorption (a)	4,614
Additions	2,797	Additions	808
Reclassifications	0	Reclassifications	(69)
Disposals / derecognition	(61)	Disposals / derecognition	0
Valuation / gross cost at 31 March 2021	**12,599**	Valuation / gross cost at 31 March 2020	9,863
Amortisation at 1 April 2020 - brought forward	**5,644**	Amortisation at 1 April 2019 - as previously stated	1,693
Transfers by absorption	0	Transfers by absorption (a)	3,020
Provided during the year	1,478	Provided during the year	1,000
Reclassifications	0	Reclassifications	(69)
Disposals / derecognition	(61)	Disposals / derecognition	0
Amortisation at 31 March 2021	**7,061**	Amortisation at 31 March 2020	5,644
Net book value at 31 March 2021	**5,538**	Net book value at 31 March 2020	4,219
Net book value at 1 April 2020	**4,219**	Net book value at 1 April 2019	2,817

Note a: Relates to the incoming assets of North Cumbria University Hospitals NHS Trust and also the transfer out of assets relating to mental health services during 2019/20.

Note 14.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**6,159**	**166,623**	**557**	**13,337**	**54,890**	**206**	**17,835**	**2,686**	**262,293**
Additions	0	10,614	0	22,068	11,635	40	3,990	123	**48,470**
Impairments	(3,169)	(47,345)	(24)	0	0	0	0	0	**(50,538)**
Reversals of impairments	500	1,417	135	0	0	0	0	0	**2,052**
Revaluations	0	1,646	0	0	0	0	0	0	**1,646**
Reclassifications	0	2,726	0	(2,943)	234	0	0	0	**17**
Disposals / derecognition	0	(251)	0	0	(2,329)	0	(220)	(45)	**(2,845)**
Valuation/gross cost at 31 March 2021	**3,490**	**135,430**	**668**	**32,462**	**64,430**	**246**	**21,605**	**2,764**	**261,095**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**1,981**	**0**	**0**	**35,879**	**133**	**11,416**	**1,910**	**51,319**
Provided during the year	0	4,912	19	0	5,167	21	1,774	272	**12,165**
Impairments	0	(4,286)	(16)	0	0	0	0	0	**(4,302)**
Reversals of impairments	0	(140)	(3)	0	0	0	0	0	**(143)**
Revaluations	0	(356)	0	0	0	0	0	0	**(356)**
Reclassifications	0	17	0	0	0	0	0	0	**17**
Disposals / derecognition	0	(103)	0	0	(2,305)	0	(217)	(45)	**(2,670)**
Accumulated depreciation at 31 March 2021	**0**	**2,025**	**0**	**0**	**38,741**	**154**	**12,973**	**2,137**	**56,030**
Net book value at 31 March 2021	**3,490**	**133,405**	**668**	**32,462**	**25,689**	**92**	**8,632**	**627**	**205,065**
Net book value at 1 April 2020	**6,159**	**164,642**	**557**	**13,337**	**19,011**	**73**	**6,419**	**776**	**210,974**

See Notes 15 and 16 for additional information on revaluation and impairments.

Note 14.2 Property, plant and equipment financing - 2020/21

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2021									
Owned - purchased	3,490	77,985	668	32,462	23,881	92	8,631	620	**147,829**
On-SoFP PFI contracts and other service concession arrangements	0	54,938	0	0	0	0	0	0	**54,938**
Owned - donated/granted	0	482	0	0	1,808	0	1	7	**2,298**
NBV total at 31 March 2021	**3,490**	**133,405**	**668**	**32,462**	**25,689**	**92**	**8,632**	**627**	**205,065**

Note 14.3 Property, plant and equipment - 2019/20 restated*

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	5,669	53,317	248	0	6,545	253	13,832	1,955	81,819
Transfers by absorption (a)	4,022	146,448	735	7,796	44,220	0	4,804	746	208,771
Prior period adjustments relating to 1 October absorption transfer	0	(19,589)	7	0	0	0	0	0	(19,582)
Additions	0	4,911	0	7,318	5,232	0	2,512	336	20,309
Impairments	(3,379)	(23,841)	(479)	0	0	0	0	0	(27,699)
Reversals of impairments	0	1,431	47	0	0	0	0	0	1,478
Revaluations	17	2,591	0	0	0	0	0	0	2,608
Reclassifications	0	1,777	(1)	(1,777)	(623)	(47)	(3,260)	(241)	(4,172)
Transfers to / from assets held for sale	(170)	(401)	0	0	0	0	0	0	(571)
Disposals / derecognition	0	(21)	0	0	(484)	0	(53)	(110)	(668)
Valuation/gross cost at 31 March 2020	6,159	166,623	557	13,337	54,890	206	17,835	2,686	262,293
Accumulated depreciation at 1 April 2019 - brought forwarc	0	1,330	0	0	3,572	159	7,676	1,471	14,208
Transfers by absorption (a)	0	717	(3)	0	30,756	0	5,606	570	37,646
Prior period adjustments relating to 1 October absorption transfer	0	(1)	0	0	0	0	0	0	(1)
Provided during the year	0	2,978	24	0	2,564	21	1,447	217	7,251
Impairments	0	(2,498)	(20)	0	0	0	0	0	(2,518)
Reversals of impairments	0	(661)	0	0	0	0	0	0	(661)
Revaluations	0	118	0	0	0	0	0	0	118
Reclassifications	0	(2)	(1)	0	(621)	(47)	(3,260)	(241)	(4,172)
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	0
Disposals / derecognition	0	0	0	0	(392)	0	(53)	(107)	(552)
Accumulated depreciation at 31 March 2020	0	1,981	0	0	35,879	133	11,416	1,910	51,319
Net book value at 31 March 2020	6,159	164,642	557	13,337	19,011	73	6,419	776	210,974
Net book value at 1 April 2019	5,669	51,987	248	0	2,973	94	6,156	484	67,611

Note a: Relates to the incoming assets of North Cumbria University Hospitals NHS Trust and also the transfer out of assets relating to mental health services and Millom Community Hospital. The assets of North Cumbria University Hospitals NHS Trust included two general hospitals, one in Carlisle and one in Whitehaven, as well as substantial medical equipment. The transfer of mental health services included the Carleton Clinic Site at Carlisle. Assets under Construction includes redevelopment of West Cumberland Hospital and the construction of a new cancer centre at the Cumberland Infirmary.

Note 14.4 Property, plant and equipment financing - 2019/20 restated*

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	6,159	97,391	557	13,337	18,427	73	6,336	768	143,048
Finance leased	0	0	0	0	0	0	78	0	78
On-SoFP PFI contracts and other service concession arrangements	0	66,755	0	0	0	0	0	0	66,755
Owned - donated	0	496	0	0	584	0	5	8	1,093
NBV total at 31 March 2020	6,159	164,642	557	13,337	19,011	73	6,419	776	210,974

* Please refer to Note 37 for details

Note 14.5 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	5,669	53,317	248	0	6,545	253	13,832	1,955	81,819
Transfers by absorption (a)	4,022	146,448	735	7,796	44,220	0	4,804	746	208,771
Additions	0	4,911	0	7,318	5,232	0	2,512	336	20,309
Impairments	(3,379)	(28,768)	(549)	0	0	0	0	0	(32,696)
Reversals of impairments	0	2,111	0	0	0	0	0	0	2,111
Revaluations	17	6,426	0	0	0	0	0	0	6,443
Reclassifications	0	1,777	(1)	(1,777)	(623)	(47)	(3,260)	(241)	(4,172)
Transfers to / from assets held for sale	(170)	(401)	0	0	0	0	0	0	(571)
Disposals / derecognition	0	(21)	0	0	(484)	0	(53)	(110)	(668)
Valuation/gross cost at 31 March 2020	6,159	185,800	433	13,337	54,890	206	17,835	2,686	281,346
Accumulated depreciation at 1 April 2019 - brought forward	0	1,330	0	0	3,572	159	7,676	1,471	14,208
Transfers by absorption (a)	0	717	(3)	0	30,756	0	5,606	570	37,646
Provided during the year	0	3,157	24	0	2,564	21	1,447	217	7,430
Impairments	0	(2,669)	(20)	0	0	0	0	0	(2,689)
Reversals of impairments	0	(646)	0	0	0	0	0	0	(646)
Revaluations	0	94	0	0	0	0	0	0	94
Reclassifications	0	(2)	(1)	0	(621)	(47)	(3,260)	(241)	(4,172)
Disposals / derecognition	0	0	0	0	(392)	0	(53)	(107)	(552)
Accumulated depreciation at 31 March 2020	0	1,981	0	0	35,879	133	11,416	1,910	51,319
Net book value at 31 March 2020	6,159	183,819	433	13,337	19,011	73	6,419	776	230,027
Net book value at 1 April 2019	5,669	51,987	248	0	2,973	94	6,156	484	67,611

Note a: Relates to the incoming assets of North Cumbria University Hospitals NHS Trust and also the transfer out of assets relating to mental health services and Millom Community Hospital. The assets of North Cumbria University Hospitals NHS Trust included two general hospitals, one in Carlisle and one in Whitehaven, as well as substantial medical equipment. The transfer of mental health services included the Carleton Clinic Site at Carlisle. Assets under Construction includes redevelopment of West Cumberland Hospital and the construction of a new cancer centre at the Cumberland Infirmary.

Note 14.6 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	6,159	116,568	433	13,337	18,427	73	6,336	768	162,101
Finance leased	0	0	0	0	0	0	78	0	78
On-SoFP PFI contracts and other service concession arrangements	0	66,755	0	0	0	0	0	0	66,755
Owned - donated	0	496	0	0	584	0	5	8	1,093
NBV total at 31 March 2020	6,159	183,819	433	13,337	19,011	73	6,419	776	230,027

Note 15 Revaluations of property, plant and equipment

The Trust revalued its land, buildings and dwellings on 31 March 2021. The revaluation was carried out by RICS Registered Valuers at Cushman & Wakefield, and is consistent with the requirements of IAS 16. As the Trust has specialised assets for which there is no active market, the valuer has used Modern Equivalent Asset (MEA) valuations as a substitute for fair value. MEA assumes that assets will be replaced with modern assets of equivalent capacity which meet the location requirements of the services being provided. Alternative sites have been used where location requirements are met.

COVID-19 Update

The valuation exercise was carried out in March and April 2021 with a valuation date of 31 March 2021. The valuer's report states: "*The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. 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, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards".*

The values in Cushman & Wakefield's report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. A 10% change in the valuation of land and buildings would have £13.6m impact on the Statement of Financial Position.

Note 16 Impairment of assets

	2020/21	2019/20 restated*	2019/20
	£000	£000	£000
Net impairments charged to operating surplus / deficit			
Changes in market price	40,396	17,752	22,072
Other	0	(1,126)	(1,126)
Total net impairments charged to operating surplus / deficit	**40,396**	16,626	20,946
Impairments charged to the revaluation reserve	3,645	6,416	6,304
Total net impairments	**44,041**	23,042	27,250

* Please refer to Note 37 for details

To ensure that the carrying amount of land and buildings did not differ materially from its fair value at 31 March 2021, based on a Modern Equivalent Asset valuation, impairments of £40.4m were charged to operating expenses and a further £3.6m of impairments were charged to the revaluation reserve.

Of the total net impairments, £17.8m relates to the value of the main hospital block at the Cumberland Infirmary, with £17.3m applicable to the new hospital block at West Cumberland Hospital (WCH). In valuing the land component of the specialist assets, the area of the sites required to accommodate modern equivalent assets with the same service potential as the existing assets would be smaller than the existing land area which has generated a net impairment of £1.2m, plus a further £1.5m charge set against revaluation reserves.

Note 17 Donations of property, plant and equipment

The Trust received donations of £152k from the North Cumbria University Hospitals Charitable Fund for the purchase of assets (2019/20: £32k from the North Cumbria University Hospitals Charitable Fund and £33k from League of Friends) .

The Trust received £1,227k of equipment from the Department of Health and Social Care to support its response to the pandemic (2019/20:nil).

Note 18 Investments in associates and joint ventures

The Trust maintained its £35k investment in the joint venture with the partners of Waterloo House Surgery and University Hospitals of Morecambe Bay NHS Foundation Trust with each organisation having one third control over the GP Practice.

Note 19 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	2,522	2,536
Consumables	4,471	4,101
Energy	30	61
Other	179	154
Total inventories	**7,202**	6,852

Inventories recognised in expenses for the year were £76,453k (2019/20: £31,321k). Write-down of inventories recognised as expenses for the year were £375k (2019/20: £67k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £8,004k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

In 2019/20 a small number of the Trust's inventory counts, including Theatres at the West Cumberland Hospital and Cumberland Infirmary, were unable to proceed due to COVID-19 priorities. The Trust reviewed previous inventory counts and used this information to estimate inventory values for 31 March 2020 for the affected areas. The total value of inventory included above that has been estimated is £2,650k. The normal inventory count processes resumed at the end of 2020/21.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	12,278	43,913
Allowance for impaired contract receivables / assets	(282)	(328)
Prepayments (non-PFI)	4,813	2,748
PFI lifecycle prepayments	138	1,478
Interest receivable	0	16
PDC dividend receivable	2,686	0
VAT receivable	1,081	0
Other receivables (b)	603	10
Total current receivables	**21,317**	47,837
Non-current		
Contract receivables (a)	552	644
Allowance for impaired contract receivables / assets	(85)	(106)
PFI lifecycle prepayments	1,098	14,047
Other receivables (c)	1,250	1,124
Total non-current receivables	**2,815**	15,709
Of which receivable from NHS and DHSC group bodies:		
Current	11,612	32,231
Non-current	849	723

Note a: Included in current receivables at 31 March 2021 is £958k (2019/20: £826k) for the Injury Cost Recovery Scheme and in non-current £552k (2019/20: £644k). Credit scoring is not appropriate for the Scheme as it only includes person(s) who have been found to be, or accept, responsibility for injury caused. A provision of 15.41% has been applied for any potential non recovery costs based on the Trust's average withdrawal rates (2019/20: 16.42%).

Note b: Other receivables relates to the Trust's loan to North Cumbria Primary Care Ltd to support primary care provision throughout Cumbria (2019/20: £401k).

Note c: Includes £849k (2019/20: £723k) which reflects the offsetting asset in respect of the provision for clinician pension tax charges for 2019/20. See Notes 1.14 and 26.1.

Note 20.2 Allowances for credit losses

	2020/21 £000	2019/20 £000
Allowances as at 1 April - brought forward	**434**	474
Transfers by absorption	0	345
Changes in existing allowances	(67)	(385)
Allowances as at 31 Mar 2021	**367**	434

These allowances relate to contract receivables and contract assets.

Note 21 Non-current assets held for sale and assets in disposal groups

During 2019/20 the Trust transferred Voreda House and Crozier Lodge with a total net book value of £617k from PPE into assets held for sale. Both properties were sold during 2020/21. There are no non-current assets held for sale at 31 March 2021.

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**24,585**	7,239
Transfers by absorption	0	1,852
Net change in year	53,387	15,494
At 31 March	**77,972**	24,585
Broken down into:		
Cash at commercial banks and in hand	10	20
Cash with the Government Banking Service	77,962	24,565
Total cash and cash equivalents as in SoFP	**77,972**	24,585
Total cash and cash equivalents as in SoCF	**77,972**	24,585

Note 22.2 Third party assets held by the Trust

The Trust held £401k cash at bank and in hand at 31 March 2021 (2019/20: £396k) which comprises £76k monies held by the Trust on behalf of patients (2019/20: £71k), and £325k held on behalf of the West, North and East Cumbria Sustainability and Transformation Partnership (2019/20: £325k). These amounts have been excluded from the cash at bank and in hand figure reported in the accounts.

Note 23 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	8,283	10,365
Capital payables	15,626	7,125
Accruals	23,095	21,369
Social security costs	3,207	2,996
VAT payables	0	264
Other taxes payable	2,661	2,531
Other payables	4,506	3,898
Total current trade and other payables	**57,378**	48,548
Of which payables from NHS and DHSC group bodies:		
Current	9,717	7,381

Note 24 Other liabilities

Other liabilities as disclosed in the Statement of Financial Position relates to deferred income of £5,270k (2019/20: £3,895k).

Note 25.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	0	301,074
Obligations under finance leases	0	59
Obligations under PFI, LIFT or other service concession contracts	4,031	2,041
Total current borrowings	**4,031**	303,174
Non-current		
Loans from DHSC	0	858
concession contracts	44,968	49,020
Total non-current borrowings	**44,968**	49,878

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. In September 2020 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment, the affected loans totalled £301,033k. The balance of DHSC loans at 31 March 2020 related to interest and this was paid in August 2020.

The fair value of the outstanding PFI liabilities at 31 March 2021 is £69,261k (2019/20: £72,208k). The fair value of these liabilities has been obtained with reference to the current fixed interest rates offered by the Department of Health & Social Care for similar loans for period matching the remaining life of the existing loans/liabilities.

The PFI liabilities are discussed further in Note 30.

Note 25.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	**301,932**	**59**	**51,061**	**353,052**
Cash movements:				
Financing cash flows - payments and receipts of principal	(301,033)	(59)	(2,041)	**(303,133)**
Financing cash flows - payments of interest	(899)	(11)	(4,931)	**(5,841)**
Non-cash movements:				
Application of effective interest rate	0	11	4,910	**4,921**
Carrying value at 31 March 2021	**0**	**0**	**48,999**	**48,999**

Note 25.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	4,143	136	5,324	9,603
Cash movements:				
Financing cash flows - payments and receipts of principal	41,205	(77)	(476)	40,652
Financing cash flows - payments of interest	(2,079)	(14)	(1,523)	(3,616)
Non-cash movements:				
Transfers by absorption	256,526	0	46,213	302,739
Application of effective interest rate	2,137	14	1,523	3,674
Carrying value at 31 March 2020	301,932	59	51,061	353,052

Note 25.4 North Cumbria Integrated Care NHS Foundation Trust as a lessee
Obligations under finance leases where the Trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**0**	69
of which liabilities are due:		
- not later than one year;	0	69
Finance charges allocated to future periods	0	(11)
Net lease liabilities	**0**	59
of which payable:		
- not later than one year;	0	59

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	**Pensions: injury benefits £000**	**Legal claims £000**	**Redund-ancy £000**	**Other £000**	**Total £000**
At 1 April 2020	**413**	**3,290**	**497**	**0**	**1,149**	**5,349**
Change in the discount rate (a)	(7)	119	0	0	0	**112**
Arising during the year	10	113	152	48	566	**889**
Utilised during the year	(79)	(166)	(46)	0	(426)	**(717)**
Reversed unused	(2)	0	(104)	0	0	**(106)**
Unwinding of discount	(1)	(16)	0	0	0	**(17)**
At 31 March 2021	**334**	**3,340**	**499**	**48**	**1,289**	**5,510**
Expected timing of cash flows:						
- not later than one year;	67	166	499	48	**440**	**1,220**
- later than one year and not later than five years;	179	604	0	0	**0**	**783**
- later than five years.	88	2,570	0	0	**849**	**3,507**
Total	**334**	**3,340**	**499**	**48**	**1,289**	**5,510**

Note a: The discount rate used in the calculation of the Pensions and Personal Injury Benefit provisions was minus 0.95% in 2020/21 compared to minus 0.50% 2019/20

Pensions: Early departure costs
The Pensions provision is based on an estimate of the number of years individual pensions will continue to be paid and is considered a realistic assessment of future pension costs.

Pensions: Injury benefits
The Injury Benefits provision is based on an estimate of the number of years individual pensions will continue to be paid and is considered a realistic assessment of future pension costs.

Legal Claims
Provisions for legal claims includes claims made through NHS Resolution. This includes on-going cases where the date of conclusion and settlement figures are not certain. The total value of the provision made for the Trust through NHS Resolution is £499k for 2020/21 (2019/20: £497k)

Other
Other provisions includes a claim for retrospective reimbursement of premises costs and also £849k in respect of clinician pension taxes. Senior clinicians who face a tax charge in respect of the growth of their NHS benefits above their pension savings annual allowance threshold will be able to have this charge paid for by the NHS Pension Scheme. See Note 1.14. Also included is a provision in respect of the costs of restoring a leased property to the condition it was in at the date the lease was signed.

Note 26.2 Clinical negligence liabilities
At March 2021 £152,618k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities for North Cumbria Integrated Care NHS Foundation Trust (2019/20: £148,665k).

Note 27 Contingent assets and liabilities
The Trust recognises a contingent liability of £250k at 31 March 2021 (31 March 2020: £245k) relating to employer's liability claims made against the Trust as advised by NHS Resolution, which handles claims on the Trust's behalf. These claims are expected to be resolved within 1 year.

Note 28 Contractual capital commitments

The Trust has capital commitments totalling £29,376k as at 31 March 2021, of which £25,303k is for West Cumberland Hospital redevelopment; £470k is for the Northern Centre for Cancer Care and £2,377k is for investment in electronic prescribing. The Trust had capital commitments totalling £14,885k as at 31 March 2020, £14,509k relating to the ongoing redevelopment of West Cumberland Hospital and the remainder for medical and IT equipment.

Note 29 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2021 £000	31 March 2020 £000
not later than 1 year	627	1,008
after 1 year and not later than 5 years	735	465
Total	**1,362**	1,473

The Trust has revenue commitments for IT equipment and software support for its two data centre buildings, electronic patient record system and Community of Interest Network connections.

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has two PFI schemes, both for the provision of hospital facilities, with one at the Cumberland Infirmary in Carlisle and the other at Workington Community Hospital.

The Cumberland Infirmary scheme was completed in 2000 and the contract runs for 45 years with a break clause after 30 years. At the end of the contract period, or at the break clause, the buildings included in the contract will transfer to the Trust.

The Workington Hospital scheme transferred to the Trust on the 1 April 2013 as a part of the Cumbria Primary Care Trust asset transfer. The agreement is for a 25 year term ending 31 March 2030. The Trust had been in dispute with its Private Finance Initiative (PFI) provider relating to fire defects and other issues at Workington Hospital. The dispute was subject to a legal process and was concluded during 2020/21.

Payments made to the Health Management (Carlisle) consortium in respect of the Cumberland Infirmary for 2020/21 were £25.1m. Payments made for Workington Hospital during 2020/21 were £1.2m. The recurring annual commitment for both schemes is £26.3m (at March 2021 prices) subject to changes in inflation, performance of provider, availability of asset, and agreed variations to services provided by the PFI operators.

Note 30.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**73,911**	**80,912**
Of which liabilities are due		
- not later than one year;	8,688	6,951
- later than one year and not later than five years;	32,970	33,754
- later than five years.	32,253	40,207
Finance charges allocated to future periods	(24,912)	(29,851)
Net PFI, LIFT or other service concession arrangement obligation	**48,999**	**51,061**
- not later than one year;	4,031	2,041
- later than one year and not later than five years;	18,621	17,669
- later than five years.	26,347	31,351

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**269,768**	**301,324**
Of which payments are due:		
- not later than one year;	27,233	26,697
- later than one year and not later than five years;	115,259	114,205
- later than five years.	127,276	160,422

Note 30.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21 £000	2019/20 £000
Unitary payment payable to service concession operator	**26,335**	**11,541**
Consisting of:		
- Interest charge	4,910	1,523
- Repayment of balance sheet obligation	2,041	476
- Service element and other charges to operating expenditure	13,481	6,072
- Capital lifecycle maintenance	1,342	850
- Revenue lifecycle maintenance	96	0
- Contingent rent	2,523	1,021
- Addition to lifecycle prepayment	1,942	1,599
Total amount paid to service concession operator	**26,335**	**11,541**

Note 31 Financial instruments

Note 31.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

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

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in contract receivables, as disclosed in note 20.

Liquidity risk

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

Note 31.2 Carrying values of financial assets

	Total £000		Total £000
Trade and other receivables excluding non financial assets	13,712	Trade and other receivables excluding non financial assets	44,540
Other investments / financial assets	35	Other investments / financial assets	35
Cash and cash equivalents	77,972	Cash and cash equivalents	24,585
Total at 31 March 2021	**91,719**	Total at 31 March 2020	69,160

Note 31.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	**Total £000**	Carrying values of financial liabilities as at 31 March 2020	Total £000
Loans from the Department of Health and Social Care	0	Loans from the Department of Health and Social Care	301,932
Obligations under finance leases	0	Obligations under finance leases	59
Obligations under PFI, LIFT and other service concession contracts	48,999	Obligations under PFI, LIFT and other service concession contracts	51,061
Trade and other payables excluding non financial liabilities	43,936	Trade and other payables excluding non financial liabilities	39,070
Total at 31 March 2021	**92,935**	Total at 31 March 2020	392,122

Note 31.4 Fair values of financial assets and

The financial instruments above are shown at carrying (book) value. The PFI finance lease creditors are considered to have fair values that are not the same as their carrying values the value of which is £69,261 (2019/20: £72,208k).

Note 31.5 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	52,624	347,164
In more than one year but not more than five years	32,970	34,604
In more than five years	32,253	40,215
Total	**117,847**	421,983

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 32 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	**Total value of cases £000**	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	99	31	75	8
Stores losses and damage to property	4	175	3	67
Total losses	**103**	**206**	78	75
Special payments				
Ex-gratia payments	36	23	32	45
Special severance payments	0	0	1	18
Total special payments	**36**	**23**	33	63
Total losses and special payments	**139**	**229**	111	138

Note 33 Related parties

Dr Howarth, the Trust's Executive Director of Strategy until 31 August 2020, was also a director of North Cumbria Primary Care (NCPC), a not for profit model for primary care. The Trust has a facilities agreement in place with NCPC and has injected £401k of working capital into the arrangement (2019/20: £400k and 2018/19: £1k). This is repayable to the Trust and is included in the Trust's non-current receivables (See Note 20.1).

No other Board Members or members of the key management staff or parties related to them have undertaken any material transactions with North Cumbria Integrated Care NHS Foundation Trust during 2020/21.

The Department of Health & Social Care is regarded as a related party. During the year North Cumbria Integrated Care has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These include:

Health Education England
NHS England
NHS North Cumbria CCG
NHS Resolution
University Hospitals of Morecambe Bay NHS Foundation Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the NHS Pensions Agency, HM Revenue & Customs, the Scottish Office (in respect of Scottish Health Boards) and the local councils.

North Cumbria Integrated Care NHS Foundation Trust is the sole corporate Trustee for the North Cumbria University Hospitals Charitable Fund. In 2020/21 the Trust's Charities spent £617k (2019/20: £429k) on medical and education equipment, salaries and training courses from which the Trust benefitted. The Trust also received £70k from the Cumbria Partnership Charitable Fund as a final settlement of amounts owed. The Charity's assets were transferred to Cumbria Community Fund on 1 October 2019.

Note 34 Transfers by absorption (2019/20 only)

	North Cumbria University Hospital NHS Trust restated* £000 Incoming	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust £000 Outgoing	Lancashire Care NHS Foundation Trust £000 Outgoing	University Hospital of Morecambe Bay NHS Foundation Trust £000 Outgoing	Total North Cumbria Integrated Care NHS Foundation Trust £000 Net
Non Current Assets	196,554	(19,421)	(8,434)	(2,323)	166,376
Current Assets	57,658	0	0	0	57,658
Current Liabilities	(170,583)	0	0	0	(170,583)
Non Current liabilities	(162,072)	0	0	0	(162,072)
	(78,443)	(19,421)	(8,434)	(2,323)	(108,621)

	North Cumbria University Hospital NHS Trust £000 Incoming	Cumbria, Northumberland Tyne and Wear NHS Foundation Trust £000 Outgoing	Lancashire Care NHS Foundation Trust £000 Outgoing	University Hospital of Morecambe Bay NHS Foundation Trust £000 Outgoing	Total North Cumbria Integrated Care NHS Foundation Trust £000 Net
Non Current Assets	216,135	(19,421)	(8,434)	(2,323)	185,957
Current Assets	57,658	0	0	0	57,658
Current Liabilities	(170,583)	0	0	0	(170,583)
Non Current liabilities	(162,072)	0	0	0	(162,072)
	(58,862)	(19,421)	(8,434)	(2,323)	(89,040)

North Cumbria Integrated Care (formerly Cumbria Partnership NHS Foundation Trust) acquired North Cumbria University Hospital on 1 October 2019 and all assets and liabilities transferred as detailed above.

On 1 October 2019 the Trust's mental health services transferred to Cumbria Northumberland Tyne and Wear NHS Foundation Trust and Lancashire Care NHS Foundation Trust, assets relating to these services were also transferred as detailed above.

On 1 April 2019 as a part of the South Community services transfer Millom Hospital was transferred to University Hospitals of Morecambe Bay NHS Foundation Trust following the completion of the site redevelopment.

Note 35 Events after the reporting date

On 1 April 2021 the Trust's Cancer and Oncology services transferred to The Newcastle Upon Tyne Hospitals NHS Foundation Trust. This represents a reduction in Trust income for 2021/22 of £11.6m.

Note 36 Adjusted Financial Performance

The adjusted financial performance shows the Trust's performance against its agreed control total with NHS Improvement. The Trust's agreed control total for 2020/21 was £8.9m deficit (2019/20: £37.8m deficit).

	2020/21	2019/20 restated*	2019/20
	£000	£000	£000
Surplus / (deficit) for the period	(45,874)	(162,876)	(147,794)
Remove net impairments not scoring to the Departmental expenditure limit	40,396	16,626	20,946
Remove (gains) / losses on transfers by absorption	0	108,621	89,040
Remove I&E impact of capital grants and donations	(1,192)	50	50
Remove net impact of inventories received from DHSC group bodies for COVID	(699)	0	0
Adjusted financial performance surplus /	**(7,369)**	(37,579)	(37,758)

Note 37 Prior Period Adjustment

During the work to finalise the accounts for 2020/21 an issue affecting valuation of the West Cumberland Hospital site was identified. The site has undergone extensive redevelopment in recent years, however, following a new build and extensive refurbishment of the retained estate there had been changes to floor areas which had not been reflected in the valuations of some of its buildings and dwellings. To address the error the Trust submitted revised floor areas to its valuers who prepared revised valuations for the affected 2018/19 and 2019/20 periods. As a result of an overstatement of floor areas there has been a reduction to the value of Property, Plant & Equipment of £19.053m.

Up to 30 September 2019 the reduction to Property, Plant & Equipment was £19.581m which resulted in a reduction of £19.581m in net asset/liabilites recognised on absorption (see Note 34).

For the 6 month period to 31 March 2020 there was an increase to the value of Property, Plant & Equipment of £528k made up as follows:

	£000
Depreciation	179
Reduction in net impairments charged to operating expenses	4,320
Net impact on operating expenses	**4,499**
Increase in impairments charged to the Revaluation Reserve	(112)
Reduction in revaluations added to the Revaluation Reserve	(3,859)
Total comprehensive income / (expense) for the period	**528**

Detailed Impact on Financial Statements

Statement of Comprehensive Income

	2019/20 Original	**PPA**	**2019/20 Restated**
	£000	**£000**	**£000**
Operating income from patient care activities	240,031		240,031
Other operating income	34,614		34,614
Operating expenses	(328,782)	4,499	(324,283)
Operating surplus/(deficit) from continuing operations	**(54,137)**	**4,499**	**(49,638)**
Finance income	192		192
Finance expenses	(4,714)		(4,714)
PDC dividends payable	0		0
Net finance costs	**(4,522)**	**0**	**(4,522)**
Other gains / (losses)	(95)		(95)
Gains / (losses) arising from transfers by absorption	(89,040)	(19,581)	(108,621)
Surplus / (deficit) for the year	**(147,794)**	**(15,082)**	**(162,876)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	(6,304)	(112)	(6,416)
Revaluations	6,349	(3,859)	2,490
Total comprehensive income / (expense) for the period	**(147,749)**	**(19,053)**	**(166,802)**

Note 37 Prior Period Adjustment - cont'd

Statement of Financial Position

	2019/20 Original £000	PPA £000	2019/20 Restated £000
Non-current assets			
Intangible assets	4,219		4,219
Property, plant and equipment	230,027	(19,053)	210,974
Investments in associates and joint ventures	35		35
Receivables	15,709		15,709
Total non-current assets	**249,990**	**(19,053)**	**230,937**
Current assets			
Inventories	6,852		6,852
Receivables	47,837		47,837
Non-current assets for sale and assets in disposal groups	617		617
Cash and cash equivalents	24,585		24,585
Total current assets	**79,891**	**0**	**79,891**
Current liabilities			
Trade and other payables	(48,548)		(48,548)
Borrowings	(303,174)		(303,174)
Provisions	(1,163)		(1,163)
Other liabilities	(3,895)		(3,895)
Total current liabilities	**(356,780)**	**0**	**(356,780)**
Total assets less current liabilities	**(26,899)**	**(19,053)**	**(45,952)**
Non-current liabilities			
Borrowings	(49,878)		(49,878)
Provisions	(4,186)		(4,186)
Total non-current liabilities	**(54,064)**	**0**	**(54,064)**
Total assets employed	**(80,963)**	**(19,053)**	**(100,016)**
Financed by			
Public dividend capital	52,390		52,390
Revaluation reserve	16,068	(2,685)	13,383
Income and expenditure reserve	(149,421)	(16,368)	(165,789)
Total taxpayers' equity	**(80,963)**	**(19,053)**	**(100,016)**

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**37,023**	**9,400**	**4,996**	**51,419**
Surplus/(deficit) for the year	0	0	(147,794)	(147,794)
Surplus/(deficit) for the year - PPA			(15,082)	(15,082)
Restated surplus/(deficit) for the year	**0**	**0**	**(162,876)**	**(162,876)**
Transfers by absorption: transfers between reserves	0	6,670	(6,670)	0
Transfers by absorption: transfers between reserves - PPA		1,286	(1,286)	0
Restated Transfers by absorption: transfers between reserves	**0**	**7,956**	**(7,956)**	**0**
Impairments	0	(6,304)	0	(6,304)
Impairments - PPA		(112)	0	(112)
Restated Impairments	**0**	**(6,416)**	**0**	**(6,416)**
Revaluations	0	6,349	0	6,349
Revaluations - PPA		(3,859)		(3,859)
Restated Revaluations	**0**	**2,490**	**0**	**2,490**
Public dividend capital received	**15,367**	**0**	**0**	**15,367**
Other reserve movements	**0**	**(47)**	**47**	**0**
Taxpayers' and others' equity at 31 March 2020	**52,390**	**13,383**	**(165,789)**	**(100,016)**