#1BigTeam

NHS
University Hospitals Plymouth
NHS Trust

Emerging Stronger

Annual Report and Accounts 2020 - 2021

Contents

Welcome

When we wrote the foreword to last year's Annual Report we paid tribute to the skill, dedication and professionalism of our staff who had worked at a remarkable pace to transform our hospital in readiness for the impact of the coronavirus pandemic.

Since then the whole world has risen to the challenge, and although tremendous progress has been made and mass vaccination has given real hope for the future, we remain in the global grip of a pandemic that has caused more than three million deaths and huge damage to the livelihoods of many of our fellow citizens.

Throughout this year, our people have been at the forefront of the national response. They have worked through the various stages of the pandemic with a quiet dedication and selfless professionalism; they have stood alongside patients and families who have faced personal tragedy and loss, and they have shared moments of joy and hope with many who have recovered from the virus. Alongside our partner organisations in the city, the county of Devon and the south west peninsula, they have worked to support our communities and to implement a programme of mass vaccination which has been truly outstanding. You can read more about this in our section 'A community response to COVID-19' on page 15.

Those who have worked in the frontline clinical areas have understandably been the focus of much of the public praise and gratitude. Their work, however, has only been made possible by the many who have done so much to ensure that we have maintained our essential services, working behind the scenes to ensure that our people are supported and our infrastructure maintained – the hospital and the Trust is #1BigTeam. A consultant can only do their work successfully if theatres and wards are kept clean, supplies are ordered and patients are fed. To have witnessed the work of this great team throughout the year has been extraordinary. The people who work in this Trust are amongst the best of us, and we should all be proud and humbled to stand alongside those who have selflessly dedicated themselves to the service of others during this prolonged period of national crisis.

Annual reports are an opportunity to look back, but they also provide a moment for us to look to the future. For our generation there has never has been a more important time to assess the many challenges that lie ahead of us and to envisage how we will work to provide great health and social care for the generations to come. As we emerge from this latest stage of the pandemic our focus will be upon:

Recovering our ability to provide for our elective patients: As a result of the pandemic huge numbers of people are now waiting for treatment and operations. Last year following the first phase of the pandemic we showed that we could recover well and we must once again apply ourselves to this essential task.

Working with our partners to provide seamless and integrated health and social care for the future: Throughout the year we have continued to work with Livewell Southwest and with councils in Devon and Cornwall as well as NHS providers. Our partnership with Livewell will be recast within a new contract this year and the Devon Integrated Care System (ICS) has been recognised as being ready to take on the responsibilities of new health and social care legislation due in 2022.

Planning how we will invest Hospital Improvement Programme funding to build a hospital fit for the future: Our plans are taking shape to invest more than £126m of HIP funding in Plymouth, alongside further investment across the south west peninsula. This provides a once in a lifetime opportunity to create a hospital estate and digital infrastructure which will help transform the way in which we provide health and social care.

Supporting our people: Nothing can be achieved without the continued work of our incredible people. The pandemic, however, has taken its toll. We must redouble our efforts to support our staff as they recover from the rigours of the past year, and we must redouble our efforts to ensure we have an open and caring culture that is the bedrock of safe and compassionate care.

The year 2021/22 has truly been a year like no other and it is right that we take a moment to acknowledge the grief and loss of so many around the world, and to pay tribute to those who have done so much to protect us and the impact this has had on them. But the pandemic has also proved just how much can be achieved when people come together to face a generational challenge and, as a result, we are Emerging Stronger. Our responsibility now is to rise in the same way to meet the challenges and opportunities of the future.

Ann James
Chief Executive

Richard Crompton
Chairman

Our Year in Pictures

April 2020

In order to improve our reach and care for patients during COVID-19, we launch video consultations. Patients are able to see and talk to their consultant from the comfort of their home, using any device, such as a laptop, tablet or mobile phone. This new service is progressively opening to different specialities and clinics. Patients receive a letter from the hospital with their appointment details and instructions on how to join the video call. The letter also includes contact details in case the patient has any questions, technical difficulties or will not be able to make the appointment, so they can get in touch with us.

May 2020

Plymouth researchers thank local patients who have taken part in a clinical trial of the antiviral drug Remdesivir in the treatment of coronavirus. Remdesivir was recently approved by the NHS to treat COVID-19: the first drug to be licensed for this use in the UK .

The trial took place at Derriford Hospital in Plymouth, part of a global study across North America and Europe. It is the altruism of participants that has impacted on clinicians most. John Corcoran, Consultant Chest Physician and Principal Investigator for the study said: "For patients, taking part has allowed them to receive treatment that they wouldn't otherwise have access to, whilst we learn how best to manage the epidemic in the future. Being involved in a research effort like this is hugely positive. For our patients it has been a really beneficial experience as they feel like they're part of something bigger. They are contributing to the successful treatment of people in future who are suffering with Covid-19."

June 2020

Chief Operating Officer Kevin Baber opens our Planned Investigation Unit (PIU) in its new home on Level 5 of Derriford Hospital on Wednesday 10 June. The opening includes a little surprise for Sister Angie Newton.

Some interesting facts about the new PIU:

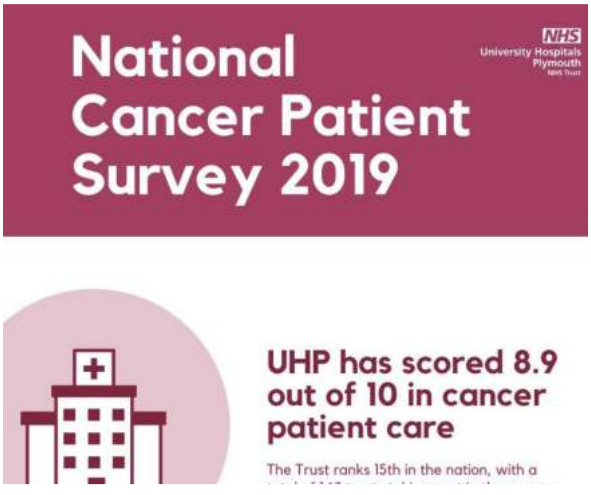
- Staff there will see and treat around 70 patients per week
- There are 8 beds in the unit
- The team care for patients from most specialties across the hospital
- The unit will be instrumental in helping see patients who have had to wait while planned appointments have been on hold during COVID-19.

Watch the video to find out what the surprise was.
https://www.youtube.com/watch?v=ZU68QOBJyd8

"Our colleagues at UHP make up an amazing team. From those willing to participate [in research] we've attracted comments about how having regular testing ensures they feel reassured of their COVID status. Our #1BigTeam always seems to pull out the stops when asked"

July 2020

University Hospitals Plymouth has been scored 8.9 out of 10 by cancer patients, in the National Cancer Patient Experience Survey. The Trust ranks 15th in the nation, with a total of 143 trusts taking part in the survey. The hospital has scored above the expected range in communication with patients and teamwork. This is due largely to the Trust's recent investment in cancer care, including the recruitment of more support workers and healthcare navigators who are there to answer any questions patients might have during their treatment. Sian Dennison, Head of Nursing Cancer, said: "We are delighted with the survey results. It's an honour to be one of the top ranked Trusts in the south west and receive such good feedback from our patients."



August 2020

University Hospitals Plymouth takes part in a country-wide urgent public health study to understand whether healthcare workers who have antibodies to COVID-19 are protected against future infections of the virus. Sarscov2 Immunity and Reinfection Evaluation, or SIREN, aims to recruit 500 members of Trust staff - a number which it is fast approaching after just four weeks. Julie Alderton, Research and Development Team Leader for SIREN has been overwhelmed by the response to the study. She said: "Our colleagues at UHP make up an amazing team. From those willing to participate we've attracted comments about how having regular testing ensures they feel reassured of their COVID status. Our #1BigTeam always seems to pull out the stops when asked and I have every confidence that we will meet the target of 500 members of staff for SIREN."

September 2020

We appoint Kyeiyanne James as our first BAME Network Chair and Rez Rogers as Deputy Chair. They are the first Chairs to be appointed across each of our five networks: BAME; Disability and Wellbeing Network (DAWN); Faith and Beliefs; LGBT+; Women. The networks aim to promote inclusivity in the workplace by encouraging all of our staff members to speak up and giving them safe space to do so.

"I've made history? Well I'm proud of that of course" Dennis Lyne, the first patient in Devon and Cornwall to receive the Pfizer COIVD-19 vaccine.

October 2020

Specialist Sister in the Intensive Care Unit (ICU), Kate Tantam is named on the Queen's Honours list and will receive a British Empire Medal for her services to improve patient experience in response to the COVID-19 pandemic. Kate has been instrumental in the development of a 'secret garden' which, during the acute period of COVID-19, became a dedicated space for patient rehabilitation and staff resilience, providing a sense of normality during a frightening, unfamiliar time. Kate says all of this has been made possible thanks to the amazing multi-disciplinary team she works with. Kate and the ICU Rehab team facilitate recovery by humanising the Critical Care environment. They created the 'Secret Garden' to support rehabilitation in ICU promoting positive mental health for staff, patients and loved ones.

November 2020

We are offering patients and their loved ones an opportunity to record a short video message or take photos of themselves holding a poster to send a message to those who cared for them.

In normal times, families are able to bring in cards or patients return to the ward or department they have been cared for in with their personal messages and thanks. With this currently not possible, we have set up a webform for patients and their families to share a message with those who cared for them, in a different but still very personal way: by photo or video.

These messages have a profound impact on NHS staff and encourage everyone at Derriford and our other sites to keep up their hard work. We would like to hear the stories of patients and their rehabilitation and progress outside the hospital. With the patients' consent, the images will be put up on walls for staff to see and remind themselves of the long term difference their work makes. To send your message visit our 'Saying Thank You' page.

December 2020

"I've made history? Well I'm proud of that of course" … the words of 88-year-old Dennis Lyne, who is the first patient in Devon and Cornwall to receive the Pfizer Covid-19 vaccination, following its clinical approval.

"I feel now that I am not so vulnerable because obviously I was vulnerable before," he added." Of course, everyone is at the moment, but particularly myself because of my age being over 80. Having the vaccine has given me peace of mind. In time I'll be able to go and see my family, it's protecting me, protecting them, the people I mix with."

Staff at Derriford Hospital are able to vaccinate patients after receiving their first delivery of the vaccination. In line with the clear national direction set out by the Joint Committee on Vaccination and Immunisation, the focus is on offering the vaccine to those aged over 80 and those working in care homes first.

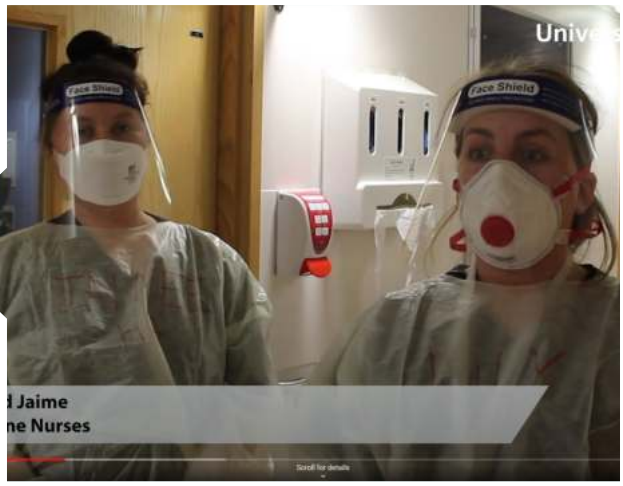
January 2021

In the midst of another COVID surge, we produce a series of videos with patients and staff, called Stories from the COVID Wards. We continue the series with pleas from our staff on Intensive Care, and working in the COVID red and amber wards.

Their message is clear:

- We are getting busier with COVID patients
- COVID affects everyone, young and old
- Please do your bit by staying at home

Watch the staff video here: https://youtu.be/w_ehcEVKCm0



February 2021

Professor Matthew Cramp wins the Excellence in Transplantation Award as part of the 2021 UK Awards for Excellence in Organ and Tissue Donation and Transplantation.

Presented at the British Transplantation Society and NHSBT Organ Donation and Transplantation Joint Congress, held virtually this year, the awards recognise outstanding professionals and volunteers in the field of organ donation and transplantation across the UK.

Professor Cramp, Consultant Hepatologist at University Hospitals Plymouth and Chair in Hepatology at the University of Plymouth, was nominated by a number of his colleagues due to his commitment and dedication in ensuring that patients across the south west receive equitable access to liver transplantation opportunities. This greatly impressed the judges.

March 2021

As part of our work with NHS, council and voluntary sector partners across Plymouth and more widely, we're addressing head-on the questions people have about getting their COVID vaccination. One of those is a concern about future fertility.We work with our Acting Head of Midwifery and Children's Services, Charlotte Wilton, to share a short message explaining how the vaccine works and providing reassurance that there is no evidence it can affect your present or future fertility.

You can watch Charlotte here:
www.youtube.com/watch?v=Mt8rILNYMsM

PROUD!

Our **#TeamClearbook** clap for patient Sue, as she leaves hospital having been cared for with COVID-19. Sue is one of more than 80 patients with confirmed COVID-19 whom we have cared for and discharged. Sue has given us permission to share her story:

"My name is Sue, I fell ill at home on the 11th March and was diagnosed with Covid 19 on 14th March. I had been feeling lethargic and had a reduced appetite for around 5 days prior to falling ill. I was admitted to Derriford Hospital and my stay lasted 4 weeks in total. The care, kindness and compassion I received from doctors to nurses, health care assistants to physios, cleaners to the discharge co ordinators was inspirational. In the face of adversity, troubles and tragedies they made me feel safe and cared for when my loving husband and family were at home isolated and unable to do so. I will forever be indebted to all the hospital staff and I thank them that I left the hospital with my life. A special mention to A and E, Tavy, Tamar, Braunton, Penrose and Clearbrook wards for the care and kindness they gave to me at the most vulnerable time in my life, thank you all!"

Watch the video: **https://youtu.be/maGal4c1dfY**

"I will forever be indebted to all the hospital staff and I thank them that I left the hospital with my life."

About Us

University Hospitals Plymouth NHS Trust is the largest hospital in the peninsula. We deliver a full range of general hospital services to people living in Plymouth, south and west Devon and Cornwall.

We serve a diverse population with a wide variation in health and life expectancy, within which there are pockets of deprivation. For example, in Plymouth the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains significant; life expectancy in the most deprived areas of Plymouth (at 78.4 years) is 4.4 years lower than in some of the least deprived areas (source: The Plymouth Report 2017).

As a specialist hospital, we operate at the heart of the south west peninsula providing specialist hospital services within a wider peninsula population of more than 1.5 million.

We are a teaching hospital in partnership with the University of Plymouth and working with Plymouth Marjon University. As host to the Joint Hospital Group South West (JHG(SW)) in a city with a strong military tradition, we have a tri-service staff of nearly 200 military doctors, nurses and allied health professionals who are fully integrated within the hospital workplace. The Unit marked 25 years in the Trust in 2020.

Our Chief Executive sits on the Plymouth Growth Board, is a board member of the NHS South West Leadership Academy, Regional Chair for Talent Board and is a member of One Plymouth. As such, we are ideally placed to support our local health and social care system as it develops into an Integrated Care System, supporting new investments to ensure people are cared for as close to home as possible and developing new collaborative practices.

We provide services for patients at the following main sites as well as through clinics at other local hospitals and care centres:

Derriford Hospital including The Royal Eye Infirmary (REI)
We offer the widest range of hospital-based services in the peninsula. Services include emergency and major trauma, maternity, paediatrics, a full range of diagnostic, medical and surgical sub-specialties as well as many regional specialist services such as the south west peninsula cardiothoracic services, transplant services including kidneys and stem cells, and specialist neurosurgical services.

Minor Injuries Units
We offer urgent care for minor injuries and illness at the Minor Injury Unit Cumberland Centre as well as at minor injury units in Tavistock and Kingsbridge.

Child Development Centre
Developmental services for young children are provided at the Child Development Centre, Scott Business Park.

The Plymouth Dialysis Unit
Patients needing treatment for renal failure are cared for in state-of-the-art, purpose-built facilities in Estover.

Radiology Academy
The Plymouth Radiology Academy is the only purpose-built Radiology Academy in the world and provides an inspirational environment in which to learn radiology.

During our response to COVID-19, we also provided services at Plymouth Nuffield Hospital, the Peninsula Treatment Centre, Home Park Stadium and Centre for Reproduction and Gynaecology Wales (CRGW) at its Plymouth centre.

Looking forward

In the summer of 2021, we will take on the contract and responsibility for managing beds at the following community hospitals:

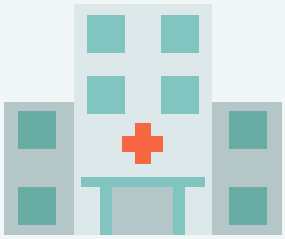
- South Hams Hospital – 15 beds
- Tavistock Hospital – 13 beds
- Local Care Centre at Mount Gould Hospital – 30 beds
- Plus 15 beds for stroke patients

We pride ourselves on leading with excellence and caring with compassion.

Our Values
The values defining how we work:

Putting People First
Taking Ownership
Respecting Others
Being Positive
Listening, Learning and Improving

Our Year in Numbers

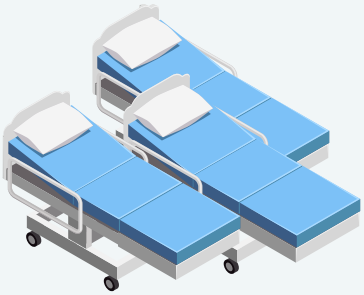


106,000 patients cared for on our wards

550,000 outpatient appts with 237,000 consultations delivered virtually via video or by telephone

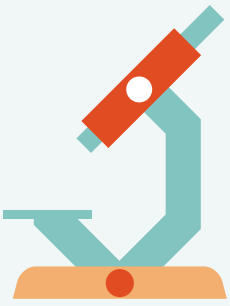
121,000 emergency attendances including to our Emergency Department, Royal Eye Infirmary and Minor Injuries Unit, plus another 5,000 that were streamed to primary care

3,601 babies delivered (registerable births)



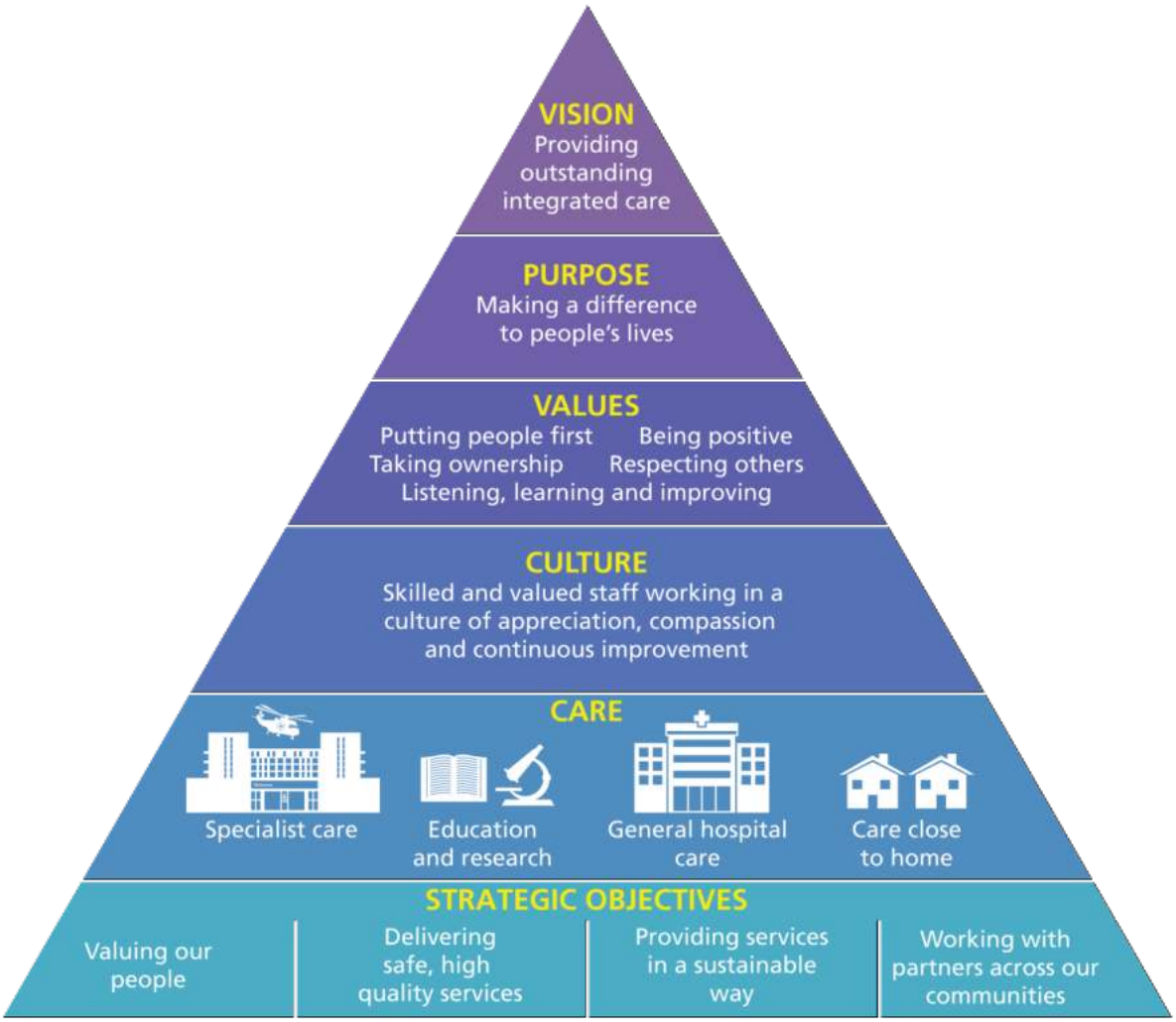
Opened 18 Level 1a Urgent Public Health (COVID-19) trials, ranking 1st of all acute trusts in the south west for recruitment with more than 3,000 participants

Published 475 research papers – an increase of 62 on the previous year



#1BigTeam of 9,194, 75% female, 8.5% from an ethnic minority background, 3.96% who consider they have a disability

The Strategic Context



Our Journey to Integrated Care

During COVID-19, throughout the health and care system we have witnessed the advantages of closer working between providers for the benefit of patients. In Plymouth, South Hams and West Devon, we are cementing this approach with our Integrated Care Partnership (ICP) to improve the care and experience of the people we serve.

We are working together to better support people using our services to get the right care at the right time in the right place.This will particularly support people whose care currently falls across existing organisational boundaries and more intensive users of services who are often frail or vulnerable and have complex needs. Our intention is that services are always evolving, always more effective, always more sustainable.

We are working diligently to formalise the partnership with Livewell Southwest and are looking to formally launch in the summer of 2021. Nonetheless, even without this formality in place, we are already working together very closely and have been since 2019 when we signed a Memorandum

of Understanding setting out a commitment for the two organisations to work in collaboration and support each other.

The use of population health data, i.e. what do the people in our local communities need, and which services will have the most impact on their health, has resulted in the identification of the following areas to be prioritised for integrated pathway design:

1. A single point of access for all healthcare service referrals – 'The Service Hub'
2. An Enhanced Primary Care model, providing specialist support to care homes and multi-disciplinary team input where needed
3. A system-wide approach to caring for people living with Frailty
4. Development and delivery of the Community Mental Health Framework
5. Design and delivery of end-to-end pathways for respiratory, cardiology and stroke services
6. A unified Infection Prevention and Control strategy that is coherent across all services

The integration of the community beds at Mount Gould, Tavistock and South Hams is providing a great platform from which to build working groups that span organisations and think about services in a more joined-up way. We can utilise the wealth of experience across our region to address unnecessary barriers and duplication that often exists at the interfaces between community and acute settings. Working groups for frailty, stroke pathway and cardiology are currently being established, and we look forward to seeking input from staff, patients, relatives and voluntary sector organisations as the design work progresses.

COVID has been the catalyst which has accelerated our approach to joint working. We are already working well as a partnership which has been embodied in the success of our COVID vaccination clinics.

Sue Wilkins, Director of Mass Vaccination and Testing for UHP said: "Bringing together the most amazing team of colleagues from UHP, Livewell, the voluntary sector and ex NHS staff has made it a pleasure to lead on vaccination.

"The opportunity to work with so many people who are all, without exception, committed to ensuring we deliver a vaccination programme at pace to the local population is an absolute highlight of my career. There is no blueprint for doing this and brave decisions have had to be made at times, but I know every decision made is for the right reason. I am absolutely committed to doing everything we can to get vaccination into our local population as quickly as it is available to us."

Shona Cornish, Community Modern Matron for Livewell Southwest added; "I would agree with Sue in that this has been a real career high, I have to admit I was a little apprehensive about the scale of the challenge but everyone involved has pulled together so well to make it work, it's just been an absolute pleasure and I'm so proud of what we've achieved."

Some of our vaccinating team at the DCHW Vaccination Hub.

Our local Sustainability and Transformation Partnerships (STPs)

We are closely aligned to the STPs of both Devon and Cornwall, recognising that we serve communities from both counties.

The Devon Sustainability and Transformation Partnership (STP) – One Devon worked successfully during the year to achieve designation as an Integrated Care System (ICS).

The new ICS in Devon sees the three local authorities, NHS Devon CCG, NHS trusts, general practice, community services, mental health services, and the voluntary and community sector working together to improve the health of all residents, better support people living with multiple and long term conditions, prevent illness, tackle variation in care and deliver joined up services while getting maximum impact for every pound spent.

The One Devon vision is: "Equal chances for everyone in Devon to lead long, happy and healthy lives" and its route to achieving this is being set out in the Devon Long Term Plan.
Partnership working under the STP has been at the heart of the Devon-wide response to COVID-19 and to the successful delivery of the vaccination programme.

To support the thousands of staff who work across the STP, a Devon Health and Wellbeing Hub was set up as one of 40 across the country, to provide guidance and support to colleagues who have been under tremendous pressure since the beginning of the pandemic.

The Devon STP did work during the year to understand and improve the experience of care of our non-white ethnic minority communities, taking account of the stark inequalities nationally among different ethnic groups. This has been highlighted by the COVID-19 pandemic.

One Devon partners worked with Devon and Cornwall Police to help ensure that those without access to the internet got vital information about COVID-19 and how to get help. A special Devon Together newsletter providing this information was delivered to 300,000 homes, mostly in rural and isolated communities.

A community response to COVID-19

This has been a challenging year for our staff, our patients and their families as further COVID-19 surges have put more pressure on the local health and care system and our on wards and services at Derriford Hospital.

Our staff stepped up to the ask of them magnificently and in 2020/21 we cared for 1,173 patients with COVID and discharged 950 of those. Our staff have been dedicated and innovative in the response. We have moved services, for example our Minor Injuries Unit moved to the Plymouth Nuffield, our Phlebotomy Services moved to Manadon Sports Club and latterly the Future Inn and we have worked closely with our colleagues in the private health sector to make the best possible use of all local clinical

Our military colleagues have been by our side throughout the pandemic.

capacity.

It truly has been a #1BigTeam effort, not just with our staff but across our community. We have supported care homes with testing and infection control advice, worked with our colleagues in the community and Plymouth City Council, for example, on a joined-up response to rolling out COVID vaccination as quickly as possible. We have worked with Plymouth City Council and Devon CCG to provide dedicated Question and Answer sessions both for Plymouth residents and for churches with high ethnic minority congregations, such as the The Overcomers Christian Fellowship International in Plymouth. This was well received and, from feedback received, positively influenced attendees at both events to choose to get vaccinated.

We involved our community in making sure the vaccination process was as easy as possible for people with visible and hidden disabilities, including autism, learning disabilities, and dementia. We made a video with trainee nurse Hannah Graham, who is autistic, explaining the fast-track process.

Watch the fast-track process video here: **www.youtube.com/watch?v=WMzueWBTwro**

Our two large vaccination clinics, at Home Park and Derriford Centre for Health and Wellbeing, could not have successfully vaccinated the thousands upon thousands of people they have without the support of teams of volunteers. We are truly grateful to them.

We are proud that our Derriford Centre for Health and Wellbeing vaccination clinic has featured as one of the top five for best practice among Trusts nationally.

We have continued to be overwhelmed by the love and support shown to our staff and patients by our local communities. As a small but important example, schoolchildren from Burraton School in Saltash, Cornwall wrote letters to our staff thanking them for their work – and our staff were so moved, they wrote personal and beautiful letters back to the individual schoolchildren.

Partners with the military in responding to the pandemic

Throughout the pandemic military clinicians embedded within the Trust worked side-by-side with their civilian colleagues across a wide range of clinical areas including the COVID red wards, clinical imaging, operating theatres, Intensive Care Unit (ICU) and Emergency Department (ED). They assisted in creating and staffing additional ICU capacity, delivered training and played key roles in the Trust's planning for the pandemic response.

Many military nurses were moved into COVID wards to increase staffing levels, working continuously in red PPE. During the third wave the Emergency Department requested assistance with staffing their COVID emergency area and military staff were seconded to this area for a focused six week period, delivering a successful model to optimise patient care.

During this time they were further supplemented by support from 29 Commando, Royal Artillery based

at The Citadel in Plymouth. This Unit provided 14 soldiers and marines to assist in ED, ICU, Crownhill and Braunton Ward. They carried out additional nursing duties allowing qualified staff the time to deliver direct patient care. Working regularly in full red PPE, their roles included portering, reception and duties to improve patient flow along with assisting in the buddy-buddy system. 29 Commando personnel made and delivered beverages and meals to patients and, most importantly, took the time to speak with them. Many of these individuals had been shielding since the first lockdown and this was their first contact outside their homes so all the more valued as an opportunity. The soldiers and marines had never worked in a clinical environment before but remained enthusiastic and motivated throughout their time in the hospital. No ask was too big and several nurses commented they 'could not have got through their shift without them'.

All military clinicians remain on standby to deploy at short notice; the pandemic has not changed this with a number of personnel deploying throughout 2020 to a variety of locations around the world both in support of the UK Government's Covid support to Overseas Territories and on military operations. Due to the nature of military placements, many clinicians in Plymouth are not co-located with their families and have not seen their own loved ones for more than a year. Despite this they have remained dedicated to their NHS teams and to delivering the highest standards of care to patients within Plymouth. Joint Hospital Group (South West) looks forward to being able to, belatedly, celebrate its Silver Anniversary within the Trust when lockdown restrictions are lifted.

Surg Cdr Jo Keogh OBE RN
Commanding Officer
Joint Hospital Group (South West)

Building for the Future

Our Future Hospital Plans: A new Urgent and Emergency Care Centre

Selected as one of 40 hospitals to benefit from the government's Health Infrastructure Plan (HIP2) funding as part of the New Hospital Programme, we have exciting plans to develop Derriford Hospital. This phased development programme will start with building a new Urgent and Emergency Care Centre, at the top of the Derriford Hospital site.

We have been shortlisted alongside four other Trusts within Devon & Cornwall to develop our business case for investment into our estate. In phase one, our focus will be on delivering improved provision for urgent and emergency care.

The New Hospital programmes in Plymouth, North Devon and Torbay will form an integral part of Devon's Long Term Plan. As part of this, we are working together across the county's health system and more widely to ensure these exciting building schemes benefit patients from Devon and Cornwall. Our clinically-driven design has been informed over several years by best practice and through listening to the views of our patients and staff.

We shared our plans with key partners in health and social care, voluntary sector organisations and the public in spring 2021. Due to COVID-19, we were unable to hold meetings, so instead we shared our plans digitally and invited feedback online. At the time of writing, we are collating and analysing nearly 100 comments and pieces of feedback, which will be used to inform our development plans.

Video link: **https://www.youtube.com/watch?v=zcYYO35cZOI**

Plymouth Lighthouse Laboratory

In early spring 2021, we opened our new Covid-19 Lighthouse Laboratory - converting a former engineering warehouse into a high-tech lab. The Lighthouse Laboratory Plymouth is a purpose-fitted 6,000m2 facility on Plymbridge Road.

Plymouth was chosen as a prime location by the Department of Health and Social Care, following a successful site visit led by the Plymouth Health Innovation Alliance, a cross-sector partnership which includes the Trust, the University of Plymouth and Plymouth City Council.

The Plymouth site joins a national network of testing labs and is performing PCR tests (polymerase chain reaction) on COVID-19 swabs from across the UK. Testing remains a vital part of our national response to COVID-19 and our staff will be at the forefront of those efforts. As a city-wide partnership, we identified early on that Plymouth possessed the specialist skills and expertise to host a high-throughput laboratory.

Bringing this facility to the city is a real achievement, as in the longer term it will leave a legacy as we look to realise our molecular ambitions.

Read more about the Lighthouse Laboratory here and watch the video:
https://www.plymouthhospitals.nhs.uk/latest-news/covid-testing-lab-opens-in-plymouth-4655

Unprecedented investment

By the end of March, the Trust had delivered a capital programme that exceeded £47.8 million plus an additional £26.3 million converting and fitting out the Lighthouse Laboratory. This investment compares with total spend of £26.7m in 2019/20 and £19 million in 2018/19. This unprecedented level of expenditure has delivered two new MRI scanners, a CT scanner, supported the roll-out of electronic prescribing, the start of electronic observations and theatre information developments, investment in the resilience of our electricity, heating and ventilation systems, new windows, the conversion of Ocean Suite into a ward, the rapid acquisition of medical and IT equipment to support the Trust's COVID response and much more.

PROUD

Specialist Senior Sister in the Intensive Care Rehabilitation Team, Kate Tantam, has shared stories of the kindness she's experienced during the COVID-19 outbreak. Kate explains that staff at UHP have been pulling together to make remarkable things happen. Teams from across the Trust and external contractors have worked tirelessly to put together a new Intensive Care Unit (ICU) and continue to support the team in many different ways to support patient care.

"We've been really lucky we've had lots of people volunteer to come and help us in intensive care and we've had lots of people who have been redeployed to help us," she said.

Kate also expressed her thanks to members of the community for their kind gestures and donations. With the support of kind members of the public, the ICU team have started a 'knitted heart' scheme. Local people have been making crocheted hearts for patients in ICU so one heart can stay with the patient and another is sent to the family. The team are sending the knitted hearts to the families along with a photo of their loved one holding their own version to give them a sense of connection. "The morale lifting gestures have just been beautiful, remarkable, humbling and just so kind," said Kate. "So thank you to everyone who has donated."

The response we have had from our local and national community, in support of us and our work has been absolutely heart-warming. Thank you from everyone at #1BigTeam.

Our Activity

NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Elective spells	62,321	62,774	62,877	59,446	66,756	70,192	53,126
Emergency + non elective spells*	53,152	54,623	56,752	58,726	70,911	58,488	53,521
Outpatient attendances	485,423	487,435	492,968	~~485,812*~~ 528,207	~~493,994*~~ 554,130	~~518,376*~~ 573,582	550,178
Emergency Department attendances	92,780	94,560	97,126	100,319	106,223	98,786	92,500
Babies delivered	4,555	4,570	4,180	4,166	3,848	3,874	3,601

*Numbers struck out are historical outpatient numbers which did not include telephone appointments. We started recording telephone appointments as outpatient activity in 2017/18 but they were not included in outpatient contracting as activity until 2020/21. The historical outpatient numbers dating back to 2017/18 have therefore been updated to include telephone appointments to enable a fair comparison across years.

Social media snippet

Our Performance

	Standard Required	What did University Hospitals Plymouth achieve?
Infection Control		
Hospital apportioned MRSA bacteraemia	0	0
Hospital onset healthcare associated Clostridium difficile	N/A	40
Referral to treatment times		
Incomplete pathways: Total number of pathways		33,407
Incomplete pathways: % waiting less than 18 weeks	92%	64.7%
52 week waits	0	2,553
Emergency Department		
We are part of a national pilot and not reporting against the 4 hour standard		
Cancer urgent referral to first outpatient appointment waiting times:		
All cancer two week wait	93%	89.1%
Two week wait for symptomatic breast patients (cancer not initially suspected)	93%	56.7%
Cancer diagnosis to treatment waiting times:		
31 day (diagnosis to treatment) wait for first treatment: all cancers	96%	97.3%
31 day wait for second or subsequent treatment: surgery	94%	89.9%
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	99.8%
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	94.6%
Cancer urgent referral to treatment waiting times:		
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%	75.8%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	89.1%
62 day consultant upgrade wait for first treatment: all cancers	85%	72.1%
Diagnostic waits:		
% of patients waiting 6+ weeks for a diagnostic test	<1%	11.5%
Cancelled operations		
Cancelled operations by the hospital for non-clinical reasons on the day or after admission (as a % of total elective activity)	N/A	894 (1.7%)
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	0	23.3%
Other key standards		
% stroke patients spending 90% of their stay on ASU	80%	69.2%
Clinically unjustified mixed sex accommodation breaches	0	0
% patients receiving appropriate VTE risk assessment	95%	96.5%

Social media snippet

Our Performance explained: challenges and recovery

We faced a unique and complex challenge with the COVID pandemic requiring significant transformation of services in order to provide the best care for patients admitted with COVID whilst maintaining a safe service for patients who still required hospital care during this period. The transformation required within the Trust was wide ranging with key challenges including the rapid redesignation of existing wards to COVID-only areas which restricted capacity for key specialties previously located in these spaces. To maximise COVID safety we incorporated enhanced infection control measures which reduced patient throughput and productivity in key areas whilst simultaneously dealing with increased staff sickness due to COVID and self-isolation which further affected our ability to deliver activity. These are just a few of the examples of the many challenges which the pandemic has provided with regards to maintaining activity levels and associated waiting time performance.

Whilst referrals into the Trust were reduced during the first half of 20/21, they recovered to normal levels by the end of the year and in some cases (e.g. 2 week waits for patients with suspected Breast Cancer) referral volumes overshot previously recorded levels, creating demand and capacity gaps with associated challenges around waiting times for patients.

Despite these challenges, our teams reacted proactively and with innovative and well supported schemes to safely maximise activity including the use of telephone and virtual outpatient appointments and constant improvement in the efficiency of infection control and cleaning protocols, resulting in quicker turnaround times between patients.

As part of the recovery process, the Trust entered into a partnership with our local independent sector organisations who directed their resources towards treating NHS patients, helping to maintain treatment for patients within the area. For context, in Quarter 3 (July-September), we undertook approximately 3,200 diagnostic scans/scopes, 1,000 inpatient/daycase procedures and 1,700 outpatient appointments via our local independent sector partners.

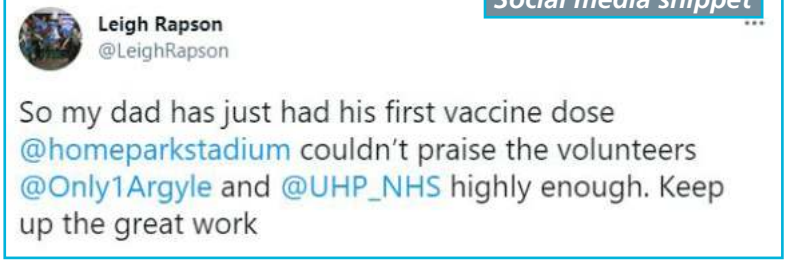
With the number of COVID inpatients reduced to less than five by the end of March 2021, the staff who were redeployed to COVID-only areas are being returned to their original departments facilitating an increase in activity in these areas. This includes theatres where the return of staff is part of a phased reopening of both on and off-site theatre capacity to restore surgical activity moving forward together with a restoration of bed capacity for recovery. We are seeking to maintain our use of telephone and video technology to sustain the increased levels of outpatient activity and contribute towards addressing the waiting lists which have built during the period of the pandemic.

Our CQC Inspection

We were the subject of an unannounced CQC inspection on Monday 8 March 2021 where inspectors visited two areas of Derriford Hospital: Diagnostic Imaging and the Emergency Department.

We received a mix of positive praise and some concerns as early feedback from the inspection team. We took immediate action to address the concerns raised and are working closely with the CQC to provide them with further information, as they require. The immediate improvement actions build on our work to improve flow for patients right across the hospital, from when they first arrive in our Emergency Department to the moment they are discharged. We have paid particular focus to processes and space

Social media snippet



within the Emergency Department, as well as onward flow. We are expecting the full report from this inspection visit to be published in May 2021.

Quality

Quality Priorities

Despite COVID-19, progress has still been achieved against the quality priorities agreed for delivery in 2020/21 resulting in a number of improvements made to services for our patients. In March 2020, three quality priorities were identified for focused attention throughout 2020/21. The proposed priorities were identified following a consultation exercise which commenced in January 2020 and involved staff, patients, members of the public, Healthwatch, Devon CCG and our Patient Council. Quality Priorities 2020/21 are described below:

Priority 1: Value our People
Improve patient and staff experience by maintaining safe staffing, ensuring our ward and departments have the correct levels of staff with the appropriate skills

Priority 2: Deliver safe, high quality services
Reduce the incidence of harm to patients in key areas such as falls, pressure ulcers, hospital acquired infections and securing a 'Good' CQC assessment

Priority 3: Provide services in a sustainable way
Improve the way our services are provided to ensure patients spend less time in beds and theatres / diagnostic equipment is used efficiently

Further detail in relation to progress against our quality priorities will be detailed in the Quality Account which will be published later this year.

In March 2020, the Trust received notification from NHSE/I that in order to free up capacity to manage the response to the COVID-19 pandemic, a number of processes would be stopped or deferred, this included publication of the Quality Account. Further information was received from NHSE/I on 5 May stating that while primary legislation still required providers to produce a Quality Account, there was no fixed deadline for publication and no requirement to obtain an independent audit opinion. A revised date of 31 January 2021 was agreed at the November Trust Board meeting. In previous years the Quality Account would form an integrated part of the Annual Report however publication timeframes did not align this year and it was therefore published as a separate document.

Clinical Audit

In March 2020, NHS England & NHS Improvement wrote to all Trusts to advise that all national clinical audit and confidential enquiries mandatory data collection were suspended. Audit providers were permitted to stay open to monitor long term condition but Trusts were not obligated to return data. A further letter received on the 26th January 2021 relating to clinical audit stated that audits will remain open but audit data collections is not mandatory at present.

The Trust has completed the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoping exercise and will be participating in all studies for 2021/22. A further review in to the National Clinical Audit Patient Outcome Programme (NCAPOP) priority audits for 2021/22 is in progress.

Always looking to improve

Our Director for Improvement, Richard Best, updates on a year in which improvement has flourished:

For improvers across the country/world it has been a challenging and important time. The fact that during this time our level of support to teams has increased and teams' delivery of improvement has increased is a testament to the principles behind People First and the feel of UHP as #1Bigteam.

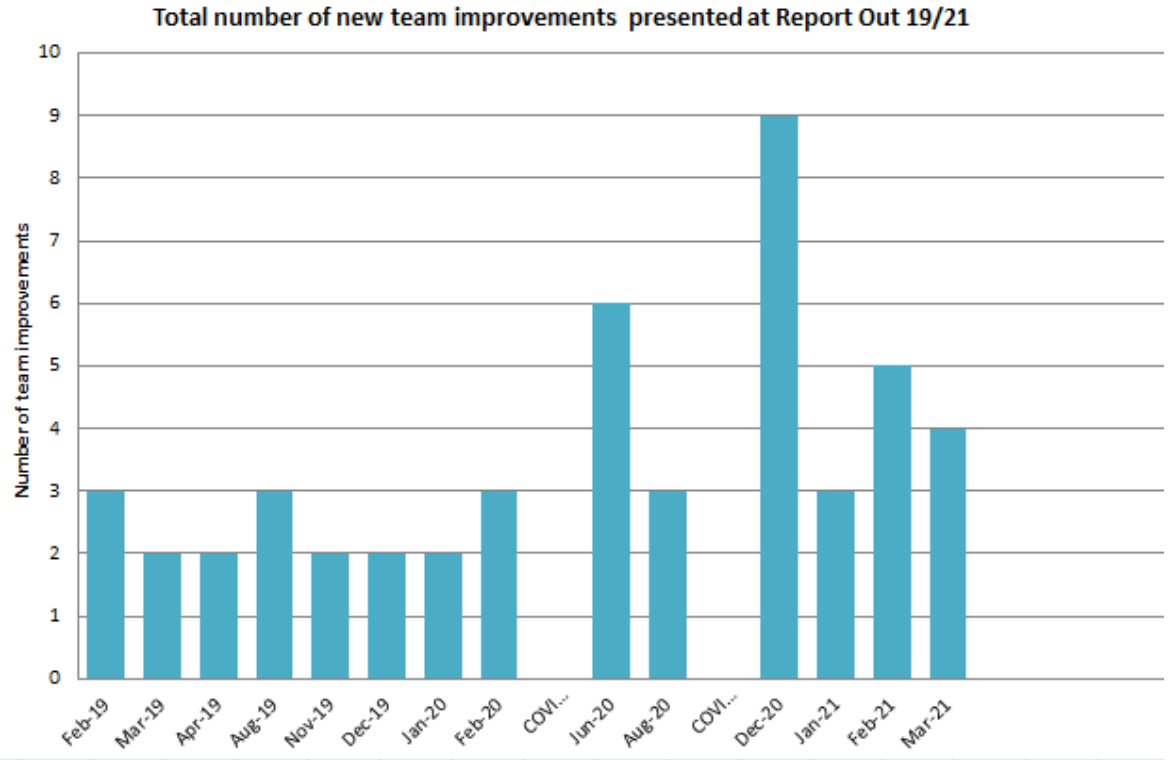


Fig 1: the number of team improvements shared at our 'Report Outs'

The spread of this work has also been amazing in the last year, including important impactful flow issues such as: early discharge, discharge lounge usage, digital ward multi disciplinary team meetings, stroke length of stay reduction, improvement in productivity in all types of imaging, reducing delays to theatre recovery, early surgical discharge times, reducing rewash in the Sterilisation and Disinfection Unit, eliminating raw material supply issues, reducing pharmacy production unit wastage, improving 'To Take Away' medicines process; increase safety compliance with MRI checklist, creation oversight 'big walls' on key topics like pharmacy/outpatients/flow ; improving sarcoma multi disciplinary team and cancer data.

So what are the supporting principles?

- Create the management environment for improvement to succeed.
  At the start of COVID, we paused our weekly 'Exec wall' practice (which provides the top tier golden thread which runs from Board to ward), In spite of this two care groups have continued to flourish with their improvement walls, keeping focus, support and pace and also developing their practice.

- Enable teams to have the skills to work on topics aligned to 'golden thread' and make evidence-based improvement. The reality is that the Quality Academy team only assist, coach and support; it's the amazing ideas of our frontline staff that is the 'engine room'. During the year although we have focussed support to flow and the Emergency Department, many people have had bespoke personal training in kata and practice coach with certifications happening monthly now at Report Out, each representing a minimum 10% change.

- Respect for staff: enabling staff to feel that they are involved, their voice is listened to and it is a safe place to have open conversations. We have improved the format of huddles during the year, revisiting a few to make sure the balance of delivery and team engagement is maintained. We have also introduced a 'Team Health' routine to some huddles. This is where teams monitor their own values and have an opportunity to have open conversations about 'how it is'. The first eight areas have gone remarkably well and it has prompted interest nationally from other Vital Signs sites, Shelford Group and Virginia Mason trusts.

- Look at value for patients from end to end. It has been great to see key whole pathway work continue on stroke with amazing reductions to length of stay through good team work and increase in therapy weekend presence.

A highlight example for the year, Imaging:

It is very hard to pick out one area as lots of teams are doing amazing work. But an example of some key aspects can be seen in the Imaging Department. They were very early adopters of daily production control, bringing all modalities together in short sharp discussion on daily action and plans. They run a weekly improvement huddle (virtual) which brings together the work across all teams (from their team huddles) to make things better. They have invested time in team huddles, practice coaches and kata - scientific Plan Do Study Act coaching. The kata approach was used to run a virtual improvement week during wave 1 of COVID with great effect at a time when we needed inpatient flow to improve. They have also added to practice with their own 'brag tags', shout outs to great things each week. With new management in place this has also reinforced the good principles laid down and it was great to receive a really positive response from the CQC around culture and learning. Well done Team Imaging.

Social media snippet

Social media snippet

PROUD

In the face of COVID-19, former and retired NHS employees were asked to return to work to support their local teams through unprecedented times.
At University Hospitals Plymouth we were fortunate enough to have had more than 100 former and retired colleagues sign up to help fight against COVID-19 and provide the best possible care for our patients.

Among the inspiring colleagues who returned to the NHS is Bridie Kent who returned via the NHSP National Rapid Response Program. Bridie had spent the last seven years in her position as Professor of Nursing at the University of Plymouth and recalls the last time she did shift work as an Intensive Care Unit (ICU) Senior Sister some 15 years ago. Bridie returned as Professor of Nursing at UHP and worked as a registered nurse in ICU.

"The training was brilliant," said Bridie. "Things just start flooding back and so much more has been standardised which makes things a lot easier. The programme put together by the Clinical Education Team was fantastic. The whole team have been amazing and Specialist Sister in ICU, Kate Tantam has been a driving force and a real source of encouragement for me personally."

Bridie described returning as coming back to the 'family' she knows through her work with the Plymouth Clinical School. Explaning why she returned to the NHS during a global pandemic, Bridie said: "I couldn't sit at home when my knowledge and skills could help others and support existing teams."

Our Patients' Experience

Understanding the experiences of our patients and those that matter to them is vital; it is one of the ways we assure and improve the quality of our services. We aim to be a safe and effective Trust highly rated by our patients and one in which staff are happy to work. In working towards this, we seek to continually improve our services, shaped by what our patients tell us, and be quick to respond to problems and people's concerns.

Patient Feedback

We hear from our patients through:

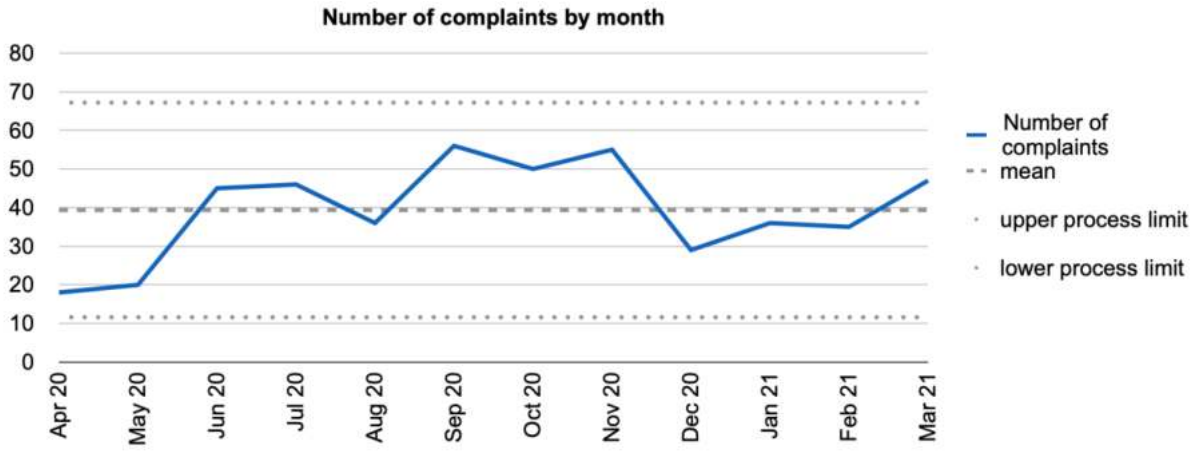
- Friends and Family Test
- Trust surveys
- CQC National surveys
- Engagement events, including the valued work of our Patient Council
- Complaints
- Compliments and concerns given to our Patient Advice and Liaison Service (PALS)
- Social media and online feedback (including Care Opinion)

The Trust has maintained strong links with Healthwatch, covering both Devon and Cornwall. Members of Healthwatch sit on our Patient Experience Committee and report on the community's feedback about our services.

We continued to hear from patients and families during the pandemic, although sadly, we had to stop some engagement activities, such as listening events, at the hospital. As a result, we interviewed patients (by telephone and Zoom) after discharge from the hospital to ask them about their experiences.

Complaints

From April 2020 to March 2021, 473 patients and relatives made formal complaints to the Trust, a 36% decrease from the previous year.



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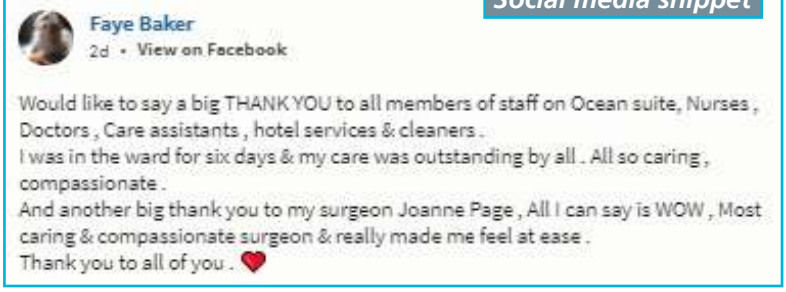
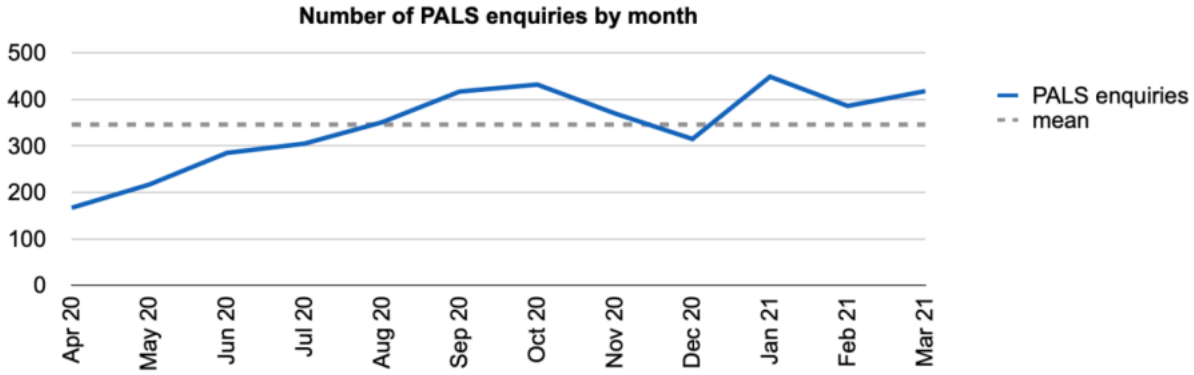


4,151 patients and relatives made enquiries to our PALS during 2020/2021. This number is a 25% decrease from the previous year; fewer contacts correspond with the start of the pandemic.



A key measure of quality concerning how we manage our complaints is the number that we reopen because the person in receipt of the response says that we have not answered their concerns. Between April 2020 and March 2021, the Trust reopened three complaints (0.6% of total closed complaints) at patients and families' request. This is a reduction from 22 reopened cases the year before.

Despite approval from NHSE to put the complaints process on hold during the initial wave of the pandemic, we maintained the formal complaints process and the Patient Advice & Liaison Service.

While we could not conduct any classroom complaints training, we have continued to provide virtual sessions for staff. We have also maintained our link with a relative who made a complaint about UHP services, who has helped us recruit to the complaints team.

Complainants continue to have the right to refer any complaint they feel we have not resolved adequately to the Parliamentary and Health Service Ombudsman (PHSO). From April 2020 to March 2021, the PHSO initiated two investigations. Of those two investigations, the PHSO decided not to investigate one case, and the second case is ongoing.

Remote consultations

During this time, 2,463 patients completed a survey to tell us about their experience of telephone and video consultations.

92.7% of respondents rated their experience of telephone and/or video appointments as good or very good. Patients described the benefits of this type of consultation, including avoiding travel (saving time and costs), not finding and paying for parking, less waiting in clinics, not having to take time off work, arranging childcare, and other practical considerations. Some respondents talked about the comfort of seeing their practitioner from the comfort of their own home. People highlighted safety concerns and were grateful they did not have to attend the hospital and still have their appointment. Others

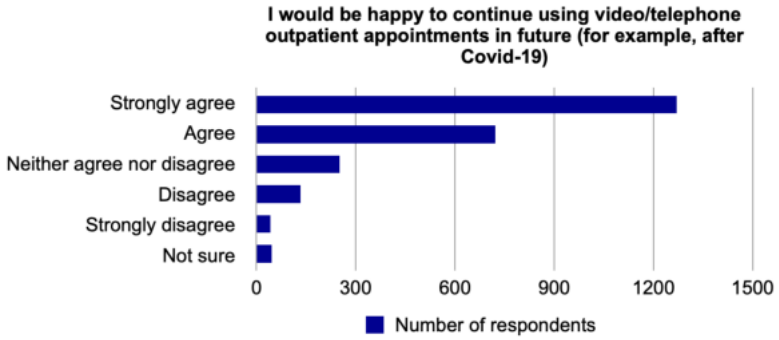
mentioned the environmental benefits and reduced carbon footprint from not having to travel to the hospital.

“In the times we are in with the virus, I did not have to go anywhere and achieved the same results.”

“Trips to Derriford are very stressful - parking a nightmare - taking time off work etc. This was ridiculously simple and much preferred it.”

“The video helped my hard of hearing partner to hear the consultant and be able support me better.”

The circumstances in which patients see the limitations of remote appointments include physical/visual examination or treatment. Patients also said they would not want a remote consultation in severe illness or cancer or where sensitive news is delivered and in circumstances where they were emotionally vulnerable and had concerns. Not having a confidential space in which they felt they could speak openly was another barrier to the use of remote appointments, identified by patients, as was having the right technology.



Most respondents are happy to continue to use this technology to see their clinician.

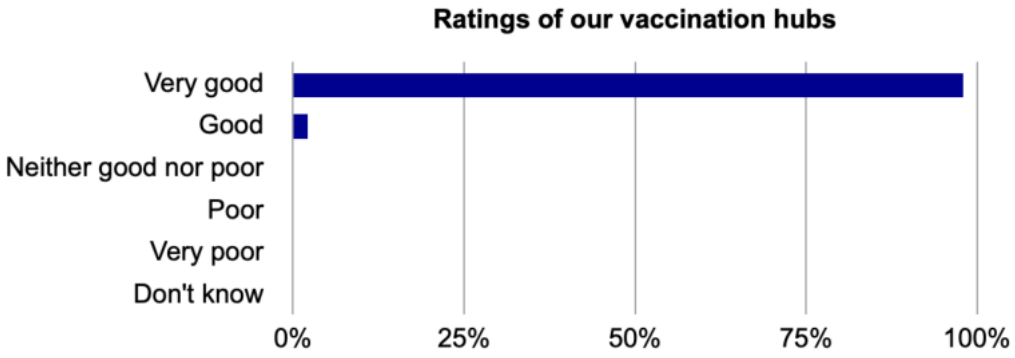
Confidence in the use of technology is an issue for a group of patients. This feedback informs the Trust’s Digital Inclusion Group, which aims to improve access to resources for people in digital poverty and improve patients’ skills and confidence to use technology to access healthcare. We cannot do this alone and have focused on building links with the Plymouth Digital Inclusion Network, primary care services, and community organisations like Complex Lives Plymouth. The Trust has recruited digital support volunteers to work with Digital Health Devon, who support the community with digital access.

Vaccination

Our vaccination hubs at Derriford Hospital and Home Park opened in December 2020 and January 2021 respectively, and have since provided vaccines to thousands of people. The feedback we get about this service is overwhelmingly positive. In March, 3,091 people gave us feedback on this service, and 98% rated it as very good.

Social feedback

Lauren Quilliam To the nurse who sat with my granddad and held his hand tidy while he passed away, thankyou, thankyou for choosing to do what you do, thankyou for being the one that was there, to watch him and to guide him to his peace. Thankyou forever #sharpward @UHP_NHS @NHSP_Plymouth



Comments made about the vaccination hubs during March (n=2,571)

Carers

We have committed to the Devon STP seven principle commitments to carers:

1. Identifying carers and support them
2. Effective support for carers
3. Enabling carers to make informed choices re their caring role
4. Staff awareness
5. Information-sharing
6. Respecting carers as expert partners in care
7. Carers whose roles are changing or who are more vulnerable

We are working hard with carers' leads across the region and developing a peninsula-wide carer's passport, which will be available for all carers to sign up to in Devon and Cornwall. This carer's passport will recognise carers and their vital contribution to our community; the key benefits will include:

- Discounts for carers at a wide range of local businesses
- Identify carers through the promotion of the Carer's Passport
- Provide carers with up to date information on their rights, available support and carers assessments
- Connect carers to workshops, training, peer support, social activities, and involvement and co-production opportunities
- Review and explore opportunities to improve training on offer for carers

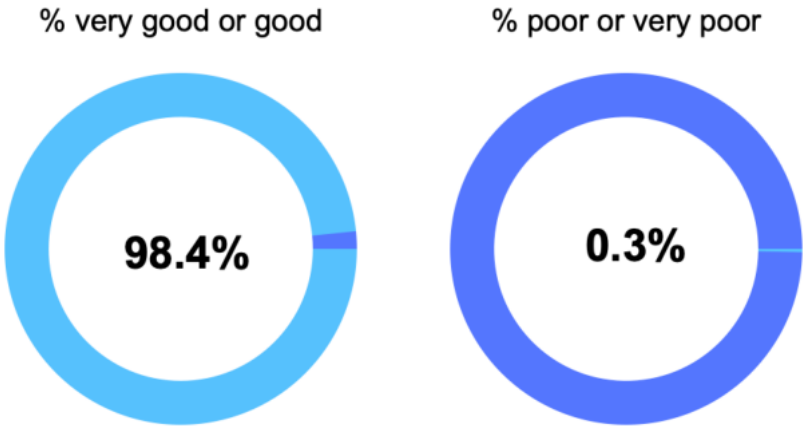
The carers ward accreditation framework has been developed to better identify and support carers of all ages. This framework has a set of five quality markers to assess the ward setting as:

1. How carers are identified and referred for assessment
2. How carers are holistically supported for health and wellbeing needs
3. How to understand and respond to the needs of carers
4. How carers are communicated with, involved and informed
5. How a carer-friendly culture is promoted

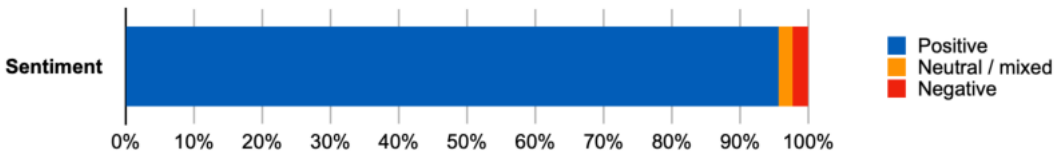
The Clinical Decision Unit (CDU) is piloting this accreditation scheme. The ward is now working towards how they identify carers and how they meet each of the five quality markers described above. The ward has been allocated a Carers Support Coordinator from Improving Lives Plymouth, who is working with them to provide evidence against each of the quality markers. If this project is successful, we will roll it out to other wards across the Trust.

FFT and sentiment analysis
We value all feedback from patients and their families. We are committed to identifying where patients have told us that we did particularly well, where we exceeded their expectations, and where staff went the extra mile. Staff appreciate this feedback, and it helps us identify areas of good practice, learning from what has gone well. Where a service has innovated, implemented successful projects, or ways of working that improves care for patients, we share these with other services, so we are continuously learning and improving.

FFT Scores for 2020-21 (n=25,319 surveys)



Sentiment analysis of over 12,000 comments made by patients this year shows these to be overwhelmingly positive:



Improvements in response to feedback

Medical Examiner Service

On 1 April 2020, the Trust implemented the Medical Examiner Service (ME Service). The purpose of this new role was to provide greater safeguards to the public by ensuring proper scrutiny of all non-coronial deaths and to ensure the appropriate direction of deaths to the coroner. The ME Service has helped improve the Trust's process for bereaved families with the opportunity to raise concerns to an independent doctor not directly involved in the care of their loved one. This is also helping to improve the death certification process.

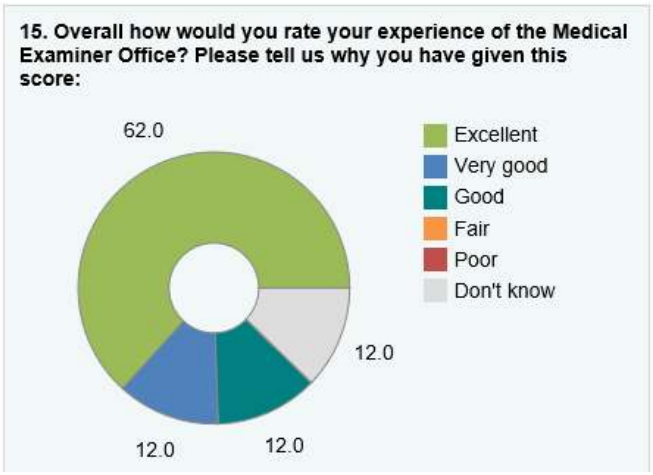
For the period April 2020 to March 2021, the ME Service scrutinised 1,425 hospital deaths. Support is available during working hours, Monday to Friday, for bereaved families to help them through the bereavement process and to support certifying doctors to provide accurate and timely certification.

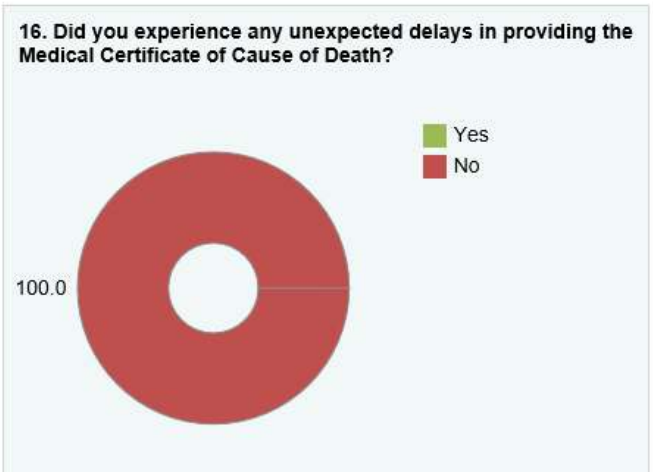
The service holds a comprehensive dataset for each death to examine themes and trends that emerge. The team works closely with the Patient Advice and Liaison Service and Complaints team to support families with any concerns raised.

Since the introduction of the ME Service, performance against the five-day target for the interval between the date of death and release of certificates to the Registry Office has significantly improved. The average for this is now three days.

During the year, the ME Service has introduced a bereavement pack that ward staff hand out to families at the time of death. This pack includes an updated bereavement booklet, a bereavement card signed by the Chief Executive, and an End of Life survey that helps us improve End of Life care. Feedback about the bereavement pack has been overwhelmingly positive from both bereaved relatives and staff.

The following data shows the overall experiences and feedback of relatives using the ME Service.





"Although we didn't have concerns about the care, we are really grateful to have spoken with the Medical Examiner who gave us some reassurance"

"Thank you for everything you have done for my family, this has been so smooth and easy for us"

"It's been really nice not to have to attend the hospital to collect the certificate, thank you"

"Although we didn't have concerns about the care, we are really grateful to have spoken with the Medical Examiner who gave us some reassurance"

"I can't thank you enough, you have been so helpful"

"Explained the next steps in full detail. Very compassionate"

Volunteering

Pre-COVID, the Trust had approximately 550 volunteers who regularly gave up their time volunteering at the Trust. In March 2020, all on-site volunteering roles were suspended, except for roles where people volunteered remotely, including:

- the hospital radio, broadcasting from home
- our Patient Council volunteers who continued to meet virtually utilising Microsoft Teams
- our FFT data input volunteers who volunteered at home

In Phase 1 of our stepping up of the volunteer programme, we introduced face mask volunteers, who distributed masks to staff and visitors as they arrive at the main entrances to the hospital. This role also evolved to help support the patient property drop-offs and collections during visiting restrictions.

Phase 2 has focused on roles that support the areas of greatest pressure in the hospital. These roles align with NHS England and NHS Improvement volunteer role profiles developed in response to COVID-19. We introduced volunteers to our Discharge Lounge and vaccination hubs at Derriford and Home Park. These volunteering roles have been fundamental to the extraordinary work being done, and the feedback from staff and patients has been overwhelmingly positive.

Kellyann Whalley, Ward Sister for the Discharge Lounge, said:

"Yesterday we were short of staff and although we weren't crazy busy like we normally are we had some complex patients to manage.

One patient in particular was muddled and so needed a lot of our time. Pauline was with us and she was an amazing support. She kept on top of cleaning our chairs, offering hot drinks and occasionally was able to settle the muddled patient we had. But, what stood out the most was her offering more of her time to us to support us for longer. This was amazing and truly went above and beyond her role.

The volunteers have been an absolute godsend and have been making a real difference to staff and most importantly the patients. Thank you, thank you, thank you!"

Some of the feedback from our social media channels can be seen below:

In January 2021, supported by the Trust's charity, we introduced our volunteer uniform, intending to:

- make our volunteers more visible to patients, visitors and staff
- provide a sense of belonging
- encourage a feeling of investment and feeling valued
- provide parity of dress

The feedback following the introduction of the volunteer uniform has been overwhelmingly positive. As we start to see the reintroduction of more volunteering roles, we're looking forward to seeing more of our volunteer orange army returning to the Trust.

We would like to take this opportunity to say a sincere THANK YOU to all of our committed volunteers who have supported us during what has undoubtedly been one of the most challenging times in the history of the NHS.

Our Patient Council Reports

The Patient Council is a group of lay people, patients and carers, who meet to exercise the role of 'critical friend' to the hospital. Supported by the Patient Experience and Engagement Team, we have modified our working processes to function as well as we are able during COVID.

The Council is represented at many groups within the hospital, including: The Patient Experience Committee, Nutritional Steering Group, Charity Operational Group, Quality Assurance Group for Medicine, Outpatient Programme Board, Dementia Steering Group.

We are currently involved in ongoing projects, including: Wellbeing/Garden of Life, Discharge, Imaging and Digital Inclusion.

It is very pleasing to see a marked increase in requests from many hospital teams for a patient voice in 'one-off' activities, including Recruitment Campaigns, Focus Group for Trainee Nursing Associates, commenting on patient information leaflets and other communication issues. We have been invited to participate in the Future Hospital project. An initial meeting is already scheduled, and we are excited to be involved at the initial planning stage.

We are very much a UHP-based team, but with the development of a more community-based NHS, there will be times when we need to look outside hospital boundaries. We are involved with Plymouth and Cornwall Carers Boards, Cornwall Learning Disabilities, Autism and Carers' Partnership Boards, Patient Leader Programme (joint initiative with Cornwall, Devon and Plymouth trusts).

A very significant development over the past year has been the increased recognition of the importance of carers in patient wellbeing and we feel this will continue.

"The highlight of the year for us is the renewed recognition of the role of the volunteer in the hospital. We participated in the development of the new Volunteering policy, and various members have been working at the Welcome and Vaccine Hubs as well as the Discharge Lounge and have provided feedback to improve systems."

We continue to be available to provide a patient/carer voice whenever needed!

Chair John Osborn

Plymouth Healthwatch Reports

Due to the COVID-19 pandemic, the last 12 months have been like no other in recent memory for individuals, NHS and social care services, business, and the nation in general as we all came to grips with lockdown requirements and the uncertainty of day-to-day life that saw many of us affected in various ways by this virus.

NHS and social care services have had to adapt at pace to tackle the virus, keep people safe and where needed provide treatment for not only Covid-19, but for other illnesses and conditions be it routine or emergency. As we moved into winter, hope arrived in the form of a Covid-19 vaccination and the possibility of life returning to something like normal.

Throughout the pandemic, Healthwatch Plymouth have maintained contact with staff at Derriford Hospital where we have been amazed at the reactions that have happened to deal with the challenges being faced on a day-to-day basis. These have seen an increase in capacity of intensive care beds, dedicated COVID-19 treatment wards, development of the Emergency Department over two sites and the move of more elective surgery from the main hospital to other facilities in Plymouth. All of this achieved despite the pressures felt by staff. Latterly the lead the Trust has taken in the vaccination process both at the hospital and the mass vaccination site at Home Park should also be recognised.

As the vaccination programme starts to take effect, the focus on restoring services will become ever more important as will the significant challenge of reducing waiting lists for both surgery and outpatient appointments. New ways of working with digital technology that started as the first lockdown eased in June 2020 will undoubtedly be part of the process moving forward.

It will be equally important to listen to patient feedback as this has been an area that has challenged us all during the pandemic. We have been able to maintain some of this by sharing Healthwatch reports and patient feedback with the Trust. Healthwatch Plymouth is looking forward to continuing working with the Trust, as circumstances allow, to ensure that the patient voice remains at the centre of processes that look to develop services for the future.

Tony Gravett MBE
Manager Healthwatch Plymouth

For a Greener Future - Our Sustainable Development Green Plan 2020 – 2025

We are very conscious of the impact we have on the environment. Whether it's through management of our buildings or how we provide clinical care to patients, as an organisation we directly and indirectly contribute to the amount of carbon emissions in the environment.

In 2020 Sir Simon Stevens, NHS Chief Executive launched the 'Delivering a Net Zero National Health Service' report with its aim to be the world's first net zero national health service. To meet our obligations, our Trust Board approved For a Greener Future - Our Sustainable Development Green Plan 2020 – 2025. The five year plan sets out five clear objectives that we have committed to meeting:

1. Reduce the Trust's carbon footprint by 20% by 2025 (and work towards net carbon zero by 2030)
2. 10% net biodiversity gain by 2025
3. 85% avoidance of waste going to landfill by 2025
4. 70% score in NHS Sustainable Development Assessment Tool by 2025
5. Embed sustainability into every Trust service and activity by 2025

To achieve these objectives we have set out clear targets and actions grouped in four key modules:

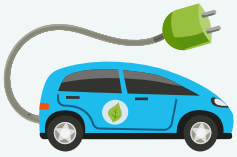
- Healthy & Sustainable Organisation
- Healthy & Sustainable Care Services
- Healthy & Sustainable Environment
- Healthy & Sustainable Communities

With clear governance and reporting structures, we will seek all opportunities to meet these objectives and will report annually to the Board on progress. By engaging with staff, stakeholders and partners, we will work hard to honour our commitment to helping to make Plymouth a healthy city in which to live and work. Our plans "For a Greener Future" can be downloaded from our website: **www.plymouthhospitals.nhs.uk/our-publications**

Building for a greener future

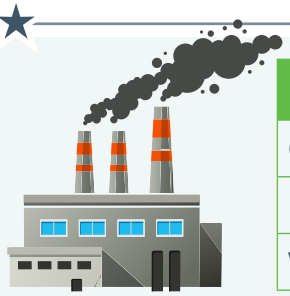
Our Future Hospital Programme presents an opportunity to redevelop our estate with sustainability at the forefront of the design. There are several publications that will shape the design of our new infrastructure including emerging guidance on Net Zero Carbon from NHS E/I and the UK Building Council's Net Zero Standard for Hospitals. The team is also liaising with the local planning authority in terms of their requirements, such as achieving Building Research Establishment Environmental Assessment Method (BREEAM) 'Excellent', and working with local partners to share ideas and expertise in decarbonising our estate and activities. Outside the hospital, we are also sharing sustainability guidance as part of our involvement in community health and wellbeing centres and the design of future community diagnostic hubs. A Sustainability Committee is currently being established which will provide programme assurance and challenge to our Future Hospital Programme to ensure we remain ambitious in our objectives.

Our Environmental Year in Numbers

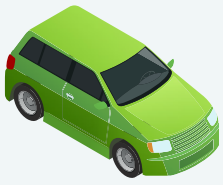


	2019/20	2020/21
Car charging points	11	11
Charging sessions	1292	1733

	2019/20	2020/21
Clinical waste (T)	1203	1270
General waste (T)	722	532
Recycled (T)	384	248



	2019/20	2020/21
Gas KWH	28.6m	29.5m
Electric KWH	23.2m	23.2m
Water m^3	225k	212k



	2019/20	2020/21
Parking spaces	1808	1738
Cycles parked	6425	6425
Bus services	19	18

	2019/20	2020/21
Trees planted	30	13

PROUD!

Explorer and conservationist Robin Hanbury Tenison captured the imagination and support of people worldwide when he was diagnosed, treated and discharged after having COVID-19.

Robin, who is an author and President of charity Survival International, became ill in early March 2020 after returning from a skiing trip and came to Derriford Hospital to be cared for. Robin's son Merlin wrote in detail about his father, his life story and achievements and his recent illness. Some of these articles are linked to here:

- The Spectator: Was this the moment my father won his fight against coronavirus? **www.spectator.co.uk/article/the-moment-my-father-turned-a-corner-in-his-fight-against-coronavirus**
- The Spectator: The old explorer is returning to the land of the lucid **www.spectator.co.uk/article/the-old-explorer-is-returning-to-the-land-of-the-lucid**
- Daily Mail My hero explorer dad was felled by the plague he predicted **www.dailymail.co.uk/debate/article-8281061/Son-83-year-old-Robin-Hanbury-Tenison-father-one-coronavirus-victims.html**

Robin was cared for in ICU and on Braunton Ward and visited our secret rehabilitation garden, where he enjoyed the sun on his face and unfiltered fresh air. As he left hospital to go home, he proudly clutched his #rehablegend badge. We wish Robin and his family all the very best for his recovery and their future.

It was recognised across the organisation that staff adopted a real 'can do' attitude to deliver change to services at pace

Emergency Preparedness, Resilience and Response

We are required to have a variety of emergency arrangements in place, in order to respond safely and effectively to the full spectrum of threats, hazards and disruptive events that may occur. Over the last year, many of these have been put into practice as part of our COVID-19 response and in preparation for exiting the European Union.

Following the first wave of COVID-19, Care Groups and Corporate Services participated in "Emerging Stronger (our new normal)", a process for all staff to pause, reflect and learn from the experience. It was recognised across the organisation that staff adopted a real 'can do' attitude to deliver change to services at pace and implemented innovative ideas that made a real difference, as we moved into the second wave, including:

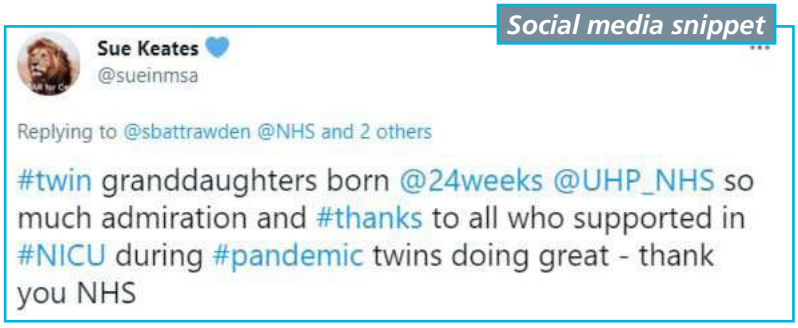
- providing equipment to enable 500+ staff to work from home, including telephone clinical assessments and encouraging flexible working to meet service demands
- creation of a centralised hub to support staff, co-ordinate absence reporting, staff testing, redeployment and provide advice
- adapting infection control policies to meet the demand of COVID-19 and associated patient pathways
- undertaking 15,000+ mask fitting tests to ensure staff were fitted with the latest available personal protective equipment, issued from national supplies
- move to 24/7 service by microbiology providing testing capacity to support hospital and community services
- creating capacity elsewhere by moving services to other healthcare organisations including minor injuries, endoscopy and phlebotomy
- up-skilling staff to work in other areas including support to the Intensive Care Units, to potentially expand capacity from 42 to 118 beds
- reducing footfall in the hospital through visiting restrictions, zoning wards and implementing changes to maintain social distancing
- providing dedicated support to COVID-19 end of life patients and their families
- using a secret garden where patients including those on ventilators could experience quiet outdoor space. Staff also utilised this area for respite during challenging shifts

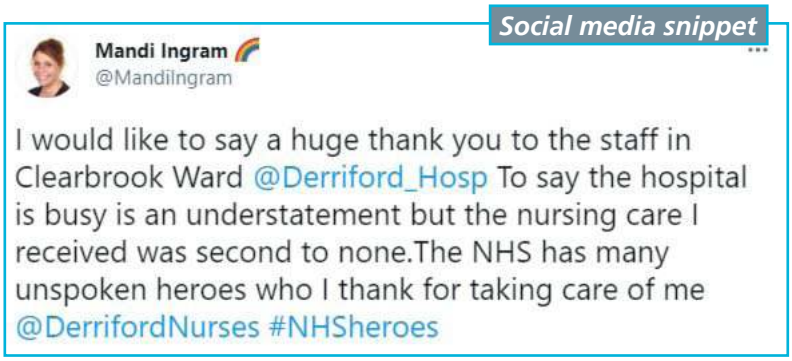
Our COVID-19 response did not deflect from other EPRR work priorities including the potential impact of exiting the European Union. To ensure suppliers had appropriate plans for any disruption, Procurement contacted more than 800 suppliers, to determine resilience arrangements in place and assurance on supply routes.

Human Resources continues to support the remaining circa 200 staff who are EU citizens and have not yet received confirmed status, to ensure that any potential impact upon service provision is minimised, before the legal change comes into effect in June 2021.

Across the year, the requirement to develop and strengthen business continuity plans remained a Trust priority. Since March 2020, Service Lines have been supported in the development of plans, taking into account risks identified within individual areas, as well as COVID-19 related issues, with 95% of Service Lines now having plans in place.

Emergency Response Plans were also issued to wards and departments, to provide easily accessible advice and guidance for use during periods of disruption. These were validated in October when IM&T and a cross section of clinical staff participated in a joint exercise where an IT outage affected communication and clinical systems.





Incidents Involving Data

Whilst we have strict information management policies, occasionally an incident occurs when information is not handled in the correct way. We continue to improve our monitoring and reporting, therefore we are more aware of incidents and each is fully investigated and, where relevant, changes are made to any controls in place.

All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (DATIX). Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital.

Incidents are categorised as either: low impact incidents (very low in severity), local investigation incidents (investigated by the IG team with recommendations and lessons learned) or reportable incidents (which are reported to the Information Commissioner's Office).

In 2020/21 there were five reportable incidents, as follows:

- A patient who works for a GP Practice had two clinical letters sent to their place of work rather than their registered GP Practice.
- A patient was contacted by a member of the public explaining they had received the patient's appointment letter as it was incorrectly posted to them.
- A number of patients have received letters from the hospital with other patients' letters printed on the back.
- A clinic letter that should have been sent to a patient's school was sent to a member of the public.
- Evidence has been found to show that a staff member has looked up healthcare data and disclosed it inappropriately.

The Trust has cooperated fully with the Information Commissioner's Office who has welcomed the remedial actions taken. The Trust continues to actively raise Information Governance awareness and encourages the reporting of incidents.

Health and Safety

We have a moral and legal duty to protect the health and safety of staff as detailed in the NHS Constitution. We must also apply these principles to our patients and visitors. We have robust overall arrangements in place for managing the Trust's health and safety responsibilities. This includes strong leadership, clear governance, staff-side engagement, specialist management resources and a dashboard for monitoring health and safety incidents and outcomes.

We have developed a strategic plan for delivering our overall aim of reducing the incidence and risk of harm to staff, patients and visitors. This aim is underpinned by the following four objectives. Our annual plan identifies a number of more specific improvement priorities against each of these objectives.

Our overall aim is to reduce the incidence and risk of harm to staff, patients and visitors by continuing to adopt the highest standards of health & safety practice at all times			
Objective 1 Reducing Harm	**Objective 2** Promoting Awareness	**Objective 3** Ensuring Compliance	**Objective 4** Improving Systems
Reduce likelihood and incidence of harm in key areas	Promote awareness and ownership of key health & safety issues	Ensuring compliance with all national health & safety standards	Maintain effective risk and incident reporting systems

Preventing Fraud

We have a clear strategy for tackling fraud, corruption and bribery and our Counter Fraud Policy details staff responsibilities and how to report suspicions of fraud or bribery.

The Trust contracts with ASW Assurance to provide a lead accredited local counter fraud specialist (LCFS), who ensures any fraud risks are mitigated and systems are resilient to fraud and corruption. The Director of Finance has responsibility for the Trust counter fraud arrangements and the Audit Committee receives and approves the Counter Fraud Annual risk-based Work Plan and Annual Report. It also monitors the adequacy of counter fraud arrangements and reports on progress to the Board of Directors. The LCFS provides regular update reports to the Audit Committee in respect of recent counter fraud activity and briefings on national developments and areas of interest in relation to counter fraud.

The programme of counter-fraud work was delivered in 2020/21, addressing all strategic areas of the national counter-fraud strategy, as issued by the NHS Counter Fraud Authority. The LCFS develops and maintains key relationships across the Trust and this, coupled with the work undertaken by the LCFS, has resulted in the development of an anti-fraud culture within the Trust. The ongoing COVID-19 pandemic has resulted in the likelihood of fraud intensifying due to an increase in fraudulent attempts and in some cases reduced control measures. The LCFS has worked with the Trust to ensure these opportunities are minimised.

"Our Research strategy is to embed research as core business in key clinical services. 2020-21 provided an opportunity like never before..."

Research, Development and Innovation

The strap line of our Research strategy is to embed research as core business in key clinical services. 2020-21 provided an opportunity like never before, highlighting the extraordinary importance of research to provide an exit strategy from the COVID-19 pandemic.

Our vision is to improve the health and wellbeing of our local population by conducting high quality, well run research which is relevant to their needs by embedding research as part of our core business

Strategic Intent 1	Strategic Intent 2	Strategic Intent 3	Strategic Intent 4	Strategic Intent 5	Strategic Intent 6
Reflect the needs of the local population	Reflect transformation in healthcare delivery	Grow a research rich climate	Involve a multi-disciplinary workforce	Ensure financial stability	Achieve Clinical Research Facility Accreditation

Strategic enablers
High standards of governance and ethics
Internal and external communications strategy
Annual research plan
Collaboration with local partners

UHP Research Strategy 2019-2024

The National Institute of Health Research defines the research focus of the NHS. This year the focus was almost exclusively on COVID-19. The NIHR's RESTART framework set four levels of priority for clinical trials. Those classed as Level 1a Urgent Public Health (COVID -19) trials were allocated the highest level of resource, including research delivery workforce. UHP opened 18 of these, ranking 1st of the acute trusts in the south west for recruitment with over 3,000 participants. The south west peninsula is ranked 1st overall of the 15 regions (adjusted for population) in England for recruitment to COVID studies.

- We contributed substantially to platform trial national testing of treatments for acute COVID, including RECOVERY, identifying Dexamethasone and Tociluzimab as some of the first therapeutic agents against COVID-19; trials to establish Remdesivir as a treatment for severe COVID-19; and studies in critical care & acute medical wards to map the pattern of COVID disease progression and the genetic basis for severe respiratory disease in some individuals. This has been facilitated through embedding of research into service lines. Critical care, Respiratory and Trauma & Emergency are all speciality areas where research nurses work on a daily basis, or are partially employed by the clinical directorate.

- Through our collaboration with the national Vaccine Task Force, we have contributed to the UK's early adoption of COVID-19 vaccines to protect the most vulnerable of our population. We were the first global site to reach >500 participants to the ENSEMBLE 2 vaccine study in less than two months, a success attributable to our large generic research delivery workforce, our two Clinical Trials Fellows employed in the R&D service line, and the outstanding work of our Immunology service line in largely embedding themselves into the delivery of this vaccine trial.

- We were the first site in the UK to recruit to the large scale Public Health England study SIREN, a study of tens of thousands of NHS staff looking at how infection or vaccination affects people's COVID antibody levels, how well it protects them against COVID going forward and, most importantly, addressing the question of whether people can still develop asymptomatic infection and potentially be a risk to others.

- Several academic research projects in COVID such as Immune & Biochemical markers Of COVID (IBOC) (Ashwin Dhanda) and CORD-LUS (John Corcoran) were developed and delivered by University Hospitals Plymouth clinicians & research teams.

Principal Investigators and R&D teams had to make difficult decisions about which studies to suspend and continue during these exceptional times. Prioritisation of the Trust's portfolio of research (in excess of 520 studies) is not an easy decision, as every study was felt to be important. Through three COVID peaks we have worked through the NIHR restart framework to re-open many studies, but apart from some targeted successes for example in cardiology, hepatology and surgery where we have been the first UK site since COVID to recruit - our recruitment has been severely restricted. The knock-on effects of COVID as staff decompress and clinical/ support services catch up on a long waiting list backlog are likely to persist far into 2021 and possibly beyond. Reducing footfall within the hospital but ensuring patient access to clinical trials remains a full time logistics task.

There will be many things that we will want to leave behind in 2020/21 but there have also be many opportunities to learn how to do things differently and more efficiently. MS Teams has become our friend not only from a work perspective but also providing a platform to check in and support each other. MS Teams has provided the ability to quickly build collaborations, share ideas, deliver training opportunities for people who are many miles apart and allowed people to keep in touch and up-to-date even through long periods of home working. Lockdown has provided an opportunity to complete papers with UHP recording 475 published papers in 2020/21: an increase of 62 on the previous year and we now look forward to 2021/22 with renewed energy and enthusiasm for taking research forward.

Dr Gary Minto
Director of Research

Our Charity

At the beginning of the year the NHS became the focus of a huge groundswell of public gratitude as hospitals across the country became the front line in the urgent response to care for people seriously unwell with COVID-19. Suddenly NHS Charities everywhere were responding to the emergency and supporting people who wanted to say 'Thank you' to NHS staff. Through the incredible generosity of people both locally and across the country, UHP and Plymouth Hospitals Charity worked together to distribute funds and all manner of donations to staff and patients.

Together with our amazing fundraisers and supporters we were able to fund food parcels for staff and patients. We also had hundreds of offers of "gifts in kind" and lots of text messages of gratitude for our staff. An example of which was:

> **"Thank you all so much for going above and beyond what's expected to help those that are so gravely ill in these unprecedented times ...not all heroes wear capes."**

There is not enough space to mention everything and everyone, but Oliver aged 5, raised over £3,500 and captured our hearts. He was on a mission to run a marathon before his sixth birthday and raise money for the poorly people he knew were in hospital. He smashed his £150 target and his enthusiasm and commitment lifted a lot of spirits.

How donations have helped...

- We purchased iPads so that critically ill and isolated COVID-19 patients can communicate with their loved ones.
- We refurbished changing areas and locker spaces for staff working in COVID red and amber zones.
- We bought new toys for Children's Theatres and funded activity packs for older patients who are waiting for results in hospital on their own.

These are just a few of the things we were able to fund.
For more details please visit our website. **www.plymouthhospitals.nhs.uk/charity-home**

NHS Charities Together

NHS Charities Together is the membership body for all NHS Charities and they co-ordinated the national emergency fundraising appeal. They are supporting Plymouth Hospitals Charity with grants of more than £135k. Staff told us that a key priority for them looking ahead was outside green space where they could take a break, meet colleagues in a relaxed environment and step out of the clinical environment during their breaks. To facilitate stepping away from the stress, the charity is funding some large garden spaces and sprucing up some of the existing garden spaces. The charity has also funded the infrastructure for the new staff networks.

Plymouth Hospitals Charity Highlights

Although the year did focus around our response to COVID we celebrated some other significant milestones too:

- The wonderful Electric Shuttle Bus, bought with donations from grateful patients and families, was put to good use to take people to and from their COVID vaccine appointments with new screens inside to make it COVID-secure.
- Donations bought a fantastic rocket-shaped mock-MRI machine. Designed to ease anxiety for children, the play scanner allows the child to practise lying still in an MRI-like environment, so when they go through with a real MRI scan they are more likely to complete their scan. That means more and more children not having their scans under general anaesthetic.
- A legacy received by the neurosurgical unit helped them reach their fundraising target to buy a state-of-the-art ultrasound machine. This equipment offers a full suite of innovative technologies and advanced controls and adjustments to help achieve the best possible image quality.

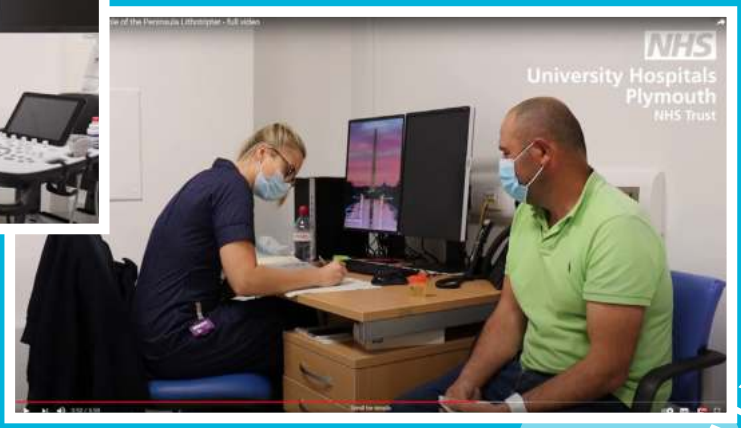
Looking to the future

We have looked at where we are and where we'd like to be and have written a three year strategic plan to get us there. Our commitment is to bring together the needs of our services with the support of generous donors to continue funding the difference. The charity exists to support the work of Trust services in providing the best possible care to patients and to support the work of staff to raise standards above the level that NHS funding alone enables.

- We are developing a grants programme that will resonate and support all our staff and patients over time.
- We are developing ways to be more visible and helpful to all.
- We want to find out what sorts of things will make it better for our patients and staff that we can then actively fundraise for.

Every donation, whatever the size, helps us make a difference and make yours and our hospitals even better.

A couple of the highlights for our charity this year.



PROUD

The New Stone Age: Patients across Devon and Cornwall to benefit from fixed site lithotripter
A new machine for treating renal and ureteric stones at Derriford Hospital is benefiting patients across Devon and Cornwall. The first of its kind, the new fixed site lithotripter supports outpatient procedures for complex stones, revolutionising how stones are treated across the south west. Lithotripsy is a technique for treating stones in the kidney and ureter that does not require surgery. Instead, high energy shock waves which are applied via the skin, pass through the body and break the stones into pieces as small as grains of sand. Because of their small size, these pieces can pass from the body along with the urine.

Consultant Urologist Richard Pearcy said: "Lithotripsy has been around for a number of years, however the original models required a water bath and for the patient to be under general anaesthetic. Subsequent models were made mobile and were much lighter and easier to use, but that was a trade off with less effectiveness in stone break up. The latest machine doesn't require general anaesthetic, just ordinary pain relief but has good effectiveness in breaking the stone." The fixed site lithotripter now delivers treatment five days a week. 41 patients have been treated during the first six weeks, including the treatment of 45 stones, of which 19 stones have completely passed or only have small fragments remaining.

"The intention for the machine based at Derriford is for it to be made fully available to other hospitals throughout the south west of England," said Richard. "This should reduce the ureteroscopy rate across these hospitals, simplifying the treatment of stones and resulting in fewer patients being admitted to hospital for acute care."

Patient, Muhedin Marraqu, who has just completed his course of treatment said: "As soon as I was done I was back to normal. As long as you drink plenty of fluids you don't have any pain."

Watch Muhedin talk about his treatment on this video: **https://youtu.be/TdwvMLhVW-0**

Our People

We have 9,194 people in our diverse, committed, capable and compassionate #1BigTeam. Of these, 75% are female, 8.5% are from an ethnic minority background, and 3.96% consider they have a disability.

Staff numbers by Staff Group, figure as of 31st March 2021	
Add Prof Scientific and Technic (inc ODPs)	308.16
Additional Clinical Services	1495.55
Adminstrative and Clerical	1648.06
Allied Health Professionals	411.72
Estates and Ancillary	622.12
Healthcare Scientists	253.25
Medical and Dental	1131.60
Nursing and Midwifery Registered	2039.06
Students	87.20
Total (wte)	7996.72
Total Headcount	9194
Annual Turnover	8.02%
Sickness	4.82%

Staff numbers by gender				
Gender	Board	Senior Manager	Other	Grand Total
Female	6	113	6787	6907
Male	10	77	2201	2287
Grand Total	16	190	8988	9194

Table showing number of new staff recruited over the financial year by staff group	
Add Prof Scientific and Technic (inc ODPs)	44
Additional Clinical Services	270
Adminstrative and Clerical	201
Allied Health Professionals	88
Estates and Ancillary	111
Healthcare Scientists	25
Medical and Dental	351
Nursing and Midwifery Registered	267
Students	321*
Grand Total	1678
* medical and nursing students temporarily in post to support COVID-19	

Staff Health and Wellbeing

We have continued to deliver a wide range of programmes for colleagues, aimed at promoting healthy lifestyles and good physical and mental health, supported by our SEQOHS-accredited Occupational Health and Wellbeing service, Department of Pastoral and Spiritual Care and our onsite Derriford Centre for Health and Wellbeing. Improving psychological wellbeing and removing the stigma surrounding mental health issues at work, continues to be a high priority. Our seasonal flu campaign this year resulted in 70.9% of patient-facing staff getting vaccinated, 300 more staff overall than in the previous year, with levels of patient-facing staff vaccinated at comparable levels.

As a result of COVID-19, we significantly enhanced the health and wellbeing support provided for our people to ensure the support needed has been in place. This has included strengthening the psychological support available with more rapid access to staff counselling, opportunities for individual and group reflective practice, and support from our Trust psychologists and chaplains. We have provided colleagues with 24/7 support for themselves and their families via our employee assistance programme, including financial wellbeing support and advice. We have ensured that COVID-19 staff risk assessments have been undertaken and kept up-to-date in line with emerging knowledge and guidance. This keeps colleagues safe, including those who are more vulnerable with underlying health conditions and in higher risk groups, and encouraged all staff to take up their COVID vaccination.

We have maintained regular communication with colleagues throughout the pandemic through a variety of channels, to support self-care, understanding and compassion towards self and others, and wellbeing will continue to be a key focus for line management discussions with colleagues through the adoption of regular wellbeing conversations. We will add to and adapt, the range of resources to support staff health and wellbeing including long COVID conditions, and will be ensuring the enhanced level of support continues as we move into the recovery phase of the pandemic and beyond.

Inclusion Makes Life Better for Everyone

Every colleague in the NHS has a duty to treat patients and each other fairly and with respect. For many of us this is set within our personal values and a reason we are proud to work for an organisation that is designed to protect, support and care for others. Creating an environment that is inclusive for people whether they are patients or colleagues is fundamental to a culture of kindness and compassion, which is important to us.

Over the past 12 months we have worked hard to create our five Staff Networks who represent protected groups* within the Equality Act 2010:-

- Faiths and Beliefs
- Disability and Wellbeing
- Lesbian, Gay, Bisexual, Transgender (the plus represents other sexual and gender identities)
- Black, Asian and Ethnic Minority
- Women

Our networks are inclusive and open to staff from all backgrounds who want to make a difference. Alongside the networks we heard from male colleagues that it is important to have a safe space to have conversations about issues affecting men. The networks and conversations with colleagues have already made a notable impact on their members and are essential in supporting our Equality, Diversity and Inclusion (EDI) objectives which include:

- Widening exposure and career pathways for colleagues in disadvantaged groups
- Developing and supporting women and colleagues from ethnic minority backgrounds into medical leadership roles
- Educating recruitment panel chairs in values based and inclusive recruitment practices
- Creating gender-balanced job interview panels as well as diverse panels for senior leadership roles
- Career and talent conversations for disadvantaged groups

Our EDI Framework aims to create and maintain an environment that values difference and fosters an inclusive workplace where colleagues from all backgrounds can be at their best, are treated fairly, are valued for their contribution and are able to progress in their careers. Equally we will develop and provide patient services that are fully inclusive and accessible to all, promoting equality and tackling health inequalities. Core elements of the framework include engaging with our colleagues and patients, to listen to their experience and seek their feedback, creating greater flexibility and, of course, ensuring that inclusion runs through our practices, procedures and behaviours of our workforce.

The NHS People Plan sets out the importance of belonging and we recognise this is a natural part of being human. We know from reporting on our Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap Reporting that there is a gap in the workplace experience for some of our colleagues who identify with protected groups*. This may impact on a sense of belonging and our strategy and objectives are aimed to bridge the gap in the workplace experience to enable all people to feel part of our #1BigTeam.

* Protected groups refer to groups who face disadvantage, unfairness and discrimination as defined by the Equality Act 2010 - age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Some of our staff networks leads

A word from our staff networks

FaB - Faiths and Beliefs Network

The FaB network was set up in November 2020 and takes a unique approach to supporting staff when compared to the four other staff networks we have.

FaB have chosen an open and informal approach to their network meetings. The purpose of the meetings and the network is, as Lenore Newson, network member explains: "to bring people together in a safe environment to share experiences, exchange views, thoughts and ideas as well as an opportunity for colleagues to recognise they are not alone in this and there are others just like them. This allows patients to know that their own faith/ belief will be better understood and supported as the Trust has diversity of colleagues working here and can help with their own feelings of wellbeing , especially when they are poorly". This shows the Trust cares about all aspects of those working here, respecting all faiths and beliefs and none, equally.

Faiths, beliefs and religion is embraced by the Trust and shines through in every aspect of daily life. Our diverse workforce need to be open to different points of view, beliefs and simultaneously allow workers to fulfil their job role whilst feeling safe to express their individuality. Our multi-faith team at UHP are a great source of support for colleagues, patients and relatives and play a key role in our wellbeing agenda.

This network does not promote one specific religion, faith or belief and along with other networks provides a 'listening ear' for all of our colleagues as well as seeking their views to help shape our inclusion agenda and enable us to focus our efforts on actions that will make the biggest and most positive difference. The network aims to provide informative educational sessions as an opportunity for colleagues to learn about different faiths and beliefs and have the chance to share personal lived experiences. This will allow for greater understanding, leading to mutual respect and tolerance, learning and sharing.

BAME Network – Black, Asian, and Minority Ethnic

The BAME network was set up in June 2020, and is Chaired by Kyeiyanne James (Associate Practitioner in Immunology), with Deputy Chair Rez Rogers (Healthcare Science Practitioner in Neurophysiology) who are clear that:

"Privilege is not always something that you are born into. However the colour of your skin is a privilege by itself. Allyship is vital in order to have positive systematic change, so that we can have effective

"The BAME network has made me feel a sense of inclusion. It has created a platform for BAME colleagues to meet and speak about issues affecting them without a notion of judgement as well a place to share similar day-to-day experiences."
Ruth Scrivener, BAME Network member.

collective action to build on the diversity, equality and inclusion within the UHP, the wider community and in our own lives. Your actions and your words must be in sync. As an ally, we ask you to stand with us as we proceed to educate, encourage and eradicate discrimination in all forms within ethnically diverse communities. Your privileges, whether inherited or earned, can be used to amplify the voices of others who cannot be heard. It is always better to do something imperfectly than doing nothing perfectly."

The network provides a listening ear for our BAME colleagues as well as seeking their views to help shape the inclusion agenda and enable focused efforts on actions that will make the biggest, and most positive, difference. The network has 70 members, and has focused on topics such as:

- creating a safe space for BAME colleagues within the Trust to share their lived experiences in a supportive environment
- networking internally and with external organisations such as Plymouth Racial Equality Council and the Devon Wide BAME Network for example
- the importance of COVID vaccination among BAME colleagues
- Eating Disorder Awareness Week
- creating branding for the network and mission statements to create visibility of the network to the wider Trust

As with all the networks, the Cultural Inclusion Calendar was an important achievement and helps to represent the diversity of our colleagues across the Trust.

DAWN – Disability and Wellbeing Network

The DAWN network launched in July 2020, and has been co-chaired by Jane-Marie Harvey who works in Women's and Children's and Sarah Jackson who is part of the HR team since January 2021. Steven Keith is the network's Trust board champion.

The network provides a supportive environment and a safe space for colleagues who have a disability or long term condition - including but not limited to physical disabilities, mental health conditions, learning difficulties or disabilities and hidden disabilities. The network helps employees share their lived experience and enables the organisation to better understand the issues affecting them.
Network's goals include:

- Creating a supportive, safe space for colleagues with a disability to come together through meetings, email and social media
- Promoting the network across UHP at all levels
- Highlighting awareness and acceptance of various disabilities and conditions.
- Helping to shape improvement of policies and recruitment processes
- Education for leaders, managers and colleagues regarding supporting colleagues with disabilities and long term conditions
- Gaining funding for the network for future activities
- Connecting with other Trust's disability networks

The Communications team is supporting the network achieve their goals in various ways:

- Attending monthly meetings
- Advice and guidance for campaign planning (e.g. Deaf Awareness Week)

- Production of materials for promotion of the network (e.g. video for Deaf Awareness Week, support on visual identity, inclusion calendar)
- Social media training for network chairs

LGBT+

The LGBT+ network launched in October 2020 and is chaired by Elliot Atkinson (Biomedical Scientist), with Martin Jared-Davis (Senior Assistant Technical Officer) as deputy.

Our LGBT+ network aims to ensure that, regardless of an employee's sexual orientation and gender identity, opportunities are equal and staff can feel comfortable raising issues and tackling discrimination. In providing open forums for our LGBT+ colleagues to share their experience of the workplace in a supportive and safe environment, we strive to create a more inclusive environment for our staff by empowering them to feel safe and confident in bringing their whole selves to work.

As a network, members are proud to have been involved in spreading the message of inclusive healthcare through the NHS Rainbow Badge. As many as 1 in 7 people from the LGBT+ community have reported avoiding healthcare for fear of discrimination and a simple visible symbol (such as the Rainbow Badge) can make a big difference for those unsure of both themselves, and of the reception they will receive if they disclose their sexuality and/or gender identity.

There has been a fantastic response so far with 1,300 colleagues pledging to wear the badge, symbolising to patients and their families that they are someone you can talk to about sexuality and gender, without fear of being judged.

Moving forward, the network are looking to focus heavily on education by both raising awareness of issues that LGBT+ colleagues face within the workplace and also developing close working relationships with the other networks within the Trust and organisations outside of our own, with the aim of building a community that makes everyone feel safe and heard.

Women's Network

Our women's network is for all those who identify as women and their allies and is Chaired by Kerry Dungay, Medical Education Manager, alongside Vice Chair, Camilla Redding, Pathology Business Support Officer. The network currently has 80+ members and is a safe space for colleagues to share their life experiences in a supportive and safe environment. We are still very much on the exciting journey of defining and developing our identity, vision and shared objectives, which will include addressing the three main areas raised by the network members:

- Cultural Change
- To promote Inclusion and Diversity
- To provide specific support mechanisms to network members (i.e leadership mentoring, networking etc)

To achieve the above we will specifically look at championing specific key themes each year, provide support and advice to those wishing to set up their own support mechanisms such as LeanIn Circles, champion key events, work collaboratively with all UHP networks and ensure membership is inclusive

"I believe that with the enthusiasm of the members we will engender positive change for all those who identify as women, remove barriers to progression and provide resources for full potential to be realised."
Kerry Dungay, Women's Network Chair

and representative of all ages, jobs and pay bands within the Trust.

In Chair Kerry's words: "I believe that with the enthusiasm of the members we will engender positive change for all those who identify as women, remove barriers to progression and provide resources for full potential to be realised."

Our Women's Network led the Trust's first celebration of International Women's Day on Monday 8 March 2021. Kerry arranged a programme of diverse and fascinating speakers based on this year's theme of #ChooseToChallenge.

"I value this group and am very proud to be a part of it. To be honest this probably is the only bit of time I have when I truly think about how I am feeling and usually feel very emotional afterwards" - Women's Network Member Survey response.

Men's Conversation
The Men's Conversation was born from colleagues' requests to create a space to encourage and engage with men and an opportunity to speak up about issues that affect men. We have already held three men's conversations which were successful in starting open and insightful discussions.

The group was initially chaired by Nick Thomas (Deputy Chief Executive) and following his well-deserved retirement, Dr Jamie Read has taken over the role to ensure the conversation keeps on going for the men's group.

Topics that have emerged from the conversations have included:
- Mental health
- Male specific conditions/diseases
- The COVID-19 pandemic
- Cancer
- Working in a predominantly female environment

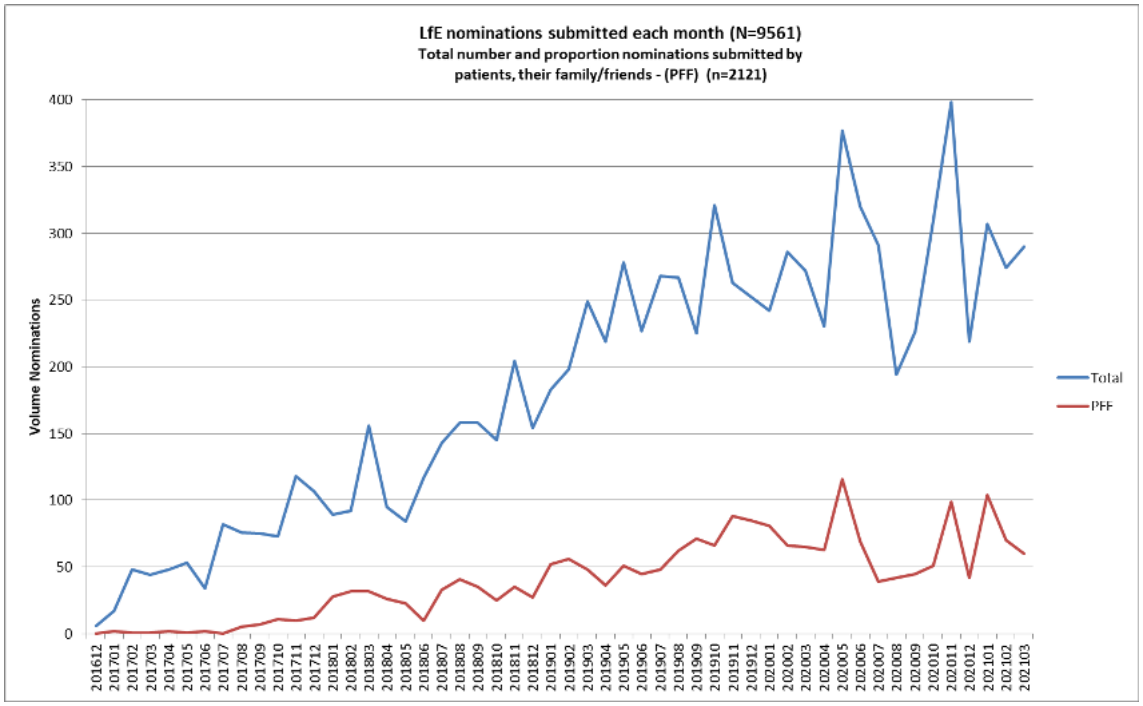
For the future, the group have looked to start a Men's Conversation podcast series. It looks at the stigma surrounding men speaking up about mental health issues, how to access support and tools, and some stories from guest speakers such as Craig Harrison from Andy's Man's Club, a national talking network for men (which is also developing a woman's club).

Dr Jamie Read said: "I'm really honoured to be taking the Chair role from Nick and would like to thank everyone who has been involved so far. This group is a safe space to discuss any issues and it would be great to see more people attend as the group becomes more established."

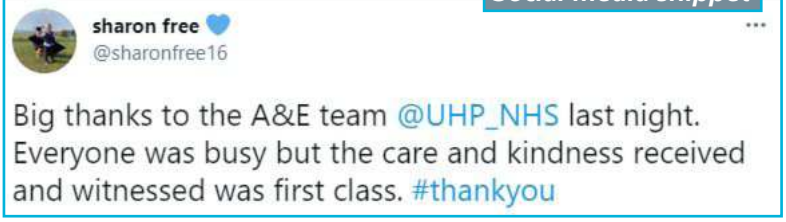
Listening to our #1BigTeam

The Trust's Say Thank You & Learn from Excellence (LfE) scheme is now in its fourth year and has become a firmly embedded mechanism to show appreciation to others and provide positive feedback. At the heart of LfE is the philosophy that we will improve our workplace culture and staff morale (and so patient safety and experience) by recognising and reflecting on positive behaviours and actions. Approximately one fifth of our nominations are submitted by patients and their families/friends, so not only do we have a growing local evidence base of 'what matters' to staff - we understand 'what matters' to patients too. We use this powerful learning to help inform staff, team and leadership development work and strengthen our services for patients.

By the end of March 2021 we had received more than 9,500 LfE nominations describing everyday excellence. More than 2,000 of these nominations were submitted by patients, their families and friends.



Social media snippet



To capture system-wide learning we theme all LfE nominations. We have learnt that the thing that staff, patients and families appreciate most concerns behaviours - how we are with each other. This ranges from staff who are positive in attitude, manner and outlook, to those who are supportive, show kindness and compassion or who make time for us. This learning was the catalyst for our successful Appreciation, Civility and Excellence (ACE) event and has led us to focused work on raising awareness of the importance of civility in healthcare - a key attribute of creating greater patient safety, staff happiness and engagement in work.

"I joined the admin team at the beginning of December and despite being on a fixed term contract X has treated me no differently to any other member of the department. Her warm and welcoming smile greets you every morning and the support she has given me since joining the department cannot be measured or thanked enough. She has the patience of a saint, when it comes to training, explains things in a way that is easy to understand and takes the time to make sure I know what I'm doing. She is a great department leader and should be recognised for her skills, patience, attitude and people skills and all I can say is THANK YOU. My introduction to life working in a hospital environment and learning my role. Without X's thorough but easy to understand training I think I would be flapping around like a fish out of water!"

"Just wanted to say a massive thank you for taking the time to ensure I got feedback and thank you via 'learning from excellence.' Getting the card through the post was a very unexpected but pleasant surprise and a real boost."

"This is an excellent program, learning from the positives of our co workers. Moreover appreciation motivates one more than complaints. Keep up the great work!"

"X did my bloods for both clexane and my glucose tolerance test. She took the time to answer all my questions and explained the process to me. She made me feel really at ease when it came to COVID as she followed all guidelines despite it being clear she was suffering from sore skin due to constant handwashing. Her smile and friendly hello instantly made me feel a lot more comfortable.

I felt reassured and well looked after.

Please encourage all staff to be like this. A smile and friendly hello goes along way" - A patient nomination

Social media snippet

Ria D George
@ria_george1

The Phlebotomy Service at Future Inn has been fantastic, brilliant set up and lovely staff. My son felt reassured and relaxed using the service today. #feelingsafe #wellorganised @UHP_NHS

"LfE is a wonderful way to acknowledge our colleagues and the hard work that often goes on behind the scenes and is not always therefore recognised as much as the face/face work. As professionals we 'get on with the job' despite our own feelings/issues/challenges etc cos that is what and who we are. Being able to send a message to colleagues so they know their work is noticed, recognised and appreciated is invaluable to them in being able to maintain the standards of care we all aspire to"

Emerging Stronger Conversations – Listening to Staff

In May the Trust embarked on a focused exercise to connect with and listen to staff through a series of virtual and face to face events. Emerging Stronger – Our New Normal, launched by Ann James was co-ordinated and supported by the Organisational Development and Communication teams.

The purpose was to give staff and teams the opportunity to pause and reflect and collectively make sense of their experiences of Phase 1 COVID response. The popular randomised coffee trial approach, Schwartz rounds, specific group chats, team meetings and existing staff PULSE survey were all used to frame different conversations. Opportunities to share stories are both important to support staff wellbeing and recovery but also ideal spaces to reflect on learning; understanding those things that worked well and why and those things that with hindsight, could have been done differently or better. Conversations focused on four key topics namely:

- Wellbeing
- New Ways of Working
- Leadership and Communication
- Teamworking

Staff Voice

Recognising the pressures staff were under through the 2020/ 21 year it was essential our staff had access and opportunities to share their experiences. Our staff voice routes were shaped in a considered and compassionate fashion, with the intention to understand and act on staff experiences, to make change – where possible – in real time but to also reflect and learn from a year like no other.
A decision nationally was taken to continue with the annual NHS National Staff Survey, titled 'Working through the pandemic'; we used this as just one feedback avenue available to staff with regular Staff Pulse surveys, Emerging Stronger and Your Voice conversations also being available.

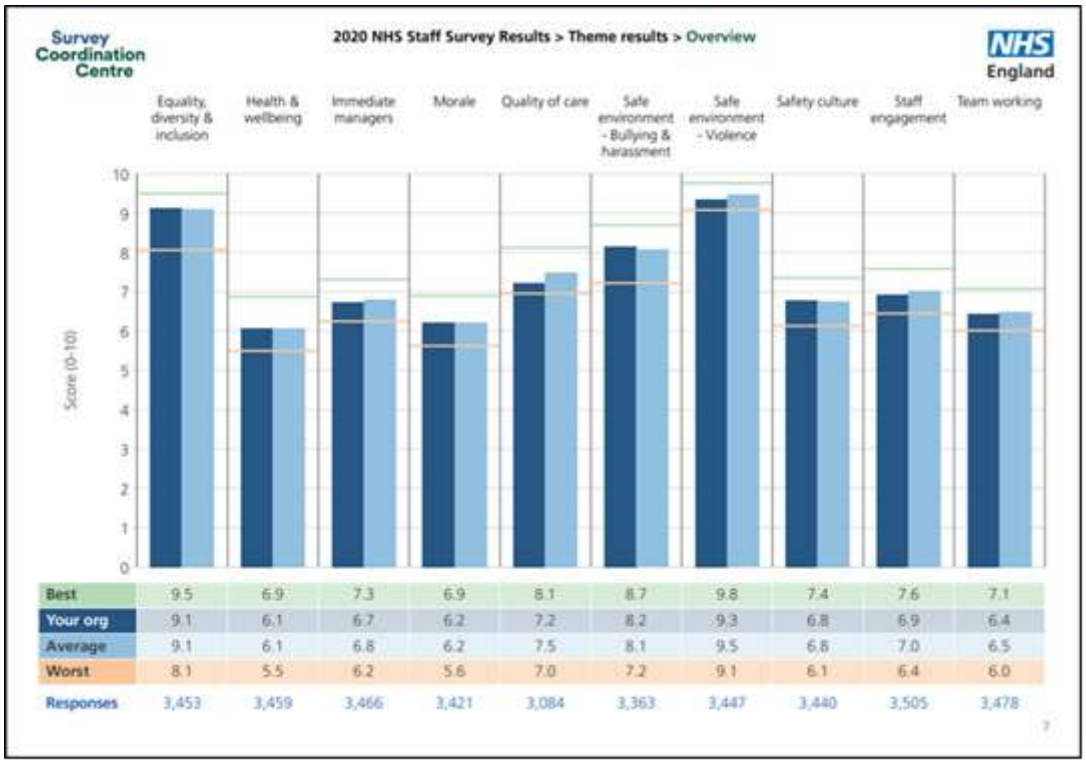
With a National Staff Survey response rate of 42% our data told a similar story to the rest of the country. When looking at the ten survey themes (groups of questions), compared to how we faired last year:

- One theme (Quality of Care) has statistically significantly improved
- Six have no significant statistical difference
- Three have statistically significantly declined (Equality, Diversity & Inclusion; Immediate Managers; Team Working)

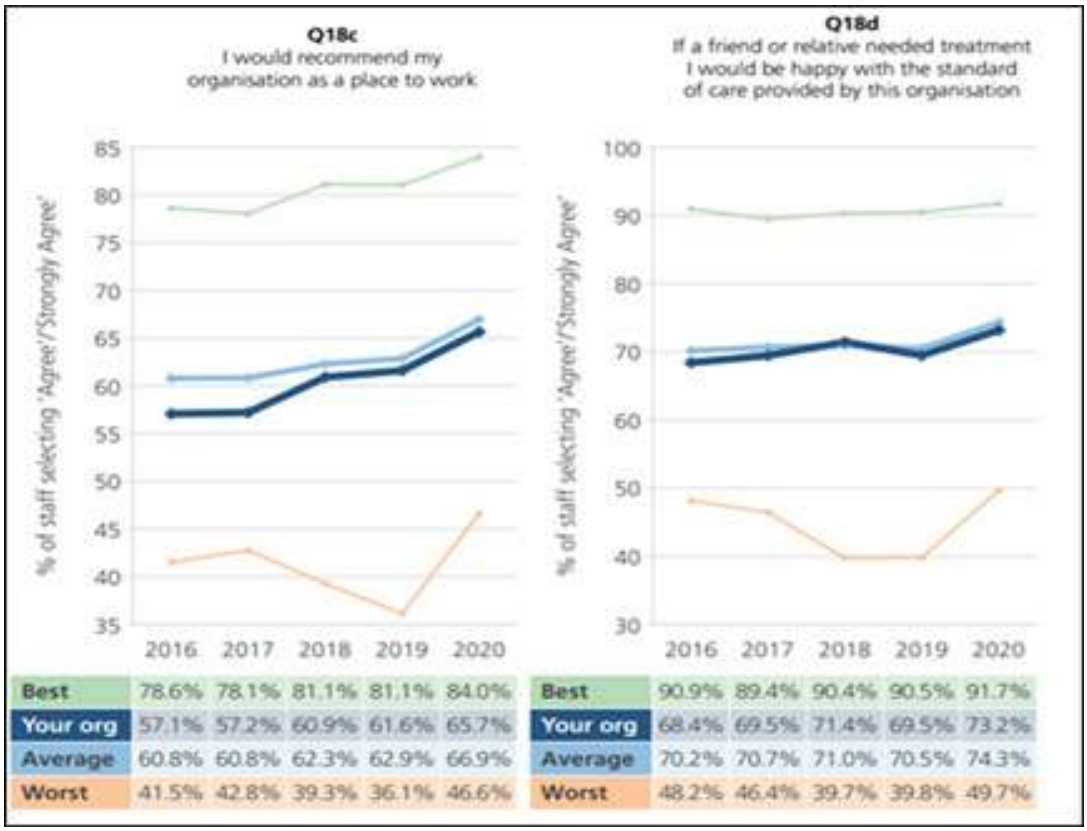
Social media snippet

Jo Agnew @TavyJo · 14h

I have to say my father's #myeloma treatment @UHP_NHS has been exemplary; remote consultations & socially distant treatments. He is one of the lucky ones, maybe if he hadn't already been diagnosed and in the system it might have been a different story.

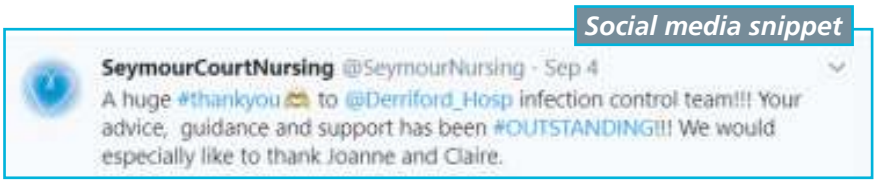


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.1	6.1	6.7	6.2	7.2	8.2	9.3	6.8	6.9	6.4
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	3,453	3,459	3,466	3,421	3,084	3,363	3,447	3,440	3,505	3,478



	Q18c 2016	Q18c 2017	Q18c 2018	Q18c 2019	Q18c 2020	Q18d 2016	Q18d 2017	Q18d 2018	Q18d 2019	Q18d 2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	57.1%	57.2%	60.9%	61.6%	65.7%	68.4%	69.5%	71.4%	69.5%	73.2%
Average	60.8%	60.8%	62.3%	62.9%	66.9%	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%	48.2%	46.4%	39.7%	39.8%	49.7%

Social media snippet



Despite the additional pressures staff have experienced, responses to the two national recommender questions have improved over the 2019 national survey (Q3); for both indicators there is a sustained year on year improvement which indicates a real sense of pride working at UHP.

Learning and Development
During the pandemic we have been providing all our mandatory training and welcome events via a digital platform which has included videos and eLearning. There has been a positive increase in compliance across all eight components during this time. In addition we provide all staff with personal development opportunities; these include a personal development passport and a manager's passport, providing tacit skills to support them in their day to day role. All workshops are provided on MS Teams and there is eLearning available to complement or in addition to the workshops.

Apprenticeships
Our overall apprenticeship programme continued to grow; we now offer 29 different apprenticeships, to nearly 400 learners, from level 2 up to level 7. We have recently started to offer the four year, direct entry Registered Nurse Degree Apprenticeship (RNDA). This is an additional option in our nursing career development pathway, and provides a shortened route to registration. This is a very exciting opportunity, and we have seen individuals who have completed our successful Healthcare Support Worker apprenticeships being accepted on to this programme.

February saw us celebrating National Apprenticeship Week, sharing the experiences and achievements of our apprentices, over what has been an incredibly difficult 12 months. More than 100 apprentices successfully completed their apprenticeships during the pandemic, against a backdrop of changing work practices, moving to different areas within the Trust, and having to take exams remotely from home. We are very proud of them, and continue to support them with the next stages of their careers.

Support during the pandemic
During the pandemic Learning and OD focused on providing opportunities for staff to connect with colleagues and our leadership teams, to provide peer support through firstly our internal coaching network who provided a "Listening Ear" service aimed at managers ranging from executive to first line level to help them feel supported throughout the pandemic and will continue to function as part of our ongoing leadership offer. The coaching network was made up of a team of trained coaches both within UHP and from other public sector organisations within the city. Secondly we launched our "Keep in Touch Scheme" aimed at colleagues who were not able to work on the Trust site, new joiners and redeployees.

Through the Keep in Touch Scheme our team engaged with more than 2,000 staff; in addition to personal contact by phone and emailing a card was sent with a personal message from our Executive Team to demonstrate our colleagues' importance to our UHP community and that they were missed. This engagement encouraged the sharing of staff experiences and supported our leaders in navigating the many management and cultural dilemmas the pandemic created such as how to support teams under pressure, virtual teams and teams that are temporarily reassigned to support other services.

The period of disruption illustrated the tremendous resilience and courage of our colleagues and generated rapid improvement and learning which we hope to continue to maximise as we support the reflection and recovery period post pandemic through ongoing reflective practice, alongside leadership development and talent development through "Project Strive" which will support colleagues to achieve their ambitions within UHP and most importantly the adoption of wellbeing check ins as a regular staff conversation.

Our workforce grew rapidly during the 2020/ 21 period with national schemes being introduced to support the COVID workforce crisis. As a Trust we are extremely grateful to staff who joined as an Aspirant Nurse or a student volunteering, staff who returned to practice or came out of retirement, along with staff who started in new roles in unfamiliar circumstances. As part of our 'Keep in Touch' programme we reached out to all of our new starters to support them, to talk to them and to hear from them.

Social media snippet

Excellent care

★★★★★

by Kate Rice - Posted on 15 May 2020

I had to take my daughter to A&E yesterday after she collapsed. She was seen quickly and everything that the doctor and nurses did for her was carefully explained - she has learning difficulties. She was treated with respect and consideration, and the nurses and the doctor who saw her were wonderful. Thank you so much for making a really traumatic incident bearable for the both of us.

Social media snippet

Emma Harrison
@disneyinferno

I would like to thank everyone at the Royal Eye Infirmary daycase unit. You were absolutely amazing and kept this very anxious patient at ease throughout my procedure yesterday @UHP_NHS @AnnJamesNHS

The Trade Union (Facility Time Publication Requirements) Regulations 2017

University Hospitals Plymouth NHS Trust Response for Period 1 April 2020 to 31 March 2021

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to publish within its Annual Report, the questions and information below in relation to trade union facility time.

Table 1
Relevant union officials
What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
49	43.42

Table 2
Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	18
1-50%	30
51-99%	0
100%	1

Table 3
Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£162,620
Provide the total pay bill (as defined by the Trade Union (Facility Time Publication Requirements) Regulations 2017)	£367,163,503
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

Table 4
Paid trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period 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	1.33%

PROUD!

Remote control hearing aid adjustments for people in lockdown
People wearing hearing aids can have their devices adjusted remotely, thanks to new technology rolled out by University Hospitals Plymouth NHS Trust. More than190 adults signed up to this service since infection control measures were implemented at Derriford during lockdown.

Using an app linked to the hearing aid, the audiology department is able to adjust hearing aid settings for people who are in the comfort of their own homes. Adam Beckman, Head of Audiology Services, said: "We were concerned about our patients, having suspended all but emergency appointments, so we started setting up hearing aids remotely and posting them out to patients. "This isn't the normal way we work, but having remote access has meant we can fine tune the sound quality of the device after it has been tried out in the real world.

"This new technology has meant we can continue to help people whilst still maintaining social distancing, reducing traffic to the hospital and even give access to those people who are shielding at home."

The new Danalogic hearing aids link to an app on a smartphone or tablet which is accessed via the cloud in the audiology department.

One patient using the app is 82 year old Edward Gigg from Plymstock who was shielding. He said: "I've found the app very simple to use and didn't have a problem downloading it. It's definitely better than going out during lockdown and I hope that it will carry on after this period to save making journeys back and forth to the hospital.

"I do find an equal benefit is that I am able to alter the programmes via the app on my phone rather than pushing buttons on the actual device."

Plymouth is one of the first parts of the country to use this technology, and other services have been following its lead. There are an estimated 100,000 adult hearing aid users in the south west peninsula. Approximately 2,000 patients are fitted with a hearing aid each year at UHP.

Thank you for your #COVIDKindness

Our Accountability Report

Members of the Board of Directors in 2020/21

Board members' details, together with declarations of their relevant interests and Committee membership, are detailed on the following pages. Directors must comply with the Trust's Standards of Business Conduct Policy and our Fit and Proper Persons Policy and are required to declare any interests that are relevant and material on appointment or which may arise during the course of their term of office.

A register of Board members' interests is maintained by the Company Secretary and is included with every set of public Trust Board papers. At the beginning of March this has been reviewed and a register of interest is being presented at to each sub-committee of the Board.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Act) introduced a 'fit and proper person' test for Directors of NHS organisations. The Trust Board approved a local 'fit and proper person' test in 2015 to enable the Trust to demonstrate that it has the appropriate systems and processes in place to ensure that all new appointees to, and holders of, Director posts, are, and continue to be, fit and proper persons. This process has been updated to incorporate subsequent Care Quality Commission guidance and in November 2020 the Board noted that, in addition to the test being carried out prior to appointment, an annual review and self-assessment demonstrated ongoing compliance with the Act, including the revisions introduced in 2017, and that Board appointees had met the 'fit and proper person' test. At this annual review the Board noted the following fit and proper person annual checks had been undertaken:

Name	Title	Date signed
Ann James	Chief Executive	23 October 2020
Nick Thomas	Deputy CEO/Director of Site Services & Planning	16 October 2020
Kevin Baber	Chief Operating Officer	19 October 2020
Lee Budge	Director of Corporate Business	20 October 2020
Sarah Brampton	Director of Finance	19 October 2020
Lenny Byrne	Chief Nurse and Director of Integrated Clinical Professions	21 October 2020
Steven Keith	Director of People	21 October 2020
Phil Hughes	Medical Director	5 November 2020 - left December 2020
Mark Hamilton	Medical Director	4 January 2021

Table continued...

Name	Title	Date signed
Mark Hamilton	Medical Director	4 January 2021
Joanne Beer	Director of Integrated Care and Partnerships	20 October 2020
Richard Crompton	Chairman	5 November 2020
Bill Boa	Associate Non-Executive Director	16 October 2020
Jacky Hayden	Non-Executive Director	17 October 2020
Elizabeth Kay	Non-Executive Director	17 November 2020
Henry Warren	Non-Executive Director	17 November 2020
Graham Raikes	Non-Executive Director	21 October 2020
Hisham Khalil	Non-Executive Director	10 November 2020
Helen Teague	Non-Executive Director	16 October 2020

Non-Executive Directors

We have six Non-Executive Directors and one Associate Non-Executive Director on our Board during 2020/21. Non-Executive Directors are appointed by NHS Improvement; Associate Non-Executive Directors are appointed by the Trust. The following served on the Board during 2019/20:

V – voting Director
NV – non-voting Director

Richard Crompton, Chairman (V)
Richard was initially appointed in August 2012. A former Chief Constable of Lincolnshire Police, Richard also served with the Metropolitan Police and the former Devon & Cornwall Constabulary. Partnership working has been a constant theme throughout Richard's career and he continues to be closely involved with organisations aimed at improving services, particularly those for the most vulnerable.

Richard was re-appointed in 2016 and 2018, and in 2020 his term was extended for one year. In April 2021, Richard's tenure was extended for a further year from 31 July 2021, which means he will serve with the Trust until 31 July 2022.

Declarations of interest:
- Independent Chairman of the Safeguarding Panel for Dimensions UK, a national provider of a range of services for the learning disabled and autistic.
- March 2021 Trustee, Lifeworks – a Devon based charity providing services to learning disabled children and adults

Bill Boa (Associate, NV)
Bill joined the Board in March 2020 for a two year term. Bill is dual qualified with the Institute of Chartered Accountants in England and Wales and the Chartered Institute of Public Finance and

Accountancy. Bill has worked as Chief Finance Officer/Director of Finance in the acute, mental health, community services and Primary Care Trust sectors and also worked in the former South West Strategic Health Authority. For the last eight years Bill has been self-employed; his company provides financial and consultancy services to the NHS and private sector. During that time has been interim Chief Finance Officer at North Bristol NHS Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Cambridge University Hospital NHS Trust, St George's University Hospital NHS Trust and Barts Health NHS Trust.

Declarations of Interest:

- Founder and Director, Boa & Associates Consultancy Ltd, a limited company providing financial and organisational consultancy services to the NHS. His spouse is also a Director of the company. Current clients include:
  Barts Health NHS Trust – acting as Financial Improvement Director of the Trust.
  Supply Chain Co-ordination Ltd – providing expert finance and organisational advice to this organisation, the co-ordinating body for NHS supply chain services in England.
- Trustee and Treasurer of Arts & Health South West, a registered and incorporated charity: a learning, advocacy, networking and development organisation promoting the value of arts and creativity for the benefit of health and wellbeing.
- Founding Trustee, National Centre for Creative Health, registered charity number 1190515.
- Chair of Audit and Risk Committee, Health Data Research UK, an independent non-profit organisation supported by Government and charitable funding that brings together Universities, NHS organisations, industry partners, patient groups and research institutes across the UK to unite the UK's health data assets to make health data research and innovation happen at scale and to enable discoveries that improve people's lives.
- The Chief Executive Officer of Health Data Research UK is the spouse of a Board Director of The PSC (previously known as The Public Service Consultants), a firm appointed as Strategic Advisor to the Future Hospital Strategic Outline Case. Both individuals are known to Mr Boa. The Chair of The PSC is a long standing former NHS colleague.
- Member of Cornwall & Isles of Scilly Health & Care Partnership Finance and Performance Joint Assurance Committee.

Professor Jacky Hayden, CBE (V)
Jacky brings to the Board a strong track record of medical leadership, both as a general practitioner and as a medical educator. With a clinical background in general practice for more than thirty years, she was the first general practitioner to be appointed as Postgraduate Dean in England and the first female doctor to be appointed as a Regional Adviser in General Practice. Jacky was awarded her CBE in 2013, the same year she was named as one of the Health Service Journal's Top 50 Inspirational Women. Jacky was appointed in October 2016 for four years and in October 2020 her term of office was extended by a further two years.

Declarations of interest:

- President of the Academy of Medical Educators.
- Member of the Council of the Faculty of Medical Leadership and Management.
- Member of the Medical Practitioner Tribunal Service Committee.
- Professor of Postgraduate Medical Education University of Manchester.
- Visiting Professor Lancaster University.

- Associate, General Medical Council.
- Suitable Person for the Medical Practitioner Tribunal Service.
- Ambassador for the College of General Dentistry.

Professor Elizabeth Kay, MBE (V)
Liz was appointed as a Non-Executive Director in October 2019 for an initial four-year term, having served as an Associate Non-Executive Director for the previous three years. Formerly the Foundation Dean of the Peninsula Dental School, Liz is a committed clinician and teacher and a Public Health Academic Consultant working with Public Health England, focusing on the delivery of appropriate care to those who find clinical care particularly challenging. Liz sits on the Editorial Boards of three journals, including the British Dental Journal and peer reviews papers for a large number of other academic publications. In addition, she authors textbooks in collaboration with colleagues from around the world. Liz was awarded her MBE in 2017 for services to dental education.

Declarations of interest:
- President Elect of the British Dental Association.
- Director, Trustee and Immediate Past President, Oral Health Foundation.
- Chair, NICE Guideline Committee for Epilepsies in Children.
- British Dental Association, Health and Science Committee member.
- Trustee and Vice Chair. British Medical and Dental Students Trust.
- Director and Trustee, College of General Dentistry.
- Member of South West Magistrate Recruitment Advisory Committee.
- Editor, Evidence Based Dentistry Journal. Springer Nature Publishing.
- Member, Platform for Better Oral Health in Europe.

Hisham Khalil, (V)
Professor Khalil is a Consultant Ear, Nose and Throat Surgeon with the Trust and Head of the Peninsula Medical School, University of Plymouth. He is the University's nominated Non-Executive Director on our Trust Board and took up this appointment in August 2018 for a period of two years. He was re-appointed for a further two-year term from August 2020.

Declarations of interest:
- Head of Peninsula Medical School, Faculty of Health: Medicine, Dentistry and Human Sciences, University of Plymouth.
- Consultant Surgeon, University Hospitals Plymouth NHS Trust.
- Consultant Surgeon, Nuffield Health Hospital, Plymouth.
- Non-Executive Director, Royal Devon & Exeter NHS Foundation Trust.
- Director, ENT Plymouth Ltd.

Graham Raikes, MBE (V)
With a public sector career spanning over forty years, Graham was formerly the Director of Resources at the Arts and Humanities Research Council. He had a successful military career with the Army and the Ministry of Defence, holding a number of staff and regimental appointments both at home, overseas and on operations and in 1997 was awarded an MBE. He also worked as the Deputy Vice Chancellor (Resources) and Director of Corporate Finance at the University of Plymouth for five years. He has been a Governor at Plymouth Marjon University since November 2017. Graham was appointed in September

2018 for an initial four-year term.

Declarations of interest:
- Chair of Governors, Plymouth Marjon University.

Helen Teague (V)
Helen Teague was appointed as a Non-Executive Director in June 2019 for a four year term. Helen is a proud Plymothian, who returned to Plymouth having worked for a number of years in London. Helen is an experienced HR leader and strategist, seasoned organisational designer and developer and executive coach, having worked as a senior leader, coach and advisor in both public and private sector organisations. Most recently Helen was the Head of Performance and Change at the University of Plymouth before setting up her own business dedicated to organisational development and executive coaching.

Declarations of interest:
- Founder of Raising Doves, a business partnership providing executive coaching and organisational development consulting. Clients and associates include:
  Cornwall County Council
  North Devon Healthcare NHS Trust
  Aduro Consulting
  Skylite Associates
  Invisible Grail
  University of Exeter

Henry Warren (Associate, NV)
Appointed as an Associate Non-Executive Director in April 2013, Henry has brought significant commercial and financial knowledge and experience to the Board, gained over a number of years in public and private practice. A former partner in Deloitte's, more recently Henry became involved with a portfolio of businesses, both as an investor and Non-Executive Director. These businesses are primarily concerned with developing problem-solving technology, such as the provision of renewable energy. Henry was re-appointed in April 2017 and again in April 2019 for a further two year term. Henry left the Trust on 22 April 2021 after completion of his final tenure.

Declarations of interest:
- Chairman and Director of Fluvial Innovations Ltd.
- Chair of Peninsula Dentistry Social Enterprise.

Executive Directors
The Chief Executive is appointed by the Chairman of the Trust and the Chief Executive appoints the members of her Executive team. All eight of our Executive Directors are on permanent contracts.

Ann James, Chief Executive (V)
Ann took up her appointment as Chief Executive in September 2012. As former cluster Chief Executive of NHS Devon, Plymouth and Torbay, her commitment to clinical engagement supported the successful

development of two clinical commissioning groups, recognised at the time as best practice for their collaborative approach. Ann led one of the country's largest primary care trusts as Chief Executive of NHS Devon, where was she CEO of Devon PCT between 2010-2012 and cluster CEO between 2011-12. This followed more than three years as Chief Executive at Cornwall and Isles of Scilly Primary Care Trust.

Declarations of interest:

- Chair, South West Leadership Academy.
- Chair, Southwest Talent Board.
- Member, One Plymouth.
- Chair, National Institute for Health Research Peninsula Partnership Group.
- Member, Plymouth Growth Board.
- Vice Chair, Board of Governors, Devonport High School for Girls.
- The Chair of The PSC (previously known as The Public Service Consultants), a firm appointed as Strategic Advisor to the Future Hospital Strategic Outline Case, is a long standing former NHS colleague. To counter any conflict of interest, perceived or actual, arising from this personal association, I will excuse myself from any decisions on the appointment or performance management of The PSC.

Kevin Baber, Chief Operating Officer (V)
Kevin was appointed in April 2013. Prior to joining the Trust, Kevin was Chief Executive of Peninsula Community Health in Plymouth. Originally qualifying as a nurse in 1986, Kevin was previously Managing Director of Community Health Services for NHS Cornwall and Isles of Scilly. Kevin also has extensive experience in private healthcare, having been General Manager of a large independent hospital in the Nuffield Health Group.

Declarations of interest:
- Member of the Cornwall and Isles of Scilly Health & Care Partnership Transformation Board.
- Employer Member of the SW Sub-Committee of the Advisory Committee on Clinical Excellence Awards.
- Partner is Associate Director, Medicines Optimisation, at Devon Partnership Trust.

Jo Beer, Director of Integrated Care and Partnerships and Interim Chief Operating Officer (NV)
Jo was appointed as Director of Integrated Care and Partnerships in May 2019. A nurse who trained in Plymouth and specialised in critical care, brain tumour nursing and community, Jo has extensive nursing and operational experience across both acute and community organisations and has held Director of Nursing, Operation and Transformation roles in Community Health and Social Care organizations. Jo's previous role was a joint role across acute and community services in Plymouth as Director of Integrated Urgent Care. Jo is a passionate volunteer and regularly travels to Ghana, where she is setting up a Community Outreach programme. Jo has declared no interests over the period covered by this report.

Declaration of interest:
- Trustee of Plymouth Access to Housing.

Sarah Brampton, Director of Finance (V)
Sarah was appointed as Director of Finance in April 2019. Sarah previously worked for the Trust as

Director of Financial Services and Deputy Director of Finance, before taking up the post of Director of Finance at Devon Partnership NHS Trust in March 2013. She was later appointed Deputy Chief Executive there in 2016. Sarah has more than 20 years' healthcare experience and has worked in all sectors of the NHS, including acute, mental health and commissioning.

Declarations of interest:

- Governor at Exeter College and Chair of the Audit Committee.

Lenny Byrne, Chief Nurse and Director of Integrated Clinical Professions (V)
Lenny took up his appointment as Interim Chief Nurse on 25 March 2019 and his appointment as substantive Chief Nurse and Director of Integrated Clinical Professions in April 2019. Lenny was previously Deputy Director of Nursing at The Royal Free Hospital and Associate Chief Nursing Officer at Barts Health. He has also held two Chief Nurse roles in a large London private hospital and more recently in the United Arab Emirates. His specialist nursing field is Haematology and Transplantation, where he has worked at a level of advanced clinical practice. He holds a Master's degree in medical law and has held a number of corporate roles supporting the adult and child safeguarding agendas, as well as supporting the implementation of the Mental Capacity Act in clinical practice for the benefit of patients. Lenny has declared no interests.

Declarations of interest:
None

Lee Budge, Director of Corporate Business (NV)
With a background in public finance and audit, Lee joined the Trust from the Audit Commission in April 2011 at the conclusion of a period of secondment. Lee leads on Board risk and assurance, regulatory compliance, health and safety, information governance and corporate business and is the Board's Senior Information Risk Owner. Lee left the Trust in December 2020

Declarations of interest:
- Trustee of Plymouth Access to Housing.
- Member of a band which fundraises on behalf of St Luke's Hospice, Plymouth.

Mark Hamilton (V)
Mark joined the Trust as a Consultant in January 2021. Mark undertook his training at St. George's Hospital Medical School and qualified in 1994. Since 2006, he has been a Consultant and Honorary Senior Lecturer in Anaesthesia & Critical Care Medicine at St. George's University Hospitals NHS Foundation Trust and Medical School. Alongside this, Mark became a member of the Governing Body of Surrey Downs CCG in 2013 and in 2016 a member of the Governing Body of Lewisham CCG. In April 2017, Mark was appointed as a part-time Medical Director for CSH Surrey, an organisation that was the first of its type in the country. From this, he moved to become Executive Clinical Director of the Surrey Heartlands ICS Academy. In 2014, Mark became the Clinical Director for Adult Critical care and the Clinical Lead for the Perioperative Assessment & Planning Unit at St George's, before being appointed as the Associate Medical Director for Quality Improvement & Clinical Transformation in 2016. He was also the Co-Director of Evidence Based Perioperative Medicine

Declarations of interest:
None

Phil Hughes, Medical Director (V)
Phil joined the Trust as a consultant in 1993, having trained in London and Manchester. He is a senior examiner for the Royal College of Radiologists and an Executive Member of the British Society of Skeletal Radiologists. Phil has previously been the Trust's Clinical Director for Imaging, Associate Director of Planning and Assistant Medical Director. Phil was appointed Medical Director in November 2013. Phil left the Trust in December 2020.

Declarations of interest:
None

Steven Keith (NV)
Steven joined the Board in February 2016 as Director of People. Steven is the Trust's Executive lead for staff engagement, our organisational development and employment strategies, and workforce planning. He is also responsible for providing professional human resources and organisational development advice and support to the Trust Board. Steven works closely with other Directors, senior managers and clinicians to ensure that we have the right staff in the right place, with the right skills to support the delivery of high quality care to our patients.

Declarations of interest:
- Member of Plymouth Employment and Skills Board as a representative of the Health sector.

Nick Thomas, Director of Site Services and Planning (NV)
Nick joined the NHS in 1984, became a member of the Chartered Institute of Public Finance and Accountancy in 1988, and was subsequently an examiner for that organisation for a number of years. Nick joined the Trust in 1994 as Deputy Director of Finance and holds Director portfolios for Information Management & Technology (IM&T) and Planning & Site Services. He joined the Board in October 2013. Nick was appointed Deputy Chief Executive in October 2015. Nick left the Trust in March 2021.

Declarations of interest:
- Non-Executive Director, Plymouth Science Park Ltd.
- Member of GS1 UK Healthcare Advisory Board

Non-Executive Directors	Meetings attended
Richard Crompton	10 of 10
Bill Boa	10 of 10
Jacky Hayden	10 of 10
Elizabeth Kay	10 of 10
Hisham Khalil	9 of 10
Graham Raikes	9 of 10
Helen Teague	10 of 10
Henry Warren	10 of 10

Executive Directors	Meetings attended
Ann James	10 of 10
Kevin Baber	9 of 10
Jo Beer	10 of 10
Sarah Brampton	10 of 10
Lenny Byrne	10 of 10
Lee Budge	10 of 10
Phil Hughes	10 of 10
Steven Keith	9 of 10
Nick Thomas	9 of 10

Directors' attendance of public board meetings in 2019/2020
The Board met in public on seven occasions during the year. Agendas, papers and declarations of interest are published on the Trust's website. The Board also holds confidential meetings from which the public are excluded for reasons of commercial or personal sensitivity.

Board evaluation and effectiveness
The Board held regular development sessions during 2020/2021 with the aims to:
- Maximising our influence
- Enhancing our knowledge
- Maintaining our visibility
- Developing our skills

Among the topics covered in Board Development during 2020/21 were:
- Ensure that the Board is fully briefed on latest developments relating to Covid-19
- Opportunity to share concerns over delivery in the context of current challenges
- Develop an understanding of demand and capacity modelling and recovery implication
- Consider how the Trust Board might make better use of digital technology going forwards
- Review progress in responding to CQC's inspection report with a particular focus on the issues and actions relevant to the well led domain
- Discuss and agree how we will implement our Board development proposal and use time together to best effect over the next few months
- Discuss and agree how we will take forward the Equality and Diversity agenda over the coming months
- Ensure the Trust Board is sighted on the most recent capital developments and agree how we will maintain oversight of this over the coming months
- Ensure that we all have a common understanding on the core principles of effective Board Assurance Frameworks
- Review and reflect on the approach to developing the 'safe staffing' section of the Board Assurance Framework
- Develop a comprehensive understanding of the national requirements for Phase 3 of the NHS

response to Covid-19
- Develop an understanding of national cyber security issues and develop the Boards skills in discharging its responsibilities in this regard
- Develop an understanding of the key principles associated with developing a risk appetite
- Introduction to BAME Network leaders and agreement of how the Board can best support them in their leadership of it
- Agreement of Non-Executive Directors' information/support requirements and of subjects for Board Development in the coming 12-18 months
- To familiarise the Board with the national HIP2 digital blueprint and the transformation agenda
- Introduction to the Women's Network Leaders and agreement of how the Board can best support them in their leadership of it
- Further consideration of the financial position of the Trust
- Agreement of the Boards priorities for 2021/22 in the context of a complex external environment

Standing Committees of the Board
Our Board has seven sub-committees, six of which are chaired by Non-Executive Directors. They are:
- Audit
- Remuneration
- Finance & Investment
- Safety & Quality
- People & Culture
- Charitable Strategic
- Research

Audit Committee
The Audit Committee ensures that an effective system of internal controls is in place and maintained. Independently of the Trust Board, it reviews and scrutinizes the Trust's objectives and the associated risks and controls set out in the Board Assurance Framework. A Committee comprised only of Non-Executive Directors, it met on seven occasions during the year and is chaired by Graham Raikes. Along with the chair, the core members are the chairs of other Committees of the Board. All Non-Executive Directors,

Non-Executive Directors	Meetings attended
Graham Raikes	7 of 7
Jacky Hayden	5 of 7
Elizabeth Kay	1 of 7
Helen Teague	4 of 7
Henry Warren	7 of 7
Bill Boa	5 of 7

with the exception of the Chair, receive papers and may attend if they wish. The Directors of Finance and Corporate Business regularly attend and all other members of the Executive team routinely receive papers and attend when the agenda demands.

Non-Executive Directors' attendance at Audit Committee meetings during 2020/21 was:

Remuneration Committee
This committee oversees the performance and remuneration of the Executive team. It is comprised only of Non-Executive Directors and all of our Non-Executive Directors are members of it. It is chaired by Graham Raikes. It met on four occasions during 2020/21. The discussions included arrangements for

Non-Executive Directors	Meetings attended
Graham Raikes	4 of 4
Richard Crompton	4 of 4
Jacky Hayden	4 of 4
Liz Kay	4 of 4
Helen Teague	2 of 4
Henry Warren	4 of 4
Bill Boa	4 of 4
Hisham Khalil	3 of 4

interim Chief Operating Officer; Executive restructure proposals; Executive Director and Chief Executive appraisal; VSM pay.

Members' attendance at Remuneration Committee meetings during 2020/21 was:

Finance and Investment Committee
This Committee oversees the Trust's financial risks, the development and delivery of the financial

Core NED/Executive Member	Meetings attended
Henry Warren, Chairman	12 of 12
Graham Raikes	12 of 12
Bill Boa	9 of 12 (joined part way through the year)
Chief or Deputy Chief Executive	10 of 12
Director of Finance	12 of 12
Chief Operating Officer	10 of 12

elements of the Trust's strategic and operational plans, monitoring performance against NHS Constitution standards and overseeing capital plans for the maintenance and development of the hospital. Henry Warren is the Committee's Chairman. Other Non-Executive members in the period were Graham Raikes and Bill Boa. This Committee meets monthly. Board members' attendance during 2020/21 was:

Safety & Quality Committee
This Committee is responsible for overseeing delivery of the Trust's quality plans and providing assurance to the Board on the key safety and quality risks. It met seven times in 2020/21 and is chaired by Jacky Hayden, Non-Executive Director. Board members' attendance during 2020/21 was:

Core NED/Executive Member	Meetings attended
Jacky Hayden, Chair	7 of 7
Henry Warren	5 of 7
Chief Operating Officer	4 of 7
Chief Nurse or nominee	6 of 7
Medical Director or nominee	6 of 7

On the occasion when the Chief Nurse was not present the Deputy Chief Nurse attended. On the occasion when the Medical Director was not present the Assistant Medical Director attended.

People & Culture Committee
This Committee oversees delivery of the Trust's people objectives, addresses our key people risks, delivery of our People Strategy and has oversight of HR policies. It met on seven occasions during the year and is currently chaired by Helen Teague Non-Executive Director. Board members' attendance during 2020/21 was:

Core NED/Executive Member	Meetings attended
Helen Teague	6 of 7
Elizabeth Kay	6 of 7
Director of People	7 of 7
Chief Nurse or nominee	6 of 7
Medical Director's nominee	0 of 7

Research Committee
This Committee has not met during the period covered by this report.

Charitable Strategic Committee
The Plymouth Hospitals General Charity was registered with the Charity Commissioners for England and Wales on 27 July 1995 under a Model Declaration of Trust for an NHS umbrella charity where the Trust acts as sole corporate trustee.

The Charity Strategic Group is chaired jointly by Executive Directors Lee Budge and Kevin Baber and it has met five times during 2020/21. Membership is drawn from across the Trust and includes the independent, external Chair of the Charity Operational Group.

PROUD!

The Duke of Cambridge thanks staff for their work during the pandemic

On Thursday 11 February, Patient Services Manager, Claire Jukes received a phone call from the Duke of Cambridge. His Royal Highness, Prince William spoke one-on-one with Claire about the work she and the Patient Experience team have been doing during the COVID-19 pandemic. The team have worked with families who have been unable to visit their loved ones in hospital, including organising iPads to be distributed to wards, facilitating Zoom calls, ensuring patients receive possessions from home and supporting bereaved relatives through challenging times. Since the beginning of the pandemic, visiting in the hospital has been restricted to help reduce the spread of the virus. Claire worked tirelessly to ensure wards had access to iPads to speak to their loved ones. Claire shared with the Duke of Cambridge that her Grandmother had a stay in hospital last year and was moved to a care home before she sadly passed away. "Having continued communication is so important," said Claire. "I could really resonate with families who had loved ones in hospital and the need for connection."

Claire worked with the Communications Team and IM&T to get the iPads up and running. "I really want to thank everyone involved. The IM&T team were really responsive; Ryan Yeoman and Jocelyn Elmes in particular were brilliant making sure everything went smoothly."

Claire has also been coordinating the volunteers to help the hospital during the pandemic. "We have volunteers helping in the mass vaccination centres, our discharge lounge and helping to distribute face masks to all visitors coming to the hospital. The response from the local Plymouth community has been heart-warming. Volunteers have been desperate to do something to help and despite how busy everyone is, staff across the Trust have been coming forward to help too. I'm just a small part of a big team who have been fantastic throughout. The work we've done wouldn't have happened without them".

"I was genuinely touched to be chosen for the call. It was lovely to speak to Prince William; he was so down to earth and genuinely interested, it absolutely made my day."

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the policies, aims and objectives of University Hospitals Plymouth NHS Trust ('the Trust'), 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 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 Trust Accountable 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 the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Towards the end of the 2019/20 financial year, the Trust, along with the wider NHS, began developing plans for responding to the spread of Coronavirus (COVID-19). This required an unprecedented response from clinical and managerial teams during 2021/21 and temporary changes to our governance arrangements. All of these changes are fully documented and in accordance with national guidance, and described in this Statement.

Capacity to handle risk

The Trust's Board ('the Board') is supported by a number of committees which review the risks and assurances associated with different aspects of the Trust's responsibilities. These are:

- Audit Committee
- Remuneration Committee
- Safety & Quality Committee
- Finance & Investment Committee
- People & Culture Committee
- Future Hospital Committee.

The Future Hospital Committee was established in 2020/21 to oversee the creation of a future hospital blueprint, ensuring that models of care are truly patient centric, digitally enabled, financially sustainable, and delivered in facilities appropriate for modern health care. This will also provide assurance to the Board with regard to the backlog maintenance risk mitigation activities across the estate and will monitor the compliance of the current hospital infrastructure with statutory and quality performance standards.

The terms of reference for each committee are reviewed and approved by the Board at least annually. Each committee is chaired by a Non-Executive Director. Committee attendance for each Non-Executive and Executive Director is summarised in the Accountability Report of the Trust's Annual Report and Accounts. Each of the Board's Committees has reviewed and refreshed its risks and priorities alongside the Board Assurance Framework (BAF).

Clinical leadership remains a central part of our governance architecture as it helps us remain focused on our primary goal of delivering high quality care. Accordingly, the Trust is organised into a series of business units known as 'Service Lines'. Each Service Line is aligned to one of four 'Care Groups' which are led by a triumvirate of Care Group Director (Medical), Care Group Manager and Associate Chief Nursing Officer or equivalent. The Care Group triumvirates work closely with the executive triumvirate of Medical Director, Chief Nurse and Chief Operating Officer and meet weekly to manage the Trust's activities. The Care Groups form part of the wider leadership team for the Trust meeting formally through the Trust Leadership Group. Leadership is given to the risk management process at Care Group Level through performance reports, which are produced by Risk & Incident Managers each month and circulated to the Care Groups, the Chief Nursing Officer and the Medical Director. These reports set out their performance on key aspects of risk management practice and are discussed at Care Group Quality Assurance Group (QAG) meetings and disseminated to service lines for review. Updates from each of the Care Group QAGs are reported to the Quality Assurance Committee (QAC) on a quarterly basis.

The risk and control framework

The Trust's Risk Management Framework ('the Framework') was last reviewed and approved by the Board in November 2020. The Framework sets out the key responsibilities for the management of risk and seeks to ensure that the risks to the achievement of the Trust's objectives are understood, reported and appropriately mitigated.

The BAF is the key strategic tool for the management of risk and assurance. The BAF enables the Board to demonstrate how it has identified and met its assurance needs in relation to the delivery of the Trust's objectives. It includes:

- GA description of the risks identified that pose a threat to the delivery of each of the Trust's strategic objectives.
- For each risk, the Executive owner and the committee responsible for assessing the adequacy of arrangements and controls in place to provide assurance that risks are appropriately monitored and managed/mitigated.
- Sources of evidence to substantiate whether or not the risk is being effectively managed and/or mitigated and actions being taken to address gaps in controls and sources of assurance.
- An 'assurance rating' to indicate the strength of assurance in respect of each risk.

Furthermore:

- The Board and its committees review the BAF frequently. The BAF was presented to the Board six times (five times in public and once in private) during 2020/21. Actions required to mitigate risks or improve the level of assurance are identified and incorporated within the forward work programme of the relevant committee.
- The Audit Committee reviews aspects of the assurance framework no less than four times a year to satisfy itself that appropriate systems of control are being maintained.

- There is an interface with the Corporate Risk Register, through which principal risks are added to the BAF and are monitored by the Board.

Key risks to the achievement of our objectives have been regularly reviewed and updated throughout the year by the Board and its committees. In 2020/21, the Trust's principal risks to delivery of our strategic objectives related to the following:

Delivering safe, high quality services	• Patient Safety • Patient Experience • Clinical Effectiveness • Mortality • CQC Compliance • Infection Control • External reviews
Workforce - Valuing our people	• Staffing • Culture • Staff Wellbeing • Education, training and development
Sustainability - Providing services in a sustainable way	• Medium Term Sustainability • Infrastructure • Securing Operational Delivery • Capital Programme • Value for Money
Partnerships – working with partners across our communities	• Integration
Governance -maintaining strong governance	• Health & Safety • Information Governance • COVID-19

During the early phases of the pandemic the Trust maintained a separate COVID BAF and a specific principal risk on the BAF, but in February 2021, it was agreed that rather than continue with one specific COVID principal risk, all BAF risks would be viewed through a COVID lens, reflecting the broad and varied impacts that COVID is having on our routine activities and enabling the BAF to better reflect the differential impact that COVID is having on the various aspects of the Trust operations.

An internal audit report in December 2020 gave 'satisfactory assurance' on the BAF, as well as setting out a number of recommendations to help move to a 'significant assurance' rating, which are now being taken forward.

The BAF has been refreshed for 2020/21 and updated to reflect the risks arising from or exacerbated

by the post COVID world in which we are now operating. The new BAF has a clear focus on the risks relating to the restoration of services and the recovery of performance, and better reflects our position as part of wider health and care systems. Most of our principal risks continue. However, in view of the assurances about the effectiveness of our controls, the principal risks relating to health and safety and information governance have been removed from the BAF, and there has been a reframing of quality and safety risks.

Discussion at Board, Committee and in Board Development Sessions has reinforced the importance of the BAF as a risk management tool, and helped to strengthen the skills of the Board in using the BAF effectively.

Quality governance

The Trust has comprehensive quality governance arrangements in place. This includes regular reports to the Board and its committees showing the Trust's performance across a wide-range of safety and quality metrics.

The Quality Assurance Committee ('the QAC') oversees the patient quality and safety agenda of the organisation and provides assurance on the same to the Safety & Quality Committee and to the Board.

The QAC convenes monthly to review and understand the Trust's current position on all matters pertaining to patient safety, identifying and responding to areas of concern and ensuring best and safe practice and service delivery for patient care. Through a quarterly cycle it focuses on the various areas of risk, quality, safety, experience and quality governance:

- Month 1: Corporate oversight with a focus on Trust quality governance, safety and risk including: risk register, incidents, Serious Incidents Requiring Investigation (SIRIs), action logs, harm free data, complaints, patient experience, infection control, audit, alerts and guidance (detailed review of core components of the integrated report and regulatory compliance assessments/position).
- Month 2: Focus on detailed service line quality governance reporting through Care Group reviews.
- Month 3: Reporting and feedback on core subject matter from clinical and professional committees.

The QAC receives reports which provide an overarching view of quality governance. This provides a themed approach to ensure cross sectional analysis and review of the core quality governance position both corporately and through Care Groups and professional committee perspectives.

As part of the routine 2020/21 audit plan, the Trust's internal auditors reviewed the Trust's risk management arrangements and underpinning systems as providing satisfactory assurance and concluded that the Trust has implemented an effective programme of change designed to reconfigure the quality governance framework, which has improved the flow of assurance within the organisation.

CQC inspection findings

The lst full inspection by the Care Quality Commission (CQC) took place in September 2019, with the report published in December 2019. The Trust was rated as 'Requires Improvement' overall for its services based upon 33 Must Do critical actions, of which 5 are duplicated (Must Do actions N=28) and 57 Should Do actions, of which 14 are duplicated (Should Do actions N=43). As part of the wider plan relating to ongoing CQC compliance an action plan to address both our Must Do and Should Do actions

was agreed.

The Trust's rating for each of the domains assessed by the CQC remains unchanged as described below:

- Safe - Requires improvement
- Effective - Requires improvement
- Caring - Outstanding
- Responsive - Requires improvement
- Well-led - Requires improvement
- Overall - Requires improvement

Progress against delivery of the Must Do and Should Do actions has been monitored on a monthly basis by the Quality Assurance Committee, with onward reporting to the Safety & Quality Committee and Trust Board. The Trust is committed to the delivery and sustainability of all actions identified as part of the 2019 CQC Inspection. During May and June 2021 all Must Do and Should Do actions were reviewed by the nominated executive lead for assurance of sustained improvement, recognising the challenges and changes required when responding to COVID and the operational pressures faced in the recovery phase of the pandemic.

Of the 28 Must Do actions, 23 confirmed the previous assessment of fully compliant and the expected outcome has continued to be sustained. Following the review, two of the original 25 fully compliant Must Do actions have been identified as not progressing as expected and have been indirectly impacted by operational pressures; these will be monitored for sustainable improvement.

A further unannounced CQC inspection took place on 8 March 2021, which focused on Diagnostic Imaging and the Emergency Department. The inspection report was received on 19 May 2021, after the end of the reporting period. No change to overall ratings was made but Well Led and Safe ratings for Urgent and Emergency Care (UEC) decreased, and a section 29A Warning Notice was issued relating to UEC.

The inspection of Diagnostic Imaging resulted in largely positive feedback. The CQC team found a positive culture within the department, and the focus for the department is to sustain the improvements. A process of ongoing improvement was evident in this service and staff were committed to continually learning and improving services for patients. The diagnostic imaging service had been through several continuous improvement changes since the Trust's last inspection in August 2019, and this process was still ongoing at the inspection in March 2021.

In the Emergency Department, inspectors raised concerns about flow through the department, oversight of safety of patients waiting to be seen and crowding.

Following the inspection immediate action was taken to address the concerns raised and assurances provided to the CQC. This work has continued to provide demonstrable and sustained improvement as a result of the CQC Action Plan which is aligned to the existing UEC restoration plan.

In addition to the urgent actions taken following the CQC inspection, the report identified four Must Do recommendations in UEC as shown below:

- Ensure patient care and treatment is provided in a safe way and risks are being fully mitigated while patients wait to access the Emergency Department. Ensuring there is adequate oversight and responsibility of the patients who are waiting to be seen, while they wait in ambulance queues or walk into the Emergency Department, and they are seen in priority based upon their clinical need. Regulation 12(1)(2)(a).
- Ensure patients are safe while they wait in crowded areas. To include appropriate protection in line with COVID-19 infection prevention and control guidelines and for staff to be clear on how they monitor patients while they wait in these areas. Regulation 12(1)(2)(h).
- Ensure the appropriate personal protective equipment is always used by staff to reduce the risk of infection and prevent and control the spread of infection. The Trust must ensure staff are maintaining good levels of infection prevention and control, to include wiping down surfaces and computers following use. High levels of cleaning should be maintained within the emergency department. Regulation 12(1)(2)(h).
- Ensure the mitigations, in the absence of a full-time paediatric emergency medicine consultant, are effective to ensure children are provided with care or treatment by clinical staff with the correct qualifications, competence, skills and experience to do so safely. The trust should ensure there is clear allocation of medical cover (or equivalent) for the paediatric department and timely response to emergencies. Regulation 12(1)(2)(c).

A further 11 Should Do recommendations, 2 in Diagnostic Imaging and 9 in UEC, were made including issues relating to recruitment, safeguarding training, mental health provision and infection control practices. An action plan to address the Must Do and Should Do recommendations has been developed and is aligned to the existing improvement plan agreed following the external UEC Review.

The QAC receives a monthly update on progress of delivery of the action plan with onward reporting to the Safety & Quality Committee (SQC) and Trust Board. There is a rolling plan of meetings with the CQC lead, Associate Chief Nursing Officer, Associate Director of Clinical Professions and Care Groups to gain assurance of progress against the actions. The CQC Insight dashboard will be utilised alongside the self-assessment reports to Care Groups. These reports are then presented to the QAC and SQC. The Audit and Assurance team will support peer audits that reflect CQC-type inspections and outcomes will support service lines on their improvement journey.

The Trust is fully registered with the CQC across all of its locations and will monitor compliance across all of the fundamental standards through routine internal CQC self-assessment meetings.

We continue to monitor, review and constantly improve the quality and safety of care across the services that we provide.

Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. This is reviewed by the Board and the Safety & Quality Committee to ensure that it represents a balanced view and that there are appropriate controls in place to ensure the accuracy of data contained within it. In previous years, the Quality Account would form an integrated part of the Annual Report, however publication timeframes are not aligned in 2021 and it will therefore be published as a separate document. The Trust

plans to publish its Quality Account on 30 September 2021.

Management and control of data security risks

The Caldicott and Information Governance Assurance Committee (CIGAC) is responsible for providing oversight of the Trust's Information Governance responsibilities including information risk. CIGAC is chaired by the Director of Finance who is the Trust's Senior Information Risk Owner (SIRO) and is the Board member responsible for overseeing the Information Governance of the Trust and owning information risk.

Ownership for the Trust's information assets is devolved further to senior staff who are Information Asset Owners (IAOs).

Information Governance risks are recorded on the Trust Incident Reporting System (DATIX) under the following categories:

- Information Governance
- IT Security
- Data Quality
- Health Records

The majority of these risks form the SIRO risk register. A regular report of open risks and the associated action plans is taken to CIGAC.

The Trust completes NHS Digital's Data Security and Protection Toolkit which provides assurance that the Trust is practicing good data security. The Trust's submission is audited each year by its internal auditors.

Management and reporting of Information Governance incidents

All information governance incidents are recorded on DATIX. Incidents are scored by the Information Governance (IG) team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital. Incidents are categorised as either low impact incidents (very low in severity), local investigation incidents (investigated by the IG team with recommendations and lessons learned) or reportable incidents (which are reported to the Information Commissioner's Office). In 2020/21 there were five reportable incidents made to the Information Commissioner's Office, as follows:

- A patient who works for a GP Practice had two clinical letters sent to their place of work rather than their registered GP Practice.
- A patient was contacted by a member of the public explaining they had received the patient's appointment letter as it was incorrectly posted to them.
- A number of patients have received letters from the hospital with other patients' letters printed on the back.
- A clinic letter that should have been sent to a patient's school was sent to a member of the public.
- Evidence was found that a staff member had viewed healthcare data and disclosed it inappropriately.

The Trust has cooperated fully with the Information Commissioner's Office, which has welcomed the

remedial actions taken such as additional training for staff and implementing technical safeguards through liaison with our IT provision. The Trust continues to actively raise Information Governance awareness and encourages the reporting of incidents.

Data quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement. The Trust monitors the quality and accuracy of data in a number of ways:

- The Data Quality Steering Group utilises the Trust's internal data quality summary reports and external dashboards to monitor key indicators;
- Each service line has a Data Quality Champion, who ensures their area is performing in accordance with the required standards. Detailed guidance is in place to support this work;
- Data quality is usually audited annually by Internal Audit. No audits were carried out during 2020/21 due to COVID restrictions but plans are being put in place for an audit this year. Audits in previous years have included Referral to Treatment (RTT), Emergency Department waiting times, Cancer performance standards and Stroke indicators;
- n July 2020, all Trusts were mandated to send their entire list of RTT incomplete pathways (patients actively waiting for first or subsequent treatment) to a national team. These pathways were then validated by a system named ClearPTL. Feedback from this process has further driven data quality improvements.
- A weekly RTT Huddle examines data quality issues and identifies specialty level problems. This leads to assistance being provided to operational teams to help improve processes, including delivery of training and deep dives;
- Oversight of assurance around the accuracy of data by the relevant committees through the framework provided by the BAF (for example, the QAC monitors the triangulation of patient safety data).
- With regard to national data quality validity and benchmarking, the trust performs consistently highly for data quality assurance on submissions to the Secondary Uses Service (SUS) for data quality assurance.

Workforce arrangements

The Trust has a number of arrangements in place to assess whether staffing processes are safe, sustainable and effective. This includes daily ward staffing review meetings, weekly forward look on ward rota gaps, regular reports to the Trust Board on safe staffing and the work of the Guardian of Safe Working Hours.

The People and Culture Committee has been overseeing compliance with national 'Developing Workforce Safeguards' requirements on behalf of the Board throughout 2020/21. The committee received a report on this in January 2021 which highlighted that whilst there is robust assurance around the methodology used to calculate safe numbers of frontline nurses, in other staff groups, there is a lack of national guidance beyond Royal College publications. Further work is continuing with senior clinicians within the Trust to strengthen the level of assurance in non-nursing staff groups with a particular emphasis on medical staff. Work to date has focussed on the junior medical establishment and ability to meet the demand due to the impact of contractual changes to rest periods, maximum consecutive

days and self-development time, as well as annual leave and study leave. Financial modelling is currently underway with the Medicine Specialties to increase capacity in recognition of this predictable demand on rotas, and thereby reduce continued reliance on the Trust locum bank to fill rota gaps. In addition, a review of e-rostering has been undertaken and a programme of work has commenced to interface junior doctor rota templates and rosters which will assist with assurance that doctors are being rostered effectively, supporting earlier and more informed resourcing decisions.

The Chief Nurse is leading a review of non-medical clinical establishments. This continues to be identified as a key risk with the Board Assurance Framework and, as such, is being reviewed by the Board.

The Trust has adopted the national Core Skills Framework for mandatory training. This means that we follow the nationally prescribed modules for the training required by all staff, which enables greater consistency, ease with passporting of staff mandatory training between organisations, and as far as is possible, minimises the burden on staff.

The nationally prescribed Mandatory Training content in relation to the Core Skills Framework subjects covered are:

- Equality, Diversity and Human Rights
- Health, Safety and Welfare
- NHS Conflict Resolution
- Fire Safety
- Infection Prevention and Control
- Moving and Handling
- Safeguarding Adults
- Prevent Radicalisation
- Safeguarding Children
- Resuscitation
- Information Governance.

These each appear on our Mandatory training dashboard and are reported to Trust Board as part of the Integrated Performance Report (IPR).

NHS Provider Licence

NHS Trusts are subject to the equivalent of certain provider licence conditions under NHS Improvement's ('NHSI's') Single Oversight Framework. The Board has reviewed its compliance with these conditions and continues to monitor its corporate governance arrangements with assurance being presented through the Audit Committee to the Board.

The Trust has been in 'Segment 3' of NHSI's System Oversight Framework (SOF) since December 2016 and as such, is subject to mandated support. In late 2018, NHSI completed an exercise to formalise the nature of this support for all NHS trusts in Segment 3 (mandated support) and 4 (special measures) by agreeing a series of 'undertakings' with each of these trusts. These 'undertakings' set out the actions which the organisation must take in order to address its challenges. The Undertakings for the Trust cover specific requirements in each of the following key areas:

- Financial sustainability.
- Operational performance.
- Quality of care.
- Governance.

The enforcement Undertakings are published on NHSE/I's website.

The Board has received updates on progress in complying with the Undertakings, with clear action plans, mitigations to risk and measures of compliance to be delivered. Significant work has already taken place to strengthen governance and internal system of control in response to the Undertakings. This has included:

- Strengthening quality governance reporting arrangements, including reporting lines, processes, reporting data and new roles of Associate Directors in the Care Groups and a deputy Chief Nursing Officer to oversee governance;
- Establishing a Corporate Recovery Unit (CRU) to enable the formation and delivery of a three-year recovery plan (see section below);
- A refresh of performance reporting currently underway;
- Strengthening of senior leadership capacity to ensure that we are optimally equipped to respond to the challenges and opportunities of 2021/22. I have already recruited a Company Secretary and Chief of Staff to bolster our corporate governance arrangements, and created a new Future Hospital Director role responsible for leading the planning of the future hospital, ensuring models of care are patient centric, digitally enabled, financially sustainable and delivered in facilities appropriate for future health care needs. We have also recently established a Director of Strategy role who will work closely with the Devon and Cornwall & Isles of Scilly Integrated Care Systems. The Trust is also recruiting to a new Deputy Chief Operating Officer; and
- The commissioning and on-going delivery of a high performing Board development programme from NHS Providers.

Responding to COVID and the challenges of recovery are impacting on some Undertakings requirements, particularly in relation to some of the operational performance requirements and compliance with Constitutional Standards. The Undertakings are a regular focus of the Trust's System Oversight Meetings with NHSE/I and system partners. Work is currently being finalised, led by the Trust, to agree with NHSE/I Measures of Compliance to be achieved for each Undertaking, and future updates will focus on progress towards these measures.

In May 2021, we completed an annual self-certification of our compliance with Conditions G6 and FT4 (Corporate Governance Statement) as part of our overall corporate governance arrangements. The Trust's Undertakings relate to Condition FT4 of the Licence, with which we recognise we are not yet able to certify full compliance. Updates on meeting the Undertakings requirements will continue to be reported to the Trust Board as well as the System Oversight Meeting with NHSE/I.

Managing conflicts of interest

Further progress has been made to embed the requirements of the guidance on Managing Conflicts of Interest in the NHS, with an agreed move to a declarations module for our Electronic Staff Record (ESR) system. This will facilitate publication on the Trust's website of its register of interests for decision-

making staff, and be introduced shortly alongside the launch and promotion of the refreshed policy on Standards of Business Conduct. In the meantime, the Trust continues to capture declarations of gifts, hospitality and interests manually and records declarations of interest for all Board meetings.

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 legislation

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

Climate change

The Trust has undertaken risk assessments and in 2020 the Board approved a sustainable development management plan, known as the Green Plan, which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has established arrangements for reviewing and improving economy, efficiency and effectiveness in the use of our resources.

The Corporate Recovery Unit (CRU) was established to oversee delivery of the Trust wide programme in response to operational and financial recovery with a £20m per year targeted financial delivery, over 3 years a £60m financial benefit programme (as designed prior to Covid-19), led by the Director of Finance. CRU is a programme with 20 separate workstreams each with an Executive lead It includes a Service Line Productivity workstream which uses Model Hospital benchmarking to support areas of financial variance, and use of supporting data including Getting it Right First Time (GIRFT) https://www.gettingitrightfirsttime.co.uk/ (through the Model Hospital metrics, UHP speciality GIRFT reports, and National GIRFT best practice reports) to support clinical efficiency and productivity opportunities to aid structure to service delivery. Other workstreams include:

- Medical workforce and nursing workforce: Both have had a particular focus on use of discretionary pay, in release of financial benefits to ensure resources are used as effectively as possible in delivery of a sustainable workforce. As at September 2020, the Model Hospital shows that the Trust was the second lowest in the country for our registered nurses' use of agency spend as a percentage of total pay costs.
- Imaging: Focusses on the reduction of outsourcing costs, which will be reduced through access to increased capacity, along with productivity and efficiency gains including structure of workforce and enablement of national workforce recommendations on working at the top of licence (e.g. increased percentage of radiographer x-ray reporting, and home reporting).

There was no annual Use of Resources external assessment undertaken in 2020/21 due to COVID, but

assessments have otherwise been undertaken annually. The Trust has had two assessments to date, the latest being in 2019. Both assessments since this new domain was introduced have received a "Requires Improvement" assessment, with the assessment weighted on overall operational and financial performance. It is expected that these will commence again nationally.

The CRU has been recently reviewed through internal audit for our governance (Part 1 review) programme management, and assurance of delivery (Part 2 review) that focussed on four selected workstream deep dives. Both assessments were "satisfactory". The programme has delivered £10.3 million of Financial Improvement Plan benefit in 2020/21, of which £7.0 million is recurrent, and £3.3 million is non recurrent. A report from the CRU is presented to the Financial Investment Committee (FIC) monthly.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and committees of the Board. Executive Directors who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by the Head of Internal Audit Opinion which states that satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives at risk. In particular, limited assurance reports were issued in respect of safeguarding Was Not Brought (Did Not Attend) policy (clinician compliance) and use of volunteers. Recommendations are being implemented to address these weaknesses, as overseen by the Audit Committee.

Significant issues

We have much to be proud of in the quality of care that we give to our patients but continue to face significant challenges in a number of key areas. During 2020/21, the Trust faced unprecedented levels of pressure in responding to the COVID-19 pandemic whilst maintaining urgent and emergency care, and ensuring our patients remain safe and our staff well supported. We are now focusing on the challenges of restoring non-COVID care and recovering our operational performance, at the same time as delivering a COVID vaccination programme of unparalleled scale and complexity.

The most significant internal control issues facing the Trust in 2020/21 may be summarised as follows:

- Ability to respond to operational pressures: COVID has exacerbated existing operational challenges and had a significant impact on elective pathways as a result of cancellation of surgery either based on national guidance, infection control requirements or due to COVID related pressures. In addition whilst the Trust saw a decrease in overall demand during COVID, the level of acuity and complexity has increased and the Trust has experienced post lockdown surges as a result of patients either being unable or unwilling to access treatment during the height of the pandemic. This has had a major impact on our delivery of constitutional standards and our ability to achieve a number of key performance standards. As the Trust moves forward with its plans for restoration and recovery, we are also aware of an as yet unquantified risk of further post lockdown surge in demand as well as potential further COVID outbreaks. , The Trust is in the process of agreeing revised improvement trajectories with NHSEI and also responding to an external review of Urgent and Emergency Care which has set out a number of recommendations to support the Trust's restoration programme.
- CQC compliance: The Trust was subject to an unannounced CQC inspection in March 2021, which focused on Diagnostic Imaging and the Emergency Department (as described earlier in this statement).

The Urgent & Emergency Care restoration plan in place prior to the CQC visit was addressing these issues but the Trust brought forward and rapidly introduced some of the changes under consideration. These changes had an immediate impact on ambulance handovers and crowding within the department, despite significant operational demands, and the focus is now on embedding and sustaining these improvements. No change to overall ratings was made but Well Led and Safe ratings for Urgent and Emergency Care decreased, and a section 29A Warning Notice was issued relating to Urgent and Emergency Care.

We have adopted a comprehensive approach to monitoring the sustainability of improvement in the care provided to our patients, regular updates are provided to the Trust Board, and the Trust's ambition is to progress our rating to 'Good' and Outstanding ratings.

- Compliance with NHS Provider Licence: In reviewing our progress in responding to the NHSI Undertakings in 2020/21, it is recognised that those relating to finance sustainability and operational performance have been impacted by the pandemic response, our consequent operating environment and the financial operating arrangements in place during 2020/21, thereby making it difficult to assess the extent of underlying progress in related Undertakings.

Whilst most of the Undertakings are broadly on track, taking into account the COVID environment, there is more work to do with regard to the Well Led Improvement Plan and pulling together our relevant improvement plans under a single framework of programme management and governance. We are also refreshing our corporate governance framework to underpin restoration, and respond to our enhanced risk profile and operating environment post COVID. The new Company Secretary role will be key to this work, supported by my Chief of Staff.

We are finalising measures of compliance in the context of the annual operating round for 2021/22 so there is a shared understanding with NHSE/I about the progress that needs to be made in order for Compliance Certificates to be issued – particularly given the national and local challenges in restoring Constitutional Standard compliance.

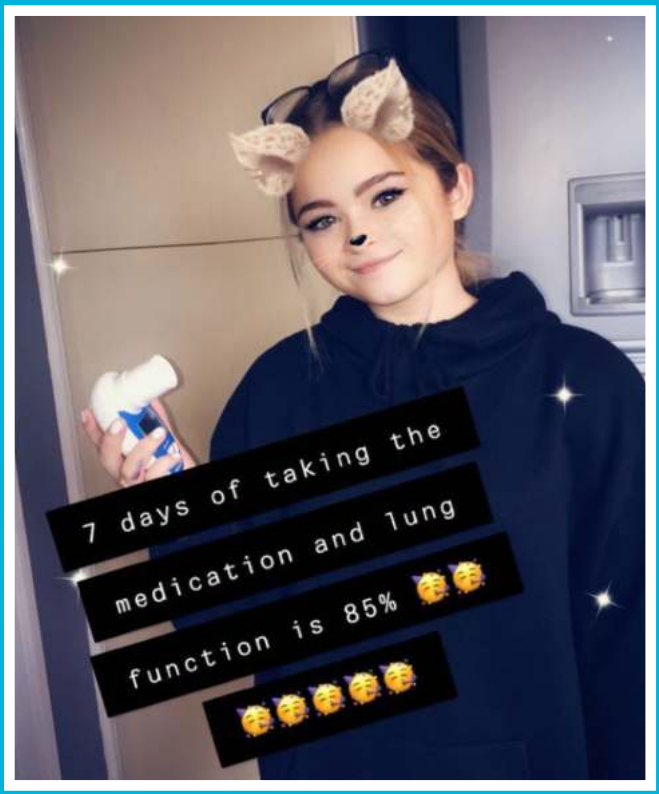
Conclusion

A number of significant internal control issues have been identified in this Annual Governance Statement, as listed above. My review confirms that whilst many key components of an effective system of internal control are in place as at 31 March 2021, there is still scope for strengthening the Trust's arrangements to provide a sound basis for securing delivery of our objectives. This will continue to be a key area of focus for the Board in 2021/22.

Signed on behalf of the Board

Ann James
Chief Executive

Date: 28 June 2021



PROUD

A new drug for those with cystic fibrosis has given people like eighteen-year-old Codie the chance to live a more normal life. Patients at University Hospitals Plymouth are among hundreds of people with CF across the south west benefitting from a 'transformative' treatment since the drug Kaftrio was released for use by the NHS last year.

Before Codie-Lei More started taking Kaftrio, her lungs were functioning at around half their capacity, and at their worse, just 32% of what they should be. This made it hard for her to enjoy family days out without getting out of breath and coughing. She would frequently have to take inhalers and medication before she could get up in the mornings, and would have choking fits at school.

But she has been amazed by the improvement the drug has made to her quality of life. Her lung function now reaches as high as 87% and she has been able to reduce her medications. She no longer has to take insulin for diabetes relating to her cystic fibrosis.

She can now keep up with her three sisters on family days out and says: "I can be a big sister now, rather than my little sisters having to look after me. Once lockdown is over I'm hopefully going to be having a celebration for my 18th and Kaftrio", she added.

"It's amazing how those two little tablets can have such a massive effect on not just my life but anyone who qualifies for it."

Caroline Whitton, Lead Adult Cystic Fibrosis Specialist Nurse, said: "To have such significant lifts in patients' spirometry and such dramatic improvements to quality of life so quickly is incredibly exciting. Amongst the craziness of COVID-19 it has been a pleasure to see this drug rolled out and patients benefiting. Although Kaftrio is not available to all patients with cystic fibrosis (patients must be aged over 12 years and have a specific genetic make-up to be eligible), there is ongoing research and a constant drive to make this, and similar drugs, accessible to all."

In this video, Codie shares her experience: **https://youtu.be/jAcK6JJxq5k**

Remuneration Report

Certain information included in the Remuneration Report is auditable and will be referred to in the audit opinion. The report is annotated to identify those items that are auditable ("subject to audit") and those that are not ("not subject to audit.")

Not subject to audit
The remuneration of the Trust's Executive Directors is overseen by a committee of the Trust Board, known as the Remuneration Committee. The Committee is comprised of Non-Executive Directors. They are guided by the Department of Health and Social Care's advice on pay for very senior NHS managers who are not part of the Agenda for Change terms and conditions of employment. All Executive Directors are appraised by the Chief Executive, who is herself appraised by the Chairman, and appraisal documentation is provided to the Remuneration Committee. Executive Directors are employed on substantive Trust contracts. The remuneration of Non-Executive Directors is established by the Trust Development Authority and all are subject to appraisal.

Salaries and allowances (subject to audit)

2020/21	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£000	£	£	£000	£000
Richard Crompton, Chairman	35-40		100			40-45
Henry Warren, Assoc. Non-Executive Director	10-15					10-15
Helen Teague, Non-Executive Director	10-15					10-15
Jacky Hayden, Non-Executive Director	10-15					10-15
Liz Kay, Non-Executive Director	10-15					10-15
Bil Boa, Non-Executive Director	10-15					10-15
Hisham Khalil, Non-Executive Director	10-15	155-160				165-170
Graham Raikes, Non-Executive Director	10-15					10-15
Ann James, Chief Executive	195-200					195-200
Kevin Baber, Chief Operating Officer	145-150					145-150
Sarah Brampton, Director of Finance	145-150			3,700	32.5-35.0	180-185
Steven Keith, Director of People	130-135				45.0-47.5	175-180
Nick Thomas, Deputy Chief Executive and Director of Planning and Site Services (see note 1)	125-130					125-130
Phil Hughes, Medical Director (see note 2)	100-105	30-35				135-140
Mark Hamilton, Medical Director (see note 3)	45-50				202-5-205.0	250-255
Lee Budge, Director of Corporate Business (see note 4)	50-55				25.0-27.5	75-80
Lenny Byrne, Chief Nurse and Director of Clinical Professions	135-140				80.0-82.5	215-220
Jo Beer, Director of Integrated Care	125-130			1,100		125-130

2019/20	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£000	£	£	£000	£000
Richard Crompton, Chairman	35-40		2,400			40-45
Michael Leece, Non-Executive Director (see note 5)	0-5					0-5
Henry Warren, Associate Non-Executive Director	5-10					5-10
Giles Charnaud, Non-Executive Director (see note 6)	0-5		900			0-5
Helen Teague, Non Executive Director (see note 7)	5-10					5-10
Estelle Thistleton, Non-Executive Director (see note 8)	5-10		1,400			5-10
Jacky Hayden, Non-Executive Director	5-10		900			5-10
Liz Kay, Non-Executive Director	5-10					5-10
Bill Boa, Associate Non Executive Director (see note 9)	**0-5**					**0-5**
Hisham Khalil, Non-Executive Director	0-5	170-175				180-185
Graham Raikes, Non-Executive Director	5-10		1,000			5-10
Ann James, Chief Executive	185-190		600	500		185-190
Kevin Baber, Chief Operating Officer	140-145		100	500		140-145
Neil Kemsley, Director of Finance (see note 10)	25-30		3,300	1,800		30-35
Sarah Brampton, Director of Finance (see note 11)	135-140		600	0	45-47.5	185-190
Steven Keith, Director of People	125-130		100		15-17.5	140-145
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	120-125		200			120-125
Phil Hughes, Medical Director	115-120	75-80	500	500		195-200
Lee Budge, Director of Corporate Business (part time)	80-85		100	400	7.5-10	90-95
Lenny Byrne, Chief Nurse and Director of Clinical Professions	130-135				30-32.5	160-165
Jo Beer, Director in Integrated Care (see note 12)	**105-110**					**105-110**

Notes

1. Left the Trust March 2021
2. Retired as Medical Director December 2020; continued working in clinical capacity part time - the note covers the entire financial year
3. Appointed January 2021
4. Left the Trust December 2020
5. Term of office completed 31 May 2019
6. Term of office completed 30 September 2019
7. Appointed 1 June 2019
8. Term of office completed 30 November 2019
9. Appointed 23 March 2020
10. Left the Trust 16 June 2019
11. Appointed 15 April 2019
12. Appointed Director of Integrated Care 1 May 2019
13. Salary for duties as director includes only that proportion of remuneration relating to non clinical duties as a director or senior manager of the Trust. All remuneration for clinical work undertaken during the period is disclosed as other remuneration.

Pension Benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2010 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Real Increase in Cash Equivalent Transfer Value £000
Ann James, Chief Executive (see note 1)							
Phil Hughes, Medical Director (see note 1)							
Kevin Baber, Chief Operating Officer (see note 1)							
Nick Thomas, Director of Planning & Site Services (see note 2)							
Lee Budge, Director of Governance (see note 2)	0-2.5	0	15-20	0	222	193	19
Steven Keith, Director of People	2.5-5	0-2.5	40-45	80-85	804	729	44
Sarah Brampton, Director of Finance	2.5-5	0	45-50	90-95	793	733	26
Mark Hamilton, Medical Director	0-2.5	2.5-5	55-60	120-125	1,049	836	38
Jo Beer (see note 1)							
Lenny Byrne, Chief Nurse and Director of Clinical Professions	5-7.5	0	30-35	65-70	560	478	54

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008. The factors used to calculate CETV changed on 29 October 2018.

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

Notes

1. Opted out of the NHS pension scheme
2. No lump sum shown for members of the 2008 scheme
3. Increase disclosures are adjusted for time in post

Fair Pay (subject to audit)
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce.

The salaries and allowances table above shows that the highest paid director was the Chief Executive, whose total remuneration fell into the £195,000 - £200,000 band (2019-20 Medical Director £195,000 - £200,000). The mid-point of this band was 7.3 times (2019-20 8.2) the median remuneration of the workforce, which was £26,970 (2019-20 £24,214.) The range of remuneration was from £7,626 to £283,989 (2019-20 £7,626 to £283,989.)

In 2020-21 fourteen employees (2019-20 eighteen) received total remuneration in excess of the highest paid director's, with total remuneration ranging from £198,131 - £294,642 (2019-20 range £198,263 - £283,989.)

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

Off payroll engagements (not subject to audit)

For all off-payroll engagements as of 31 March 2021, for more than £245 per day

	Number
Number of existing engagements as of 31 March 2021	14
Of which the number that have existed	
for less than one year at the time of reporting	14
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	14
Of which	
No. not subject to off-payroll legislation	14
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
No. of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

None of the off-payroll engagements related to a board members or senior officers with significant financial responsibility.

22 individuals have been deemed "board members and/ or senior officers with significant financial responsibility" during the year.

Exit packages (subject to audit)
There were no exit packages in 2020-21.

Analysis of staff costs (subject to audit)

	Permanent	Other	2020-21 Total	2019/20 Total
	£000	£000	£000	£000
Salaries and wages	313,111	**1,552**	**314,663**	**273,137**
Social security costs	30,420	-	**30,420**	27,278
Apprenticeship levy	1,494	-	**1,494**	1,333
Employer's contributions to NHS pension scheme	52,509	-	**52,509**	46,243
Pension costs - other	112	-	**112**	95
Temporary staff	-	17,871	**17,871**	20,133
Total gross staff costs	397,646	19,423	**417,069**	368,219
Recoveries in respect of seconded staff	(455)	(1,869)	**(2,324)**	-
Total staff costs	397,646	19,423	**417,069**	368,219
Of which				
Costs capitalised as part of assets	1,717	6	**1,723**	2,270

Average staff numbers (subject to audit)

	Permanent	Other	2020-21 Total	2019/20 Total
	Number	Number	Number	Number
Medical and dental	1,397	1	**1,398**	1,037
Administration and estates	1,634	70	**1,704**	1,797
Healthcare assistants and other support staff	1,715	162	**1,577**	1,401
Nursing, midwifery and health visiting staff	2,130	140	**2,270**	1,990
Scientific, therapeutic and technical staff	1,389	13	**1,402**	1,191
Other	12	-	**12**	7
Total average numbers	**8,277**	**386**	**8,663**	**7,423**
Of which				
Number of employees (WTE) engaged on capital projects	38	-	**38**	55

Consultancy (not subject to audit)
Expenditure on consultancy in 2020/21 was £1,522,000 (2019/20 £607,000.)

Signed:

Ann James, Chief Executive

Finance Commentary 1 April 2020 to 31 March 2021

Finances

As expected the Trust's finances have been dominated by the Covid 19 pandemic and the national and local arrangements put in place in response. Broadly speaking the Trust received additional funding during the year that enabled it to cover the additional costs of the Covid response and to breakeven.
April to September

Late in March NHS England suspended the annual Operating Planning process and implemented interim Covid 19 financial arrangements. From the 1st April 2020 to the 31st July 2020 all NHS Trusts received block contract payments from commissioners. These were based on income received in 2019/20 updated for inflation. The Trust received a further financial 'top up' from NHS England to help cover the Trust's underlying financial deficit based on the average running costs of the Trust from November 2019 to January 2020. Finally the Trust also received a 'retrospective top up' to help ensure a breakeven position during this period. This top up incorporated additional costs of Covid but also the other financial impacts there had been on the Trust, including the loss of non-NHS income, but also recognising that there were reduced costs in many areas due to the reduced service levels delivered. These arrangements were then extended for August and September.

As designed under these arrangements the Trust achieved a breakeven position for the first half of the year. The additional top-up the Trust received for the first six months of the year was £8.8m. Due to the cost reduction of significantly reduced activity levels offsetting the costs of the Covid response and the loss of non-NHS income, no additional retrospective top up was required in April. However, as clinical activity and associated clinical costs increased, an additional top up was needed from May to September.

October to March

For the second half of the year the Trust was operating under a revised financial framework. NHS England released a fixed funding allocation for the Devon STP that included the continuation of funding of the block commissioner payments and the fixed element of the financial top up to cover the Trust's underlying deficit. However, there was no longer a retrospective top up for the additional requirements and impact of Covid but a fixed Covid allocation for the system. Additional national funding was made available, however, for some defined areas of the Covid response, covering such items as the cost of Covid testing, vaccination delivery and the majority of Personal Protective Equipment (PPE).

Working with the Devon STP the Trust agreed new block contracts with Devon CCG that included an allocation of £8.5m for Covid costs for the second half of the year. The Trust submitted a deficit plan for this period to NHSE of £2.4m reflecting a shortfall in non-NHS income that was still expected and not covered by the system funding allocation. Additional income penalties under the Elective Incentive Scheme (EIS) were also expected as the Trust's activity plans for this period did not meet the targets set by NHSE. If applied the Trust's deficit would increase to £4.9m.

However, following further funding allocations, the Trust actually delivered a breakeven position for the second half of the year (excluding impairment and technical adjustments). Further funding was awarded

in February by NHSE which compensated for the loss of non-NHS income, therefore the Trust's position improved by £2.1m. NHSE also confirmed that following the second wave of Covid 19 no EIS penalties would be applied. A risk to the Trust's position was an increase in untaken annual leave due to the Covid surge of £2.8m. However, NHSE has also awarded additional income to cover this issue.

Capital Expenditure

The Trust spent £46.3m of capital for the year. This included significant amounts of central funding to support the requirements of the Covid 19 response. Outside Covid allocations, the Trust received funding to address critical estates infrastructure risks to develop the Trust Hospital Infrastructure Programme Business Case. Within the Trust's internal programme was the completion of two new 3T MRI scanners and further Estates backlog maintenance, IT developments and the medical equipment rolling replacement programme.

Cash

At the end of the year the Trust had a cash balance of £35.3m. This is mainly due to high capital creditors at the end of the year of £22.4m for which payments will be made during early 2021-22. Other working balances have also improved due to the funding arrangements and timing of payments made under the Covid financial regime.

Balance Sheet

The Trust's borrowing level has significantly reduced in 2020-21. In early April 2020 the Trust received confirmation of a new cash regime being introduced by NHSE and DHSC for 2020-21. This confirmed that historic debt would be transferred to PDC during 2020-21. This meant that £142.3m of historical debt and cash support received over the last 5 year was cleared and there was a corresponding increase in the Trust's PDC balance.

Overview of income and expenditure position

The Trust's final income and expenditure performance for the year is shown below;

Statement of Comprehensive Income	2020-21	2019-20	Diff
	£000s	£000s	£000s
Revenue from patient care activities	551,032	503,911	47,121
Other operating revenue	101,881	67,581	34,340
Total income	**652,913**	**571,492**	**81,421**
Gross employee benefits	-407,619	-361,500	-46,119
Other operating costs	-270,511	-221,043	-532
Depreciation and Amortisation	-18,348	-16,521	-1,827
Total Expenditure	**-646,478**	**-599,064**	**-47,414**
Operating surplus	**6,435**	**-27-572**	**34,007**
Investment revenue	5	150	-145
Other gains and (losses)	-94	12	-106
Finance costs	-101	-2,682	2581
Public dividend capital dividends payable	-4,705	-1,592	-3,113
Impairments and reversals	-5,030	-31,172	26,142
Retained (deficit) for the year	**-3,490**	**-62,856**	**59,366**
Retained (deficit) for the year	-3,490	-62,856	59,366
Impairments/(Impairments Reversals)	5,030	31,172	-26,142
Adjustments in respect of donated asset reserve elimination	-1,533	-154	-1379
Retain impact of DEL I&E (impairments)/reversals		-631	631
Remove impact of prior year PSFpost accounts reallocation		-480	480
Adjusted retained surplus/(deficit)	**7**	**-32,949**	**32,956**

Income

Income increased by £81m in the year primarily due to the Covid arrangements put in place. Most revenue from patient care activities comes from Devon and Kernow Clinical Commissioning Groups (commissioning services for the local population) and NHSE (who commission specialist, dental and screening services). Under the Covid financial arrangements in 2020-21 all contract income was fixed at approximately 19-20 levels with an inflation factor of 2.7% (c£13m) applied. The Trust also received a fixed 'top up' of £64.5m from NHSE to cover non-contract activity and more significantly the Trust's underlying deficit based on the Trust's running costs for the period of November 2019 to January 2020.

The Trust saw income from Private Patients virtually eliminated as services were directed towards the pandemic response and recovery of NHS services.

The Trust received £8.8m of 'retrospective top up' from NHSE to cover Covid costs and the impact of Covid on other income streams in the first 6 months of the year. The Trust then received £8.5m of Covid funding from Devon CCG for the second half of the year.

Further top ups of £3.2m were received in the second half of the year to cover the specific Covid costs of Covid testing and the delivery of vaccinations. A further £2.1m was received to compensate for the reduction in non-NHS income in the second half of the year, £2.8m to fund the increase in untaken annual leave, and £1.1m for a provision for staff claims linked to overtime pay entitlements in respect of holiday pay under the NHS terms and conditions of service. The Trust also received £7m of PPE from NHSE.

Other income reflects a significant reduction in Car Parking and other commercial income. Staff parking was free for the year and patient and visitor parking was free for the first 6 months of the year and with a significant reduction in volumes and income for the second half. Research & Development income increased due to the additional income of a number of Covid studies, and Education income increased with new funding of £0.8m for Continued Professional Development (CPD) for nursing staff.

Expenditure

Pay

With over 8000 permanently employed whole time equivalent (WTE) staff, pay costs, including salaries, national insurance and pension contributions, comprise the majority of the Trust's operating expenses and account for over 60% of the Trust's total expenditure. Staff costs increased by £46.1m in 2020-21. One of the primary reasons for the increase is, as expected, that staff increments and inflation (and associated pension costs) increased by £14.2m in line with nationally agreed pay scales. There was also a significant increase in staff costs to support the Covid 19 response of £15.2m. £12.4m was supporting the hospital response including staffing the Covid ED assessment areas and designated assessment ward. There were also significant additional costs during the Covid surge periods with additional staff on designated Covid wards and Critical Care areas. Additional support staff were also utilised to provide Covid swabbing and testing services, and additional cleaning and infection control services throughout the year. Increased staffing costs were also required to cover Covid staff absence for both Covid sickness and self-isolation. Costs also included £0.5m for Vaccination centres.

A further impact of the pandemic was that many dedicated staff were not able to take their full annual leave allowance during the year and therefore the accrual for outstanding annual leave increased by £2.8m. The Trust has also made a provision of £1.5m for a wellbeing day awarded during the year to all staff for them to take in 2021-22.

The Trust also took over the running of additional services from Livewell South West during the year for increased AAU and MSK services, increasing costs by £2m. Provisions were also included for an increase in the notification of additional pension liabilities of £1.3m. There was also an increase for a provision for staff claims linked to overtime pay entitlements in respect of holiday pay under the NHS terms and

conditions of service of £1m.

The remainder of the increase is due to the full year impact of increases from last year and continued recruitment to vacancies. One of the main factors here is an increase in support staff of £6m for the full year impact of the transfer of the Trust's hotel services staff from an outsourcing contract arrangement completed in October 2019.

Non-Pay

Non-pay costs incurred in 2020-21 totalled £220.5m, a small reduction since last year. There were a number of other offsetting movements where a reduction in clinical costs was offset by the Trust's increased costs of dealing with the pandemic.

The reduction in clinical costs was c£20m. This reflected the reduction in surgical activity reducing the cost of clinical supplies and services by £2m and a reduction in the costs of outsourcing clinical services of £18m because the National Independent Sector contract put in place by NHSE as part of the Covid 19 response picked up the costs during 2020-21. The increased non-pay costs of the pandemic response were £14.6m. This included £8m on PPE, and £2m on Covid Lab testing and £0.5m on Vaccination centres. The remainder was in support of changes required to the hospital for infection control requirements including changes to patient pathways, and supporting remote working and services.

Other movements included increased inflation costs of £3m, an increase in the Trust's premiums under the Clinical Negligence Scheme for Trusts (CNST) of £0.9m and increases in training costs in line with increased academic income supporting spend on CPD of £0.8m. There was also an increase in high cost drugs and devices of £6m for newly approved drugs and the fact that the Trust picked up the full year costs of high cost Cardiac 'TAVI' devices that were previously paid for by NHSE for most of 2019-20. There was also a reduction for the full year impact of the transfer of the hotel services contract to in house provision of £6m.

Other items

The Trust had an increase in depreciation of £1.8m reflecting the level of capital investment made in recent years. The Trust also had an increase in PDC interest of £3.1m as a result of the transfer of the Trust's historical borrowing to PDC in 2020-21 (this also resulted in a corresponding reduction of loan interest of £2.6m). Despite this increase in PDC interest the overall level of PDC interest was lower than planned because of higher than expected cash balances during the year. Under the Covid 19 financial arrangements the Trust received a month's income in advance for most of the year giving higher cash balances which in turn reduce the PDC interest charge.

The was a significant reduction in impairment values of £26m, as last year the Trust incurred two significant impairments. The 2019-20 position included an impairment of £24m following a revaluation of the Trust's main hospital site which reflected an updated assessment of the condition and notional sizing of the site and an impairment for the unforeseen obsolescence due to the changing technological advances in clinical systems of the Trust's e-Notes capital project of £6.4m. This year the Trust has incurred an impairment of £5m through the standard annual revaluation of the Trust Buildings. This reflects a small reduction in building indices and a recognition that capital works carried out has not significantly increased the overall valuation of the building.

Cash and Working Capital

As mentioned above the Trust had significantly higher cash balances during 2020-21 because under the Covid financial arrangements up until March 2021 it received monthly income in advance. This increased in year balances by c£50m. The Trust ended the year with significantly higher cash, £35.3m in March 2021 compared with £6.4m at the end of March 2020. The main reason for this is a significant increase in the Trust's capital creditors which increased from £8m to £22.4m reflecting the size and profile of the capital programme in 2020-21. Other improvements in cash reflect the Covid financial arrangements where commissioner and NHSE payments were generally made more promptly. Working balances have also increased for a number of year-end accruals for items such £2.8m for the increase in untaken annual leave and £1m for staff claims linked to overtime pay entitlements in respect of holiday pay under the NHS terms and conditions of service.

The Trust's borrowing level has significantly reduced in 2020-21. In early April 2020 the Trust received confirmation of a new cash regime being introduced by NHSE and DHSC for 2020-21. This confirmed that historic debt would be transferred to PDC during 2020-21. This meant that £142.3m of historical debt and cash support received over the last 5 year was cleared and there was a corresponding increase in the Trust's PDC balance.

Capital Investments

The Trust had a very significant capital programme during 2020-21, primarily in response to the pandemic. The Trust spent £46.3m of capital during the year. This included significant central funding to support the requirements of the Covid 19 response. £3.7m was received to cover a range of medical and IT equipment and various building works to support Covid pathways and ensure appropriate infection control measures were in place. A further £1.0m was specifically allocated to support the conversion of the old IVF unit into ward accommodation to allow the designation of a new Covid 19 Assessment Ward. The Trust also received £4m to support urgent care pathways. This supported an increase in majors bays in the Emergency Department and the conversion of three former day case units into wards (Lyd, Fal and Erme). An allocation of £7.4m was received for the creation of 10 new Critical Care beds: this project is currently in progress to be completed in 2021-22. The Trust also received £2.0m to support diagnostic recovery with a replacement of an improved CT scanner and home reporting equipment.

In addition to Covid allocations the Trust received £3.9m to address critical estates infrastructure risks and £0.8m for the development of the Trust's Hospital Infrastructure Programme business case. Within the Trust's internal programme was £6.7m on the completion of two new 3T MRI scanners and £1.2m for the continued implementation of the Electronic Prescribing system. Other spend included further Estates backlog maintenance, IT developments and the medical equipment rolling replacement programme.

Capital Spend	£M
Estates Backlog Maintenance	5.9
Estates Energy Efficiency	1.1
IMT Infrastructure and Systems	1.5
Medical Equipment and Service Line Programmes	1.5
Strategic IMT projects (E Prescribing, E-Obs, Theatre Information and RFID)	1.9
Hospital Infrastructure Programme Business Case	0.8
3T MRI Unit	6.7
Other Estates development projects	3.7
Relocatable MRI B	1.4
General Contingency	3.3
COVID 19 – Medical, Equipment, IMT and Estates works	3.7
COVID – Covid Ward	1.0
COVID - ED Flow	4.0
COVID - Diagnostics (Adopt and Adapt)	2.0
COVID - ICU Expansion	7.4
Other PDC allocations	0.3
	46.3

Lighthouse Laboratory

In 2020/21 the Trust was approached by the Department of Health and Social Care to establish a Lighthouse Laboratory to carry out mass Covid PCV testing on their behalf. This involved establishing the lab in an existing leased building and this became operational in March 2021. The contract arrangements ensure that the Trust is fully reimbursed for all costs and does not have any on-going financial benefit or risk from the arrangement. The contract under which the Trust provides these services for the DHSC from this laboratory runs until 30 June 2021. It is likely to be extended to 31st March 2022 but the life of the laboratory and its possible future use remain uncertain. The Trust has considered the various potential accounting treatments of this arrangement and has assessed that because the service delivery and specifications are controlled by the DHSC and there is no financial risk or benefits to the Trust, it has acted as an agent for the DHSC in this regard. Therefore it has not included the income and expenditure for this arrangement in its accounts. The total value of transactions under this arrangement in 2020-21 was £29.6m, of which the majority was for the set up and mobilisation of the Lab for the DHSC.

Future Plans

Unlike normal years, due to the Covid 19 pandemic, the Trust has only been asked to complete an operational and financial plan for the first 6 months (Half 1/H1) of 2021-22 by NHS England because national operational guidance and funding arrangements have only been confirmed for this period.

These arrangements are similar to those that have been in place for the last 6 months, although an efficiency factor has now been applied and additional funding for non-NHS income loss and for Elective

Recovery is now also available. The Trust has completed an assessment of the financial impact of this guidance, including working with the Devon ICS to understand any changes to financial envelopes, and forecast the Trust's clinical capacity during this period and in turn estimated the potential funding that can be earned from the new Elective Recovery Fund (ERF). The plan for H1 confirms a breakeven position but only after £4m additional income from the ERF is taken into account. The Trust has the potential to utilise the ERF further with additional investment which would give a surplus of up to £0.6m. As part of wider Devon ICS principles any surpluses from H1 will be used to support the H2 position which is expected to be more challenging.

There is still limited guidance for the second half of the year. There is a direction that the Treasury will be looking to reduce the additional funding the NHS has had and there will be an increased efficiency factor, and contractual arrangements will return to a more variable basis. The NHSE central finance team will be looking to avoid a financial cliff edge but it is reasonable to assume that financial pressure will increase during this period. It is still unclear if the Elective Recovery Fund will continue beyond September. The Trust has done some detailed work to understand potential future costs and its underlying financial position. This work will continue over the spring and summer to confirm budgets and recurrent funding arrangements for the second half of the year. The Trust will also be working with the Devon ICS to develop a Long Term Plan during the year. This plan will look to confirm the strategic pathway to ensure that all partners work together to restore operational and financial sustainability. Key elements will include actions to manage emergency admissions effectively, including reducing the number of patients awaiting transfer to alternative care settings, and ensuring we maximise our resources to support the full recovery of elective services and tackle waiting lists.

Unlike the revenue position the Trust has been asked to submit an annual capital plan. The Trust submitted a capital plan to NHS England in April of £34.9m: £10.4m of PDC funded projects and £24.5m of internally funded projects. To support the capital programme an operating leasing programme of £17m has also been approved to enable the replacement of equipment at the end of its life. The projects covered by specific Public Dividend Capital (PDC) funding of £10.4m include £5.0m for Phase 1a of the Trust's Hospital Infrastructure Programme (HIP2) which focuses on the plans for a new Urgent and Emergency Care Building, £4.3m for the development of the remaining HIP2 business case and £1.1m diagnostics programmes. The plan includes £9m for the completion of projects started last year to reflect the new operational footprint including additional ward space, new Critical Care Unit and works on Paediatric Theatres. There is £1.7m for strategic IMT investments for E-Prescribing and E-Observations. The plan also includes £3m for significant equipment replacement and enabling works including the replacement of MRI east and Interventional Radiology equipment. The plan includes £6.1m for the highest priority Estates backlog, £1.3m for the Rolling Replacement programme, £1.5m for IMT infrastructure.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the 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 my letter of appointment as an Accountable Officer.

Signed

Chief Executive

Date 28 June 2021

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

By order of the Board

Chief Executive 28 June 2021

Finance Director 28 June 2021

University Hospitals Plymouth NHS Trust

Annual Accounts for the year ended 31 March 2021

Independent auditor's report to the Directors of University Hospitals Plymouth NHS Trust

Report on the Audit of the Financial Statements

Qualified opinion on financial statements

We have audited the financial statements of University Hospitals Plymouth NHS 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 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 15 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; and
- 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 £13.132 million. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 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 Directors' 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 Directors' 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 Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of 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 satisfy ourselves concerning the inventory quantities of £13.132 million held as at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

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 guidance issued by NHS Improvement, 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 and 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 15 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; and
- 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 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 Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 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 body incurring 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; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 12 March 2020 we referred a matter to the Secretary of State under section 30 (b) and 30 (a) of the Local Audit and Accountability Act 2014 in relation to the Trust's expected breach of its statutory break-even duty for the three-year period ending 31 March 2020 and that the Trust had no plans to achieve cumulative financial balance over the period to 31 March 2022 which would lead to an ongoing breach of the Trust's breakeven duty for the three year-periods ending 31 March 2021 and 31 March 2022.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained in the Statement of directors' responsibilities in respect of the accounts the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine 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 Directors are 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 they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit 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 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 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 and the recognition of both revenue and expenditure. We determined that the principal risks were in relation to:
  - journal entries posted by senior officers; and
  - accounting estimates, including those relating to land and buildings valuations and income and expenditure accruals
- 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 and unusual journals and those posted by senior officers;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals for income and expenditure.
  - 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.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to land and buildings valuations and income and expenditure accruals.
- 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.
- 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 Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust the Chief Executive, as Accountable 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 Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 University Hospitals Plymouth NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 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 Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors 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 Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Jon Roberts, Key Audit Partner

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

Bristol

29 June 2021

Independent auditor's report to the Directors of University Hospitals Plymouth NHS Trust

In our auditor's report issued on 29 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 the Local Audit and Accountability Act 2014 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 29 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 £13.132 million. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 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.

Responsibilities of the Accountable Officer

The Chief Executive, as Accountable 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 Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 University Hospitals Plymouth NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors 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 Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

JD Roberts

Jon Roberts, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

22 July 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	551,032	503,911
Other operating income	4	101,881	67,581
Operating expenses	7, 9	(651,508)	(630,236)
Operating surplus/(deficit) from continuing operations		**1,405**	**(58,744)**
Finance income	12	5	150
Finance expenses	13	(101)	(2,682)
PDC dividends payable		(4,705)	(1,592)
Net finance costs		**(4,801)**	**(4,124)**
Other gains / (losses)	14	(94)	12
(Deficit) for the year		**(3,490)**	**(62,856)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(8)	(3,093)
Revaluations	16	310	99
Total comprehensive (expense) for the period		**(3,188)**	**(65,850)**

The following table is a note to the accounts

Adjusted financial performance (control total basis):		
(Deficit) for the period	(3,490)	(62,856)
Remove net impairments not scoring to the Departmental expenditure limit	5,030	30,541
Remove I&E impact of capital grants and donations	(1,051)	(154)
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(480)
Remove net impact of inventories received from DHSC group bodies for COVID response	(482)	
Adjusted financial performance surplus / (deficit)	**7**	**(32,949)**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	15	2,826	3,276
Property, plant and equipment	16	224,682	199,725
Receivables	20	2,278	3,337
Total non-current assets		**229,786**	**206,338**
Current assets			
Inventories	19	13,542	13,132
Receivables	20	32,234	26,680
Cash and cash equivalents	21	35,291	6,393
Total current assets		**81,067**	**46,205**
Current liabilities			
Trade and other payables	22	(82,858)	(49,192)
Borrowings	24	(314)	(142,649)
Provisions	26	(239)	(231)
Other liabilities	23	(3,022)	(2,684)
Total current liabilities		**(86,433)**	**(194,756)**
Total assets less current liabilities		**224,420**	**57,787**
Non-current liabilities			
Borrowings	24	(2,324)	(2,649)
Provisions	26	(1,129)	(1,020)
Total non-current liabilities		**(3,453)**	**(3,669)**
Total assets employed		**220,967**	**54,118**
Financed by			
Public dividend capital		377,703	207,666
Revaluation reserve		7,649	7,597
Other reserves		652	652
Income and expenditure reserve		(165,037)	(161,797)
Total taxpayers' equity		**220,967**	**54,118**

The notes on pages 120-160 form part of these accounts

Name

Position Chief Executive
Date 28 June 2021

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**207,666**	**7,597**	**652**	**(161,797)**	**54,118**
(Deficit) for the year	-	-	-	(3,490)	**(3,490)**
Other transfers between reserves	-	(250)	-	250	**-**
Impairments	-	(8)	-	-	**(8)**
Revaluations	-	310	-	-	**310**
Public dividend capital received	196,359	-	-	-	**196,359**
Public dividend capital repaid	(26,322)	-	-	-	**(26,322)**
Taxpayers' and others' equity at 31 March 2021	**377,703**	**7,649**	**652**	**(165,037)**	**220,967**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**200,548**	**10,870**	**652**	**(99,220)**	**112,850**
(Deficit) for the year	-	-	-	(62,856)	**(62,856)**
Other transfers between reserves	-	(279)	-	279	**-**
Impairments	-	(3,093)	-	-	**(3,093)**
Revaluations	-	99	-	-	**99**
Public dividend capital received	7,118	-	-	-	**7,118**
Taxpayers' and others' equity at 31 March 2020	**207,666**	**7,597**	**652**	**(161,797)**	**54,118**

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 organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

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

Other reserves
The balance on this reserve dates back many years and relates to the acquisition of property from a demising Community Trust.

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 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,405	(58,744)
Non-cash income and expense:			
Depreciation and amortisation	7.1	18,348	16,521
Net impairments	8	5,030	31,172
Income recognised in respect of capital donations	4	(1,497)	(587)
(Increase)/decrease in receivables and other assets		(3,606)	452
(Increase) in inventories		(410)	(912)
Increase in payables and other liabilities		19,601	1,589
Increase / (decrease) in provisions		128	(125)
Net cash flows from / (used in) operating activities		**38,999**	**(10,634)**
Cash flows from investing activities			
Interest received		5	150
Purchase of intangible assets		(465)	(4,429)
Purchase of PPE and investment property		(31,432)	(18,440)
Sales of PPE and investment property		120	21
Net cash flows (used in) investing activities		**(31,772)**	**(22,698)**
Cash flows from financing activities			
Public dividend capital received		196,359	7,118
Public dividend capital repaid		(26,322)	-
Movement on loans from DHSC		(141,984)	34,306
Movement on other loans		(169)	(170)
Capital element of finance lease rental payments		(167)	(31)
Interest on loans		(340)	(2,550)
Other interest		(1)	-
Interest paid on finance lease liabilities		(111)	(25)
PDC dividend (paid)		(5,594)	(1,883)
Net cash flows from financing activities		**21,671**	**36,765**
Increase in cash and cash equivalents		**28,898**	**3,433**
Cash and cash equivalents at 1 April - brought forward		**6,393**	**2,960**
Cash and cash equivalents at 31 March	21	**35,291**	**6,393**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care 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

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

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

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

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 a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside 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 from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

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

Note 1.4 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 grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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

Note 1.5 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.

Note 1.6 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 1.7 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.

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.

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.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

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

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

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.

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

	Min life Years	Max life Years
Buildings, excluding dwellings	5	45
Plant & machinery	2	35
Transport equipment	7	7
Information technology	3	16
Furniture & fittings	5	20

Finance-leased assets 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 1.8 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

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.

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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
Software licences	2	11

Note 1.9 Inventories

Inventories are valued at current cost. This is considered to be a reasonable approximation to net realisable value due to the high turnover of stocks

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.

Note 1.10 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 1.11 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

Financial assets are measured at amortised cost.

Financial liabilities are measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Note 1.12 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 as an item of property plant and equipment.

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

Operating leases

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

Leases of land and buildings

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

The Trust as a lessor

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 1.13 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

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.

Note 1.14 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.

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 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the 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 on the gov.uk website as "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 the audit of the annual accounts.

Note 1.16 Value added tax

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

Note 1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 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 1.19 Early adoption of standards, amendments and interpretations

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

Note 1.20 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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury further revised the implementation date for IFRS 16 in the UK public sector to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.21 Critical judgements in applying accounting policies

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

Land and buildings are valued on a Modern Equivalent Asset basis. Judgement has been applied in determining that an alternative site in Estover on the outskirts of Plymouth is appropriate for the land valuation and in assessing the smaller footprint than the actual Derriford building which a modern equivalent might have: the District Valuer has used a notional size of 85% following a review of functional obsolescence and occupation percentages.

In 2020/21 the Trust was approached by the Department of Health and Social Care to establish a Lighthouse Laboratory to carry out mass Covid PCR testing on their behalf. This involved establishing the laboratory in an existing leased building and this became operational in March 2021. The Trust received further funding for running costs and all future expenditure on the facility will be matched by income. The contract arrangements ensure that the Trust is fully reimbursed for all costs and does not have any on-going financial benefit or risk from the arrangement. The contract under which the Trust provides these services for the DHSC from this laboratory runs until 30 June 2021. It is likely to be extended to 31 March 2022 but the life of the laboratory and its possible future use remain uncertain. The Trust has considered the various potential accounting treatments of this arrangement and has assessed that because the service delivery and specifications are controlled by the DHSC and there is no financial risk or benefit to the Trust, it has acted as an agent for the DHSC in this regard. Therefore it has not included the income and expenditure for this arrangement in its accounts. The total value of transactions under this arrangement in 2020/21 was £20,599k, of which the majority was for the set up and mobilisation of the laboratory for the DHSC.

Note 1.22 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. The Trust considers that the only material area at risk in this regard is the land and buildings valuation:

Land and buildings were inspected and revalued by the District Valuer in March 2020, when the Covid 19 outbreak was in its very early stages. This was the quinquennial inspection. The District Valuer carried out a desktop revaluation exercise as at 31 March 2021.

In the summer of 2020 the Royal Institute of Chartered Surveyors issued an opinion on the valuation consequences of the outbreak, to the effect that there had been no diminution identified in the public sector's ongoing requirement for Trusts' operational assets nor reduction in their ongoing remaining economic service potential as a result of the incidence of Covid-19. The Building Cost Information Services (BCIS) stated that they considered new construction output was likely to fall in 2020 as a result of the Covid-19 outbreak, as it affected labour availability on sites and delays or led to cancellation of projects in the pipeline. However, BCIS advised that it was too early for Covid-19 related issues to impact on BCIS indices published and adopted in the valuation used for these accounts.

As at March 2021, the cost indices provided by BCIS showed very little movement since the previous year.

Although the District Valuer states in his report that in his opinion there is no material uncertainty attaching to his valuation of the Trust's land and buildings, some uncertainty clearly does exist, and a relatively small variation could have a material impact on the accounts. For every 5% change, the valuation could differ by £6,895,000, with a consequent effect on the PDC dividend payable in 2021/22 of £121,000; this would affect the values shown in note 16 in particular.

Note 2 Operating Segments

The Trust has no material operating segments other than healthcare and reporting to the Board is consistent with this.

	2020-21 £000s	2019-20 £000s
Income	652,913	571,492
Operating surplus/(deficit)	1,405	(58,744)
Net Assets	220,967	54,118

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	527,619	431,073
High cost drugs income from commissioners (excluding pass-through costs)	2,526	49,762
Other NHS clinical income	4,383	4,809
Private patient income	85	2,725
Additional pension contribution central funding**	15,980	14,041
Other clinical income	439	1,501
Total income from activities	**551,032**	**503,911**

*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, other than those for high cost drugs income, 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.

**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)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
NHS England	214,111	196,291
Clinical commissioning groups	332,014	298,585
Other NHS providers	1,376	1,252
NHS other	-	317
Local authorities	3,008	3,240
Non-NHS: private patients	85	2,725
Non-NHS: overseas patients (chargeable to patient)	20	377
Injury cost recovery scheme	369	933
Non NHS: other	49	191
Total income from activities	**551,032**	**503,911**
Of which:		
Related to continuing operations	551,032	503,911

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

	2020/21	2019/20
	£000	£000
Income recognised this year	20	377
Cash payments received in-year	137	206
Amounts added to provision for impairment of receivables	81	197
Amounts written off in-year	40	-

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	5,717	-	**5,717**	5,542	-	**5,542**
Education and training	28,758	1,279	**30,037**	27,276	768	**28,044**
Non-patient care services to other bodies	7,789		**7,789**	8,731		**8,731**
Provider sustainability fund (2019/20 only)			**-**	3,666		**3,666**
Financial recovery fund (2019/20 only)			**-**	2,406		**2,406**
Marginal rate emergency tariff funding (2019/20 only)			**-**	6,470		**6,470**
Reimbursement and top up funding	40,974		**40,974**			**-**
Income in respect of employee benefits accounted on a gross basis	1,946		**1,946**	1,941		**1,941**
Receipt of capital grants and donations		1,497	**1,497**		587	**587**
Charitable and other contributions to expenditure		8,047	**8,047**		1,264	**1,264**
Rental revenue from operating leases		573	**573**		771	**771**
Other income	5,301	-	**5,301**	8,159	-	**8,159**
Total other operating income	**90,485**	**11,396**	**101,881**	**64,191**	**3,390**	**67,581**
Of which:						
Related to continuing operations			101,881			67,581

Reimbursement and top up funding represents additional funding in response to the Covid pandemic.

Charitable and other contributions to expenditure includes the value of consumables donated by the Department of Health and Social Care in response to the Covid pandemic.

Note 5 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 in within contract liabilities at the previous period end	2,684	2,502

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

Due to reduced patient and visitor parking during the pandemic, and because the Department of Health and Social Care funded free parking for staff during this time, income for car parking fell below £1m in 2020-21. Details of the previous year's fees and charges are as follows:

	2019/20
	£000
Income	2,357
Full cost	(2,193)
Surplus	**164**

Note 7.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	540
Purchase of healthcare from non-NHS and non-DHSC bodies	8,362	26,328
Staff and executive directors costs	407,619	361,500
Remuneration of non-executive directors	129	103
Supplies and services - clinical (excluding drugs costs)	68,224	60,015
Supplies and services - general	5,947	12,187
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	71,937	65,146
Inventories written down	357	484
Consultancy costs	1,522	607
Establishment	3,791	4,053
Premises	20,169	17,165
Transport (including patient travel)	713	705
Depreciation on property, plant and equipment	17,433	16,129
Amortisation on intangible assets	915	392
Net impairments	5,030	31,172
Movement in credit loss allowance: contract receivables / contract assets	193	(79)
Movement in credit loss allowance: all other receivables and investments	1	-
Change in provisions discount rate(s)	32	63
Audit fees payable to the external auditor		
audit services- statutory audit	92	76
Internal audit costs	186	181
Clinical negligence	15,573	14,697
Legal fees	1,054	560
Insurance	581	511
Research and development	4,751	5,086
Education and training	4,939	3,567
Rentals under operating leases	6,336	4,472
Early retirements	117	(52)
Redundancy	-	3
Car parking & security	2,374	1,690
Hospitality	9	52
Losses, ex gratia & special payments	61	277
Grossing up consortium arrangements	378	269
Other services, eg external payroll	465	470
Other	2,218	1,867
Total	**651,508**	**630,236**
Of which:		
Related to continuing operations	651,508	630,236

Note 7.2 Limitation on auditor's liability

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

Note 8 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	631
Unforeseen obsolescence	-	6,448
Changes in market price	5,030	24,093
Total net impairments charged to operating surplus / deficit	**5,030**	**31,172**
Impairments charged to the revaluation reserve	8	3,093
Total net impairments	**5,038**	**34,265**

Note 9 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	314,663	273,137
Social security costs	30,420	27,278
Apprenticeship levy	1,494	1,333
Employer's contributions to NHS pensions	52,509	46,243
Pension cost - other	112	95
Temporary staff (including agency)	17,871	20,133
Total gross staff costs	**417,069**	**368,219**
Recoveries in respect of staff cost netted off expenditure	(2,324)	-
Total staff costs	**414,745**	**368,219**
Of which		
Costs capitalised as part of assets	1,723	2,270

Note 9.1 Retirements due to ill-health

During 2020/21 there were 4 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £157k (£252k in 2019/20).

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

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021 is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Pension costs - other scheme

Under the terms of the Pensions Act 2008 the Trust is required to provide a pension scheme for employees who are not eligible for membership of the NHS Pension Scheme. Qualifying employees are enrolled in the National Employment Savings Trust (NEST) managed scheme. NEST is a defined contribution scheme managed by a third party organisation. It carries no possibility of actuarial gain or loss to the Trust and there are no financial liabilities other than payment of the employers' contribution of qualifying earnings. Employer contributions are charged directly to the Statement of Comprehensive Income and paid to NEST monthly. Further details of the scheme can be found at www.nestpensions.org.uk.

Note 11 Operating leases

Note 11.1 University Hospitals Plymouth NHS Trust as a lessor

This note discloses income generated in operating lease agreements where University Hospitals Plymouth NHS Trust is the lessor.

The Trust lets part of its estate to commercial organisations on operating leases.

	2020/21 £000	2019/20 £000
Operating lease revenue		
Minimum lease receipts	573	771
Total	**573**	**771**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease receipts due:		
- not later than one year;	696	676
- later than one year and not later than five years;	2,740	3,519
- later than five years.	2,119	2,790
Total	**5,555**	**6,985**

Note 11.2 University Hospitals Plymouth NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where University Hospitals Plymouth NHS Trust is the lessee.

Several items of medical equipment, some vehicles and some buildings used mainly for administrative functions but also some for service provision are held on operating leases. The Trust also leases land at the site of the haemodialysis unit and a multi-storey car park adjacent to the main Derriford site.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	6,336	4,472
Total	**6,336**	**4,472**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	5,637	5,034
- later than one year and not later than five years;	16,068	18,228
- later than five years.	37,303	37,856
Total	**59,008**	**61,118**

Note 12 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	5	150
Total finance income	**5**	**150**

Note 13.1 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	-	2,664
Finance leases	111	25
Interest on late payment of commercial debt	1	-
Total interest expense	**112**	**2,689**
Unwinding of discount on provisions	(11)	(7)
Total finance costs	**101**	**2,682**

During 2020/21 loans from the Department of Health and Social Care were extinguished and replaced with Public Dividend Capital - see note 24. There has therefore been no interest payable in this category this year.

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	-

Note 14 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	-	21
Losses on disposal of assets	(94)	(9)
Total other gains / (losses)	**(94)**	**12**

Note 15.1 Intangible assets - 2020/21

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**5,615**	**-**	**5,615**
Additions	465	-	**465**
Valuation / gross cost at 31 March 2021	**6,080**	**-**	**6,080**
Amortisation at 1 April 2020 - brought forward	**2,339**	**-**	**2,339**
Provided during the year	915	-	**915**
Amortisation at 31 March 2021	**3,254**	**-**	**3,254**
Net book value at 31 March 2021	**2,826**	**-**	**2,826**
Net book value at 1 April 2020	**3,276**	**-**	**3,276**

Note 15.2 Intangible assets - 2019/20

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2019	**-**	**2,736**	**2,736**
Additions	4,429	-	**4,429**
Impairments	(1,540)	-	**(1,540)**
Reclassifications	2,736	(2,736)	**-**
Disposals / derecognition	(10)	-	**(10)**
Valuation / gross cost at 31 March 2020	**5,615**	**-**	**5,615**
Amortisation at 1 April 2019	**-**	**1,948**	**1,948**
Provided during the year	392	-	**392**
Reclassifications	1,948	(1,948)	**-**
Disposals / derecognition	(1)	-	**(1)**
Amortisation at 31 March 2020	**2,339**	**-**	**2,339**
Net book value at 31 March 2020	**3,276**	**-**	**3,276**
Net book value at 1 April 2019	**-**	**788**	**788**

Note 16.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**4,752**	**131,658**	**20,612**	**127,522**	**247**	**36,788**	**5,713**	**327,292**
Additions	-	-	43,490	3,518	32	275	17	**47,332**
Impairments	-	(5,038)	-	-	-	-	-	**(5,038)**
Revaluations	-	(5,799)	-	-	-	-	-	**(5,799)**
Reclassifications	-	12,324	(30,496)	16,414	12	1,564	182	**-**
Disposals / derecognition	-	-	-	(647)	-	-	(5)	**(652)**
Valuation/gross cost at 31 March 2021	**4,752**	**133,145**	**33,606**	**146,807**	**291**	**38,627**	**5,907**	**363,135**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**97,057**	**189**	**26,547**	**3,774**	**127,567**
Provided during the year	-	6,109	-	7,387	20	3,554	363	**17,433**
Revaluations	-	(6,109)	-	-	-	-	-	**(6,109)**
Disposals / derecognition	-	-	-	(436)	-	-	(2)	**(438)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**104,008**	**209**	**30,101**	**4,135**	**138,453**
Net book value at 31 March 2021	**4,752**	**133,145**	**33,606**	**42,799**	**82**	**8,526**	**1,772**	**224,682**
Net book value at 1 April 2020	**4,752**	**131,658**	**20,612**	**30,465**	**58**	**10,241**	**1,939**	**199,725**

Note 16.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**4,802**	**153,185**	**29,569**	**120,233**	**240**	**29,677**	**5,323**	**343,029**
Additions	-	221	16,556	5,061	-	852	177	**22,867**
Impairments	(50)	(27,136)	(5,539)	-	-	-	-	**(32,725)**
Revaluations	-	(5,846)	-	-	-	-	-	**(5,846)**
Reclassifications	-	11,234	(19,974)	2,261	7	6,259	213	**-**
Disposals / derecognition	-	-	-	(33)	-	-	-	**(33)**
Valuation/gross cost at 31 March 2020	**4,752**	**131,658**	**20,612**	**127,522**	**247**	**36,788**	**5,713**	**327,292**
Accumulated depreciation at 1 April 2019	**-**	**-**	**-**	**90,046**	**174**	**23,771**	**3,425**	**117,416**
Provided during the year	-	5,945	-	7,044	15	2,776	349	**16,129**
Revaluations	-	(5,945)	-	-	-	-	-	**(5,945)**
Disposals / derecognition	-	-	-	(33)	-	-	-	**(33)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**97,057**	**189**	**26,547**	**3,774**	**127,567**
Net book value at 31 March 2020	**4,752**	**131,658**	**20,612**	**30,465**	**58**	**10,241**	**1,939**	**199,725**
Net book value at 1 April 2019	**4,802**	**153,185**	**29,569**	**30,187**	**66**	**5,906**	**1,898**	**225,613**

Note 16.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	4,752	131,284	33,606	38,268	53	8,435	1,608	**218,006**
Finance leased	-	-	-	2,344	-	-	-	**2,344**
Owned - donated/granted	-	1,861	-	2,187	29	91	164	**4,332**
NBV total at 31 March 2021	**4,752**	**133,145**	**33,606**	**42,799**	**82**	**8,526**	**1,772**	**224,682**

Note 16.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	4,752	129,735	18,721	29,003	58	10,099	1,756	**194,124**
Finance leased	-	-	1,891	460	-	-	-	**2,351**
Owned - donated/granted	-	1,923	-	1,002	-	142	183	**3,250**
NBV total at 31 March 2020	**4,752**	**131,658**	**20,612**	**30,465**	**58**	**10,241**	**1,939**	**199,725**

Note 17 Donations of property, plant and equipment

Donated assets totalling £1,497k (2019/20 £587k) were received during the year from a number of different local and national charities and other organisations including equipment valued at £1,385k from the Department of Health and Social Care in response to the Covid pandemic.

Note 18 Revaluations of property, plant and equipment

Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land and building assets are revalued annually by the District Valuer of the Valuation Office Agency who is a Member of the Royal Institution of Chartered Surveyors. Valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Last year's valuation was the full quinquennial valuation, with a detailed physical inspection of all properties. This year's valuation was a desktop exercise.

The fall in valuation of land and buildings has been taken to the revaluation reserve, where a balance existed in that reserve, or otherwise to expenditure as an impairment.

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	2,796	3,269
Consumables	10,718	9,702
Energy	28	161
Total inventories	**13,542**	**13,132**

Inventories recognised in expenses for the year were £129,632k (2019/20: £111,510k). Write-down of inventories recognised as expenses for the year were £357k (2019/20: £484k).

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 £7,021k 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 the opinion of the Trust, inventories as at 31 March 2020 were fairly stated. However, since the Trust's auditors were unable to attend the year-end stock counts last year, owing to COVID 19 related restrictions of movement, they were obliged to issue a qualified audit opinion on the 2019/20 accounts.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	24,142	20,431
Allowance for impaired contract receivables / assets	(1,342)	(903)
Allowance for other impaired receivables	(6)	(5)
Prepayments (non-PFI)	5,934	5,448
PDC dividend receivable	1,005	116
VAT receivable	2,251	1,089
Other receivables	250	504
Total current receivables	**32,234**	**26,680**
Non-current		
Contract receivables	2,750	4,215
Allowance for impaired contract receivables / assets	(617)	(918)
Other receivables	145	40
Total non-current receivables	**2,278**	**3,337**
Of which receivable from NHS and DHSC group bodies:		
Current	17,622	10,824
Non-current	145	40

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,821**	**5**	**1,913**	**5**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**1,821**	**5**	**1,913**	**5**
New allowances arising	193	1	-	-
Changes in existing allowances	-	-	(79)	-
Utilisation of allowances (write offs)	(55)	-	(13)	-
Allowances as at 31 Mar 2021	**1,959**	**6**	**1,821**	**5**

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	**6,393**	**2,960**
Net change in year	28,898	3,433
At 31 March	**35,291**	**6,393**
Broken down into:		
Cash at commercial banks and in hand	33	28
Cash with the Government Banking Service	35,258	6,365
Total cash and cash equivalents as in SoFP	**35,291**	**6,393**
Total cash and cash equivalents as in SoCF	**35,291**	**6,393**

Note 22 Trade and other payables

	2021	2020
	£000	£000
Current		
Trade payables	20,436	15,266
Capital payables	22,366	7,963
Accruals	25,573	13,463
Receipts in advance and payments on account	65	260
Social security costs	4,641	4,055
VAT payables	215	150
Other taxes payable	4,282	3,336
Other payables	5,280	4,699
Total current trade and other payables	**82,858**	**49,192**
Of which payables from NHS and DHSC group bodies:		
Current	3,014	2,380

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	3,022	2,684
Total other current liabilities	**3,022**	**2,684**

Note 24.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	-	142,324
Other loans	170	169
Obligations under finance leases	144	156
Total current borrowings	**314**	**142,649**
Non-current		
Other loans	259	429
Obligations under finance leases	2,065	2,220
Total non-current borrowings	**2,324**	**2,649**

In April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 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.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**142,324**	**598**	**2,376**	**145,298**
Cash movements:				
Financing cash flows - payments and receipts of principal	(141,984)	(169)	(167)	**(142,320)**
Financing cash flows - payments of interest	(340)	-	(111)	**(451)**
Non-cash movements:				
Application of effective interest rate	-	-	111	**111**
Carrying value at 31 March 2021	**-**	**429**	**2,209**	**2,638**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**107,904**	**768**	**516**	**109,188**
Cash movements:				
Financing cash flows - payments and receipts of principal	34,306	(170)	(31)	**34,105**
Financing cash flows - payments of interest	(2,550)	-	(25)	**(2,575)**
Non-cash movements:				
Additions	-	-	1,891	**1,891**
Application of effective interest rate	2,664	-	25	**2,689**
Carrying value at 31 March 2020	**142,324**	**598**	**2,376**	**145,298**

Note 25 Finance leases

Note 25.1 University Hospitals Plymouth NHS 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	**2,645**	**3,065**
of which liabilities are due:		
- not later than one year;	207	258
- later than one year and not later than five years;	827	1,036
- later than five years.	1,611	1,771
Finance charges allocated to future periods	(436)	(689)
Net lease liabilities	**2,209**	**2,376**
of which payable:		
- not later than one year;	144	156
- later than one year and not later than five years;	622	581
- later than five years.	1,443	1,639

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2020	**671**	**540**	**40**	**1,251**
Change in the discount rate	15	17	-	**32**
Arising during the year	81	109	105	**295**
Utilised during the year	(85)	(71)	-	**(156)**
Reversed unused	-	(43)	-	**(43)**
Unwinding of discount	(7)	(4)	-	**(11)**
At 31 March 2021	**675**	**548**	**145**	**1,368**
Expected timing of cash flows:				
- not later than one year;	88	151	**-**	**239**
- later than one year and not later than five years;	353	108	**-**	**461**
- later than five years.	234	289	**145**	**668**
Total	**675**	**548**	**145**	**1,368**

Legal claims relate to personal injury cases.

Other provisions represent an estimate of the amount payable in respect of the clinicians pensions "Scheme Pays" initiative.

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**741**	**642**	**-**	**1,383**
Change in the discount rate	**30**	**33**	**-**	**63**
Arising during the year	**61**	**119**	**40**	**220**
Utilised during the year	(85)	(124)	-	**(209)**
Reversed unused	**(72)**	**(127)**	**-**	**(199)**
Unwinding of discount	**(4)**	**(3)**	**-**	**(7)**
At 31 March 2020	**671**	**540**	**40**	**1,251**

Note 26.2 Clinical negligence liabilities

At 31 March 2021, £227,579k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals Plymouth NHS Trust (31 March 2020: £206,940k).

Note 27 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(46)	(45)
Other	(1,093)	-
Gross value of contingent liabilities	**(1,139)**	**(45)**
Amounts recoverable against liabilities	1,093	-
Net value of contingent liabilities	**(46)**	**(45)**
Net value of contingent assets	**-**	**-**

In the last few weeks of the financial year the Trust opened a Lighthouse Laboratory, funded by the Department of Health and Social Care, in premises held on an operating lease. The terms of the lease require the building to be returned to its original condition at the end of the lease term. The cost of returning the premises to their original condition is estimated at £1,093k. No provision has been made for these costs in the financial statements, since the life and future use of the laboratory is uncertain. All costs will be funded by the Department of Health and Social Care, so the contingent liability is matched by a recoverable amount.

Note 28 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	7,428	10,628
Intangible assets	-	290
Total	**7,428**	**10,918**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust borrows from government, subject to affordability as confirmed by NHS Improvement. Interest is charged at the National Loans Fund rate, fixed for the life of the loan. All such loans as at 31 March 2020 have been replaced by Public Dividend Capital during 2020/21.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because most 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 receivables from customers, as disclosed in the trade and other receivables note 20. The total gross value of non NHS/public sector receivables at 31.3.21 was £11,962,000 (31.3.20 £14,443,000)

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care organisations, 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 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	24,927	**24,927**
Cash and cash equivalents	35,291	**35,291**
Total at 31 March 2021	**60,218**	**60,218**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	22,820	**22,820**
Cash and cash equivalents	6,393	**6,393**
Total at 31 March 2020	**29,213**	**29,213**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	2,209	**2,209**
Other borrowings	429	**429**
Trade and other payables excluding non financial liabilities	61,989	**61,989**
Total at 31 March 2021	**64,627**	**64,627**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	142,324	**142,324**
Obligations under finance leases	2,376	**2,376**
Other borrowings	598	**598**
Trade and other payables excluding non financial liabilities	34,423	**34,423**
Total at 31 March 2020	**179,721**	**179,721**

Note 29.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs from 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	62,366	177,175
In more than one year but not more than five years	1,086	1,465
In more than five years	1,611	1,771
Total	**65,063**	**180,411**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 29.5 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is considered to be a fair proxy to fair value, since they are largely short term and not subject to interest rate or currency fluctuations or other such uncertainties.

Note 30 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	30	6	12	11
Fruitless payments and constructive losses	-	-	3	7,079
Bad debts and claims abandoned	92	52	34	13
Stores losses and damage to property	127	295	230	136
Total losses	**249**	**353**	**279**	**7,239**
Special payments				
Ex-gratia payments	109	60	128	107
Special severance payments	-	-	1	160
Total special payments	**109**	**60**	**129**	**267**
Total losses and special payments	**358**	**413**	**408**	**7,506**
Compensation payments received		-		-

Fruitless payments in 2019/20 related to the impairment of IT projects, most notably the e-notes system which was subject to unforeseen obsolescence.

Note 31 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

NHS Devon CCG
NHS Kernow CCG
NHS England
Health Education England
NHS Resolution
NHS Business Services Authority
NHS Pension Scheme

Note 32 Events after the reporting date

The Trust has been commissioned by NHS Devon CCG to be the lead provider for a range of community and mental health services across Plymouth and the local area with contract income of £90.1m in year 1. These services will be delivered through an Integrated Care Partnership (ICP) with Livewell South West, with inpatient community care transferring directly to the Trust (contract income c.£15.8m year 1) and other ICP community services being commissioned from Livewell South West by the Trust (contract income c.£74.3m year 1). 234 Livewell employees and equipment with a net book value of £217k will transfer to the Trust. The new contract arrangements are expected to come into effect from 1st July 2021 with a part year effect of the income figures detailed.

Note 33 Better Payment Practice code

Non-NHS Payables	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total non-NHS trade invoices paid in the year	80,175	271,199	87,686	246,659
Total non-NHS trade invoices paid within target	77,675	264,452	84,558	236,300
Percentage of non-NHS trade invoices paid within target	96.9%	97.5%	96.4%	95.8%
NHS Payables				
Total NHS trade invoices paid in the year	2,701	11,489	3,100	12,624
Total NHS trade invoices paid within target	2,529	10,252	2,915	11,769
Percentage of NHS trade invoices paid within target	93.6%	89.2%	94.0%	93.2%

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

Note 34 External financing limit

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

	2020/21 £000	2019/20 £000
Cash flow financing	(1,181)	37,790
External financing requirement	**(1,181)**	**37,790**
External financing limit (EFL)	34,603	39,309
Under spend against EFL	**35,784**	**1,519**

This year's significant underspend against the limit is explained by the high value of creditors at the Statement of Financial Position date.

Note 35 Capital Resource Limit

	2020/21 £000	2019/20 £000
Gross capital expenditure	47,797	27,296
Less: Disposals	(214)	(9)
Less: Donated and granted capital additions	(1,497)	(587)
Charge against Capital Resource Limit	**46,086**	**26,700**
Capital Resource Limit	46,087	26,731
Under spend against CRL	**1**	**31**

Note 36 Breakeven duty financial performance

	2020/21 £000
Adjusted financial performance surplus (control total basis)	7
Breakeven duty financial performance surplus	**7**

Note 37 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,010	18	15	49	(12,988)	(4,989)
Breakeven duty cumulative position	10,046	12,056	12,074	12,089	12,138	(850)	(5,839)
Operating income		376,990	391,499	391,862	405,822	410,207	430,817
Cumulative breakeven position as a percentage of operating income		3.2%	3.1%	3.1%	3.0%	(0.2%)	(1.4%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(35,996)	(39,900)	3,407	(27,166)	(31,838)	7
Breakeven duty cumulative position	(41,835)	(81,735)	(78,328)	(105,494)	(137,332)	(137,325)
Operating income	432,771	450,348	507,781	510,301	571,492	652,913
Cumulative breakeven position as a percentage of operating income	(9.7%)	(18.1%)	(15.4%)	(20.7%)	(24.0%)	(21.0%)

Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 states that *"Each NHS trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account"*. NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. The interpretation of the statutory financial duty for NHS trusts to break even was clarified in 1997/99 which recognised that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each and every year, there may be reasons for the NHS trusts to report deficits in one year which may be offset by surpluses achieved in another year(s). This is particularly relevant to situations where NHS trusts must recognise costs in advance of cash outlay, for example for clinical negligence or pension costs, and when managing the recovery of an NHS trust with serious financial difficulties. A run of three years may be used to test the break-even duty, but in exceptional cases the Department of Health may agree to a five year time-scale.

The Trust has reported a deficit position for six out of the last eight years and the cumulative deficit now stands at £137.3m. The result was break even in 2020/21 and whilst the NHS funding regime has yet to be fully finalised for the 2021-22 financial year, the Trust continues to work on plans to deliver a breakeven position.