NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2020-21

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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Performance Report

Chairman's Statement

Over the past year we have faced a tidal wave of Covid-19 which has had a major impact on our patients, staff and services. Our hospitals have coped extremely well in very difficult circumstances, with the NHS meeting its biggest challenge since its inception in 1948. The effects of the pandemic will be felt for very many years, perhaps a decade, as we face a large back log of elective work and potentially hidden demand amongst patients who have yet to come forward for treatment.

It is particularly saddening to have lost our Emergency Department Nurse Estrella Catalan to this deadly virus. Many other staff have been sick themselves or lost friends or family members to this disease.

Our staff have performed an amazing task in coping with the pandemic, taking on new roles and challenges at a moment's notice and delivering the best possible care under very stressful conditions.

Board leadership

During this year of upheaval, our Trust board has benefitted from stable and strong leadership and we have also received unwavering support from our Council of Governors. We were also pleased to welcome Anita Prem to our board as an associate non-executive director as part of a new programme, NeXT Directors, which is designed to support the next generation of talented leaders from diverse backgrounds and to improve senior representation in the NHS. This runs alongside other schemes to support diversity in our workforce.

Community support

One of the themes that stands out this year is the outstanding support we have received from our local community which has sustained us throughout this period. On behalf of the Board, I would like to say a personal thank you and want to acknowledge how important this was in maintaining staff morale knowing that our local community was right behind us.

The assistance we received has come in a variety of ways and from a wide range of people. Local firefighters helped to train our staff in the fitting of PPE masks, retired health and social care workers volunteered to help in our vaccination centre, children sent us cards and paintings and we were overwhelmed with goodwill messages and gifts donated to the Norfolk & Norwich Hospitals Charity. Indeed, the charity has come into its own during this period, being a vital link with the local community and helping us to benefit from national support through the NHS Charities Together, which includes the money raised by Captain Sir Tom Moore.

Future plans

Now we must look ahead and tackle the legacy from the pandemic such as long waiting times and supporting patients whose conditions may have deteriorated as services were disrupted to care for patients seriously ill with Covid-19.

There has been significant change to working practices over the year as many routine outpatient appointments were conducted over the telephone or on video calls. These changes have been welcomed by patients in many cases, reducing the need to travel to hospital and bringing forward positive changes that might otherwise have taken many years. We have also launched our first Virtual Ward where patients are monitored at home using telemedicine which has been described as a 'game-changer' by one of the first patients to use the service.

This raises the issue of how our services will have to change in future to meet the challenges of increasing demand and financial constraints. We have an underlying deficit which we are tackling and it will require further significant changes to set us on a path of financial equilibrium.

Integrated Care System

The Health and Social Care White Paper, published in February 2021, describes how higher quality care will be provided to communities through health and care services working more closely together. A new era of collaboration has emerged after many years of competition amongst organisations.

This last year with our colleagues at the James Paget University Hospital and the Queen Elizabeth Hospital King's Lynn, we launched the Acute Services Integration Programme which established two joint services - a single clinical team runs the Norfolk and Waveney Urology Service across JPUH, NNUH and QEHKL; and JPUH and NNUH run the Norfolk and Waveney Ear, Nose and Throat service.

Being part of an Integrated Care System will help us to progress closer working further with other providers, community services and primary care as we move to new models of care for patients.

Working with commissioners and others, we will be tackling health inequalities and contributing to the Government's levelling up agenda. One of the key elements will be equal waiting times across the ICS footprint to create fairness for our local population. In practice this may require considerable change in linking up services, IT systems and testing the willingness of patients to travel to different centres across the county. We are in an era of enhanced co-operation where we move beyond organisational boundaries and wrap our services around our patients.

The next few years will see significant change in the NHS and, coming hard on the heels of the pandemic, it will be a challenging time for our staff and services.

Tribute to staff

Once again, I would like to pay a tribute to our amazing staff, volunteers and the local community for coming together in this most difficult of years.

The exemplary leadership shown by our Chief Executive Sam Higginson and the executive team as a whole has seen us brave the toughest period in our history. The senior team has kept our organisation on a solid footing and set the course for a successful future.

I am indebted to them for all their hard work and also thank my colleague Non Executives who have provided the necessary assurance and support during this eventful time. I am very proud of our hospitals and the superb teams who care for our patients.

In 2022, we will be celebrating the 250th Anniversary of the Norfolk and Norwich Hospital which saw its first outpatients in 1772. We look forward to marking this auspicious occasion with everyone who has supported us this year.

David White
Chairman

Chief Executive's Statement

This year has been dominated by the Covid-19 pandemic and our response to the massive challenge posed by a new, deadly and highly infectious virus.

During the first wave, we were on a steep learning curve along with the rest of the NHS and the risks of this new virus were just emerging. At the peak of the first wave in April 2020 we treated 87 patients with Covid. Our staff performed magnificently, acting with great leadership and resilience

In the second wave, the demand on our services was much greater with 350 patients being treated in hospital at the peak in January 2021, which represented 40% of our total adult bed base with the remaining 60% being reserved for crucial services including children, maternity, stroke and cardiology.

In early 2021 we had to temporarily postpone our elective programme, with the exception of lifesaving surgery, as staff were redeployed to cover our Covid wards and the Critical Care Unit.

Covid -19 pandemic

Our critical care capacity was increased from 20 beds to 80 beds spread across four areas and we accepted critical care patient transfers from other hospitals, in our role as Regional Surge Centre.

Our staff have been through huge pressures and it has been a time of worry, fear and great sadness. The death of our much loved colleague Estrella Catalan, who worked in our Emergency Department, was devastating to her family, friends and colleagues and the effect was felt across the whole organisation.

Overall, we cared for nearly 2,400 patients during the last year. Sadly we have seen over 650 patients lose their lives during this period. The vaccination programme has been one of the great achievements of the year with a huge organisational effort we have given more than 50,000 vaccinations to our community, which includes older patients, our own staff and other local health and care staff.

I would like to express my admiration for all my colleagues and offer my heartfelt thanks to everyone who played their part in caring for patients and keeping our services running during this difficult period.

We must also recognise the incredible support we have received from the local community, military colleagues and system partners (more detail on page 32). The efforts of the University of East Anglia and Norwich Research Park deserve special mention. At the start of the unfolding COVID-19 pandemic in March 2020, the organisations across NRP came together to collaborate on an immediate response which has helped to reduce the impact of COVID in the local community, providing a national standard Covid-19 testing service which has benefitted the whole of Norfolk and Waveney. NNUH and UEA staff also succeeded in establishing an antibody assay (testing procedure) before to the introduction of this process across the NHS.

This continues to be used for an ongoing research project into the presence of antibodies in care home residents.

There are many other ways in which the hospital benefitted from NRP support, from scientist volunteers, to supplies of hand sanitiser, and accommodation for our staff at UEA. We are fortunate to have such skilled and enthusiastic partners who came to our aid when we needed it most (see page 32 for more details).

Staffing and culture

We have made great progress in developing a culture of openness, developing the Freedom To Speak Up service, consulting staff and discussing difficult subjects.

We have a clear direction for what we need to achieve and the right people at NNUH to do it. We are on an improvement journey to provide the best possible care for patients and experience for staff that we can. In the last few months we have made good progress on our journey to Outstanding with some very solid foundations in place.

Our focus on equality and diversity has been reinvigorated over the last 12 months and to support this we have created a framework of equality standards and actions to measure our progress, as well as a number of hugely enthusiastic staff networks to help us drive this forward (see page 68 for more details).

We recognise the huge impact of the pandemic on our staff and the importance of a supportive environment to aid healing and recovery. We have a range of support in place including ward visits by the Clinical Psychology team, reflective groups, telephone support services and counselling sessions. This is going to be a matter of growing importance as we move into the next phase following the second wave of the pandemic.

More work needs to be undertaken following the publication of the national NHS Staff Survey conducted in 2020. Four of the ten theme scores are lower than 2019: Quality of Care, Immediate Managers, Staff Engagement and Team Working. These are the results that give us most cause for concern, and are the areas where we are taking immediate steps to address the issues raised.

A series of Listening into Action events are being launched in Spring 2021 to involve our staff in determining where we need to do better and what will make a real difference to staff experience (more information on page 73).

Performance

Treating patients for Covid-19 has had a significant impact on the achievement of performance targets as the conditions caused by the pandemic needed us to focus on those patients needing emergency and clinically urgent treatment.

Throughout this period, we have made it a priority to treat patients with cancer, utilising the independent sector with Norwich Spire providing facilities for urgent surgery and chemotherapy (see page 32 for more details). The less urgent elective procedures will take much longer to address and our recovery plan will need a multiple year approach rather than measured in months.

We review our waiting lists by prioritising clinical need and preventing harm to those who are waiting for treatment and we contact patients to monitor their health. Nevertheless, it remains upsetting and frustrating for patients and staff that waiting times have increased across the board.

In March 2021, our focus moved on to recovery with elective care restarting as we tackle the huge backlog of cases – more than 60,000 patients on the waiting list who need our care and 10,000 of those have been waiting for more than 52 weeks.

To boost capacity and help us with our plans for restoration and recovery, we have overseen the biggest construction programme for the N&N Hospital in 20 years and many of the new developments, such as the new ward block, Norfolk Centre for Interventional Radiology, two new adult day

theatres are due to go live in the summer and two new paediatric theatres will be coming on stream in the autumn.

The COVID-19 outbreak will remain with us as we move into 2021/22 and we are preparing for a third wave. Whilst we will have a significant task ahead to reset services and address the treatment needs of patients whose care was postponed, we have also learned many lessons and brought in new ways of delivering care.

Research and innovation
We have played our part in three significant studies during the pandemic - the Novavax Vaccine Trial, national RECOVERY trial and the SIREN study into Covid-19 immunity.

We recruited 500 participants to the Novavax coronavirus vaccine trial, including myself, and this trial has reported successful results, showing 89.3% effectiveness. The national RECOVERY trial was aimed at identifying treatments for COVID-19. The first significant results from the study found that the use of the steroid dexamethasone cut the risk of death by a third for patients on ventilators and reduced deaths by a fifth for patients on oxygen. The SIREN study was Public Health England's national study investigating Covid-19 immunity which aimed to find out whether previous coronavirus infection in healthcare workers results in future immunity to reinfection.

This participation confirms our commitment to supporting national research as well as running our own studies. Our partnership with the University of East Anglia is vitally important in terms of our research programme and producing skilled health professionals for our expanding services. During the pandemic, many final year students at UEA volunteered to help on our wards, boosting staff numbers at a vital time.

The pandemic has driven many innovations including moving 50% of outpatient appointments to phone and video consultation in a matter of weeks – the aspiration for this in the NHS Long term Plan was five years. We have also established a Virtual Ward enabling patients to continue their recovery at home whilst wearing a monitoring device which relays their vital signs, backed up with regular contact from the clinical team.

Use of resources
During the year, we carried out a Financial Governance Review to assist us with tackling our underlying deficit and make our finances sustainable in the longer term.

Many of our services have seen reduced levels of activity because of Covid-19 which has meant some lower costs for staffing and consumables. There is continued focus on delivering the actions identified in the review and our Cost Improvement Programme. Good progress is being made to place us on a stable financial footing and we remain on track to meet our objectives with a surplus of £7.2m against a planned deficit of £11.4m.

Regulation
In April 2020, the CQC report was received which rated the Trust as Requires Improvement overall. The inspectors recognised the sustained and significant improvements that had been made in patient care and recommended that the Trust was removed from special measures. This happened in May 2020 after confirmation by NHS England and Improvement.

The CQC praised many aspects of care from End of Life Care which is rated as Outstanding, Outpatients which is rated Good and notable improvements in Urgent and Emergency Care and Surgery. The domains of Effective and Caring are rated as Good, and the Safe, Responsive and Well-led domains are rated as Requires Improvement.

We were very pleased that the report recognised the improvements that our fantastic staff had made in patient care. Teams across the whole Trust had worked tirelessly with skill and dedication to continuously improve and develop services. This was better than the previous report and was a testament to the huge amount hard work, innovation and professionalism from staff.

The Requires Improvement rating shows the Trust still has improvements to make and marks good progress on the journey to outstanding.

Indeed, there was a further visit by the CQC to the Emergency Department in December 2020 which raised concerns about triage, infection control, staffing levels and performance against the four hour target. In terms of addressing these concerns, we have increased our nursing numbers and recruited a number of new consultants to help bolster the improved culture and stable leadership acknowledged by the CQC. Overall the ED team was rated as good for being caring and effective, with an overall rating of Requires Improvement.

In December 2020, a team from the Health and Safety Executive visited the NNUH to conduct a spot check on our Covid assurance measures. They visited offices and clinical areas to assess our Covid compliance.

We received positive feedback on the day and an action plan is in place to address issues which were raised relating to social distancing and ventilation.

It has been an unprecedented year for the NHS and for our own organisation as a result of the COVID-19 pandemic. The response from our community has been remarkable and we met the challenge thanks to the incredible efforts of our committed staff right across the entire organisation.

At the time of writing, the pandemic is still ongoing, but I have every confidence in the resilience and adaptability of the organisation, its people and its services to provide good quality care for our local population.

Sam Higginson
Chief Executive

Overview of Performance

Welcome to our 2020/21 annual report which describes our achievements during the year, covering our service improvements, finances and performance in key areas.

Purpose of the overview section

This overview section gives a short summary of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Purpose and Activities

We are one of the biggest teaching Trusts in the country with more than 10,000 staff – the N&N is our main hospital, and importantly we have a small hospital in Cromer that delivers a great service to our patients in North Norfolk.

We have world-class facilities here and many specialties at tertiary level, from robotic-assisted surgery, one of the most advanced centres for interventional radiology and our Jenny Lind Children's Hospital - meaning that our patients receive the best service possible, without having to travel further afield.

We are always looking to improve our services and patient experience which means launching new services, such as the mobile chemotherapy unit which takes vital cancer treatments to our patients near their own homes in Norfolk.

As a teaching trust, research is really important to us to work with our partners on the Norwich Research Park and we have developed a strong and thriving partnership between us, the University of East Anglia and Quadram Institute Bioscience. This has already enabled us to deliver world-leading research, such as the Norfolk Diabetes Prevention Study which looked at how diet and exercise interventions could prevent diabetes. The research programmes benefit our communities and the wider population and we are committed to continuing high quality, high value, research to improve health outcomes and people's lives for decades to come.

The Quadram Institute itself is a collaboration between the Trust, the University and the previous Institute for Food Research. Our endoscopy unit, the largest in Europe, is sited in the Institute, as is our Clinical Research Facility.

We work closely with our partners, particularly the other acute hospitals in the county, the James Paget at Lowestoft and the Queen Elizabeth at Kings Lynn. Last year we launched a urology service between all three hospitals and an ENT service between ourselves and the James Paget, and we're actively working on and developing other joint projects. These joined up services benefit patients with equitable access to care across the county, plus shared expertise and quality standards.

The Norfolk and Waveney STP has become an Integrated Care System in shadow form as we wait for the legislation to formalise the arrangement. We anticipate that this will deliver more opportunities to work together to improve services for patients and to improve staff experience.

Brief History

The Norfolk and Norwich Hospital celebrates its 250th anniversary in 2022 - the hospital saw its first outpatients on 11 July 1772 and first inpatients on 17 November 1772.

The hospital became a teaching Trust when it was rebuilt in 2001 and moved from the St Stephen's site in Norwich to Colney Lane on the outskirts of the city. We were authorised as an NHS Foundation Trust on 1st May 2008 in accordance with the National Health Service Act 2006. The NHS Foundation Trust succeeded the NHS Trust formed in 1994.

Strategy

The Trust's existing strategy reached its final year this year and under normal circumstances we would have published our next five year strategy including objectives and priorities. However, the impact of the pandemic has meant that we have decided to extend the current strategic objectives with some renewed priorities until April 2022. This will allow us to better engage our staff, patients, the public and wider stakeholders to understand their experiences of giving and receiving care in the past year, and seek their views on what the shape and vision of the hospital will be for the next five years.

Along with Cambridge, we continue to be one of the main centres for specialist work in the East of England. Patients can access many tertiary services at our hospitals rather than having to travel further afield thanks to investment in services such as robotic surgery, interventional radiology, critical care and cardiology. The pandemic saw us become a regional surge centre with critical care capacity expanded from 20 beds up to 80 depending on demand (see more about the effect of the pandemic on page 31). These types of specialist services are delivered alongside caring for people of all ages with a wide range of more general medical and surgical conditions, particularly the signficant older population that is unique to Norfolk, many of whom come to us with one or more long term conditions.

The national introduction of Integrated Care Systems (ICS), means we are seeing a real change in the way that all health and care providers work together to deliver services. We are part of the Norfolk and Waveney ICS, and are committed to working with our health and care partners to achieve the national aims of improving services, preventing ill-health and ensuring the efficient use of healthcare resources.

Partnership working has already been dramatically accelerated because of the pandemic and saw a strong collective effort between us and our neighbouring hospitals to ensure patients were safely treated. We will continue to work more closely with the James Paget and Queen Elizabeth hospitals to provide solutions for equitable and high quality care for our populations now and in the future. As part of the existing Norfolk and Waveney Hospitals Group we have set up a Committees in Common. The Committees in Common are sub-committees of the Acute Trust Boards and we are confident this will be a positive way to review, plan and improve services, health outcomes and experiences for patients needing hospital care across Norfolk and Waveney. Our Norfolk and Waveney Urology and ENT services are good examples of how these arrangements have been used to support integration and resilience. These services now have single medical teams working together to share expertise and capacity across the three hospitals.

We are very much aware that the majority of healthcare that people experience happens outside of hospital and our commitment to partnership working includes working with primary and community care colleagues to ensure that people stay healthy and only come to hospital when they absolutely have to.

In addition to our healthcare partners we particularly recognise the need to build on our strong links with the University of East Anglia and the Norwich Research Park to develop the vital role they both play in our academic mission and research programmes.

In spite of the pressures of the pandemic, our hospitals have continued to see significant development over the last year, helping us to expand capacity and upgrade our facilities. Here is a summary of our progress:

- A new £7m Norfolk Centre for Interventional Radiology (NCIR) was completed in September 2020. The NCIR is the first in the country to house two C-Arm robots and quadruples the number of interventional suites, placing NNUH among the foremost centres in the UK for interventional radiology.

- A new £14m 100-bed ward block was also opened in September 2020, housing the Acute Medical Units and stroke teams on the first two floors, with the third floor being used to treat high dependency patients during the pandemic.

- £8m is being invested to replace vital imaging equipment, thanks to the Aged Asset's national scheme, which will see the replacement of four MRI scanners a CT scanner at the Trust. An additional CT scanner will also be added in the Radiology department.

- A highly specialised negative pressure isolation unit (NPIU) was built and equipped with the latest technology for patients on high infection risk pathways.

- Purchase of a second surgery robot to carry our complex procedures for urology, gynaecology and colorectal surgery.

- Nearly 500 new beds have been delivered to NNUH as part of a rolling programme to replace equipment used across the hospital.

There are also a number of construction projects underway in 2021:

- The North Norfolk Macmillan Cancer Support Centre at Cromer Hospital which is due to open in summer 2021.

- Work has started on a £2.9m walk-in day procedure unit at NNUH as part of the trust's building improvement programme. This project will see cutting edge equipment housed in three neutral pressure treatment rooms, as well as associated support areas to enhance services for ambulatory patients attending for procedures.

- Building began in March 2021 on a £6.5m dedicated children's theatre complex. Due to be completed over two phases, in phase one we will provide a twin paediatric theatre suite, a six-bay recovery unit, as well as associated supporting facilities. Combined with the new facilities this will create a high standard of children's surgical capacity to meet the needs of NNUH younger patients, both now, and well into the future.

- Work started in February 2021 on our cutting-edge Data Centre, which will house the majority of Digital Health's IT infrastructure. The development has been made possible thanks to a £1m grant from NHSI's Critical Infrastructure fund
- Work has started on a new two-storey modular training facility at the hospital which will primarily be used for our Clinical Skills, Resuscitation, Manual Handling and Healthcare Assistants training.

Key issues and risks

We are working to improve our use of resources, ensuring that our services are efficient and sustainable for the future. We have been reviewing operational and business planning processes to ensure we optimise the use of substantive staff and reduce temporary staffing costs. Making the best use of our elective beds, reducing length of stay and improving discharge processes are key parts of our plan. New models of care such as the Virtual Ward will help us to deliver good outcomes for patients using proven techniques of remote monitoring that allow people to be at home rather than in hospital.

Becoming more efficient will involve harnessing digital technologies to help drive transformation and improve efficiency. For example, the digital transformation of the outpatient experience has been greatly accelerated as a result of the pandemic with many people now being able to access specialist care and opinion without the need to come to the hospital. The EDMS (Electronic Document Management System) is replacing paper records with electronic ones on our first step to becoming a paperless hospital. It means staff will spend more time on patient care and less time on administration with all the information in one place. Work is also progressing on the Electronic Patient Record (EPR) programme. We will be looking at learning from the issues experienced in implementation of EPR systems in other Trusts across the country. We will be aiming to implement a system that will assist communication and system-wide working across Norfolk and Waveney.

As it has across the country the pandemic has had a significant impact on our waiting lists and waiting times. As part of our recovery process, we are planning a return to pre-COVID levels of elective care for cancer, urgent and paediatric patients. We continue to review waiting lists in order to ensure that action is taken to prevent harm to those patients who are waiting for treatment. Each patient has been contacted by the hospital to discuss their condition and to determine if their symptoms indicate that they should be seen sooner.

In May 2020, the CQC rated the Trust as requires improvement overall, an improvement from the previous rating of inadequate. The inspectors recognised the sustained and significant improvements that had been made in patient care. The CQC recommended that the Trust was removed from special measures and this happened in May 2020 after confirmation by NHS England and Improvement. We continue to make improvements in our services, supported by our five year Quality and Safety Improvement Strategy which is the driving force in sustaining a culture of continuous learning and improvement.

There is more work to do on developing our workforce and ensuring our hospitals continue to attract and retain high calibre professionals. We want our hospitals to be a great place to work and develop, to train and have a long and fulfilling career. There is a commitment to invest in the leadership training and development of our managers (see more information in the Staff Report on page 97).

Work starts on new North Norfolk Macmillan Cancer Centre at Cromer Hospital

This project was supported by:

Work to build a state-of-the-art cancer care and support centre at Cromer and District Hospital began in June 2020.

The North Norfolk Macmillan Centre is being built in partnership between Macmillan Cancer Support, the Norfolk and Norwich University Hospitals NHS Foundation Trust and the Norfolk & Norwich Hospitals Charity.

In the latest local cancer strategy, potential demand for cancer services within the Trust was forecast to increase by over 200 per cent over ten years.

Currently most people from the Cromer area have to travel to Norwich for treatment and the new centre will enable more people to access cancer treatment and support closer to home.

The building work on the £4.85million project is expected to finish in summer 2021. It is being funded in a partnership between Macmillan Cancer Support the Norfolk & Norwich Hospitals Charity and the Norfolk and Norwich University Hospitals NHS Foundation Trust.

As we reach the final year of our current strategy, here is the purpose and objectives that we have been working to over the 2020/21 period:

Our purpose

- We will be a provider of high quality health and care services to our local population
- We will be the centre for complex and specialist medicine for Norfolk and the Anglia region
- We will be a recognised centre for excellence for research, education, innovation and workforce development
- We will be a leader in the redesign and delivery of health and social care services in Norfolk.

Our current 18 month objectives

Goal 1 – To be a provider of high quality health and care services to our local population

- Operating a segregation of elective and non-elective pathways to help achieve a safe environment for staff and patients and maximise efficient delivery of an elective care programme.
- Maintaining the Trusts capability to manage infection surges requiring up to 100 HDU beds.
- Ensuring a return to pre-COVID levels of elective care for cancer, urgent and paediatric patients.
- Enabling a return to pre-COVID levels of non –elective
- Fast track the outpatient transformation programme
- Achieve a rating of Good from the CQC in the anticipated 2021/22 inspection
- Have secured approval for the new Diagnostic and Assessment Centre, replacement Aseptic Unit and additional surgical capacity.
- Undertake a redesign planning process for the Emergency Department.
- Marking the Trust's 250th anniversary

Goal 2 – To be the centre for complex and specialist medicine for Norfolk and the Anglia region

- To become a commissioned centre for thrombectomy and major trauma services
- Secure the Trust's positon as the centre for complex cancer work across Norfolk and the surrounding area.
- Successfully open the new IRU facility and continue refurbishment of Cath Labs.

Goal 3 – To be a centre of excellence for research, education and staff development

- Ensure working policies and procedures are in place to support staff who are able to work remotely
- Develop and begin implementation of a plan to improve staff rest wellbeing facilities and services.
- Ensuring Covid-19 Secure hospital, supporting people back to work through adaptations to the workplace, changed working practices and public transport which support restoration of services
- Consolidate and deepen the special partnership with the University of East Anglia and Quadram Institute of Biosciences and continue to appoint more clinical academic posts.

- Deliver agreed strategic digital projects including infrastructure, cyber, e-Obs and electronic document management and measure impact on productivity and safety benefits.
- Build on the digital changes made during COVID-19 to support subsequent waves, recovery and future efficiency and quality improvements.

Goal 4 – To be a leader in the redesign and delivery of health and social care services in Norfolk

- Progress with the strategic programme of Electronic Patient Record with partner Acute Trusts to Final Business Case and Procurement
- Continue to work closely with its acute partners to develop joint clinical teams, shared posts, aligned policies and investment plans.
- To collaborate with Primary Care Networks (PCN), and our community and social care system partners

New era for robotic-assisted surgery at NNUH

This project was supported by:

More patients are set to benefit from cutting-edge surgery at NNUH following a £1m donation from the Norfolk and Norwich Hospital's Charity.

Two new robots will help double the number of robotic-assisted surgeries at the NNUH, which offer more precision for surgeons and help to reduce the time spent in hospital for patients, to up to 600 a year.

For the last four years the hospital has been using one robot for urological surgery and 18 months ago we began carrying out robotic colorectal procedures at weekends. This robot is now being replaced by two newer models.

The Urology team were the first to use one of the new robots in August 2020, followed by complex urology and colorectal procedures plus some gynaecology, thoracic and head and neck surgery.

Vivekanandan Kumar, Consultant Urological Surgeon, who carried out the first surgery using the new robot, said: "This new robot is sleeker and more versatile with added features compared to the one we have used and it makes a huge difference to our theatre capacity.

"Robotic surgery also offers far greater accuracy when removing a tumour, which means better outcomes for our patients. A number of surgical procedures require an amount of stitching and plumbing work inside the patient which is quite challenging. With a robot the patient is left with very, very small scars which is a marker of the very good services we are providing."

Emergency Preparedness, Resilience and Response' (EPRR)

We need to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak - such as the Covid-19 pandemic - or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 and the NHS Act 2006 (as amended).

This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

All NHS funded services must have robust and well tested arrangements in place to respond to and recover from these situations. The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). The Trust is audited annually on these core standards and in 2020 The Trust was fully compliant.

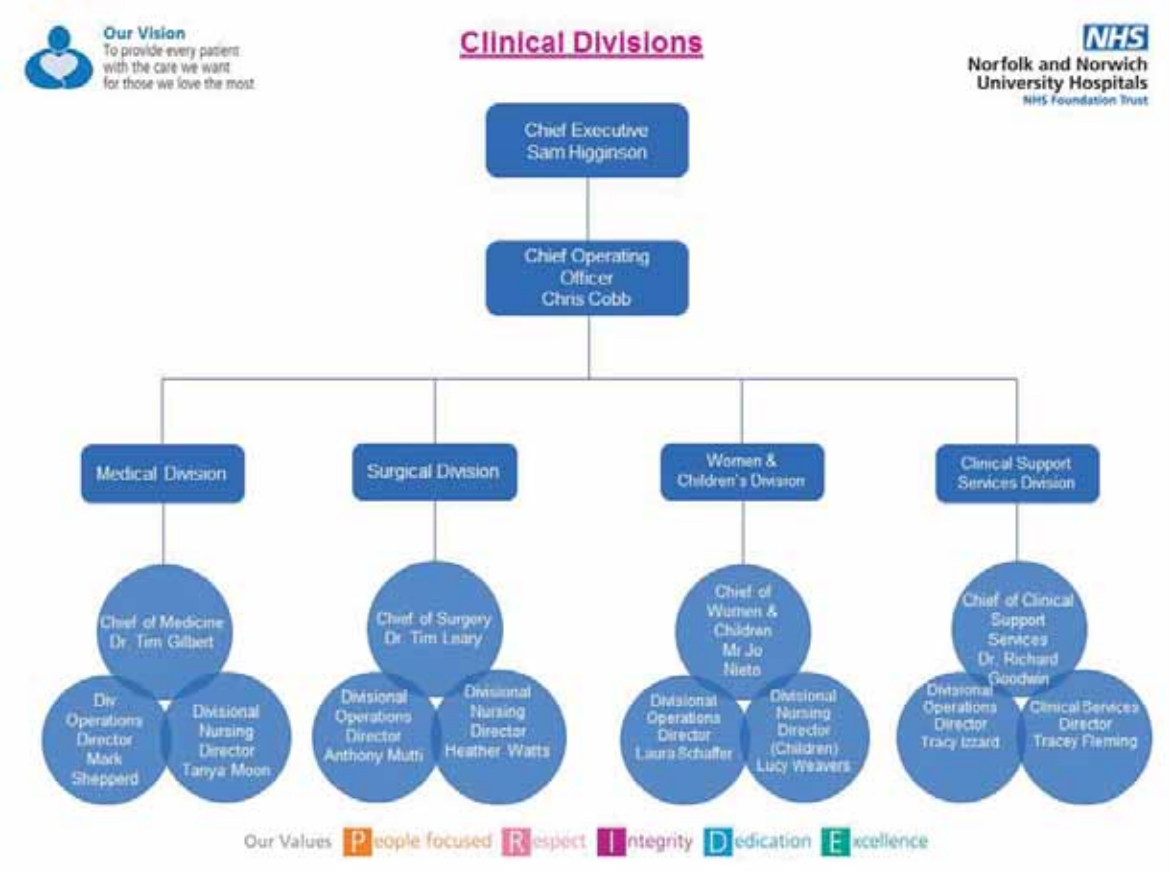
Going Concern

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

How we measure performance

Our services are clinical led with four divisions: Medicine, Surgery, Women and Children's Services, and Clinical Support. There is a Chief of Division role in each who is the overall lead for the division, with all roles within the division ultimately reporting to them. The Chief is accountable for the performance of the division. Each division also has a Divisional Operations Director whose primary role is to direct and control operations to deliver the division's business plan including recruitment and training of staff, management of service line budgets and ensuring service quality. There is also a Divisional Nursing/Clinical Services Director whose role is to direct and control divisional clinical staff including maintaining patient safety and ensuring front-line teams are appropriately motivated and trained.

The Chiefs of Division report to the Chief Operating Officer and are part of the Management Board with the Executive Directors. The Management Board is responsible for the operation and performance of the Trust, reporting to the Trust Board. The divisional structures are show below:

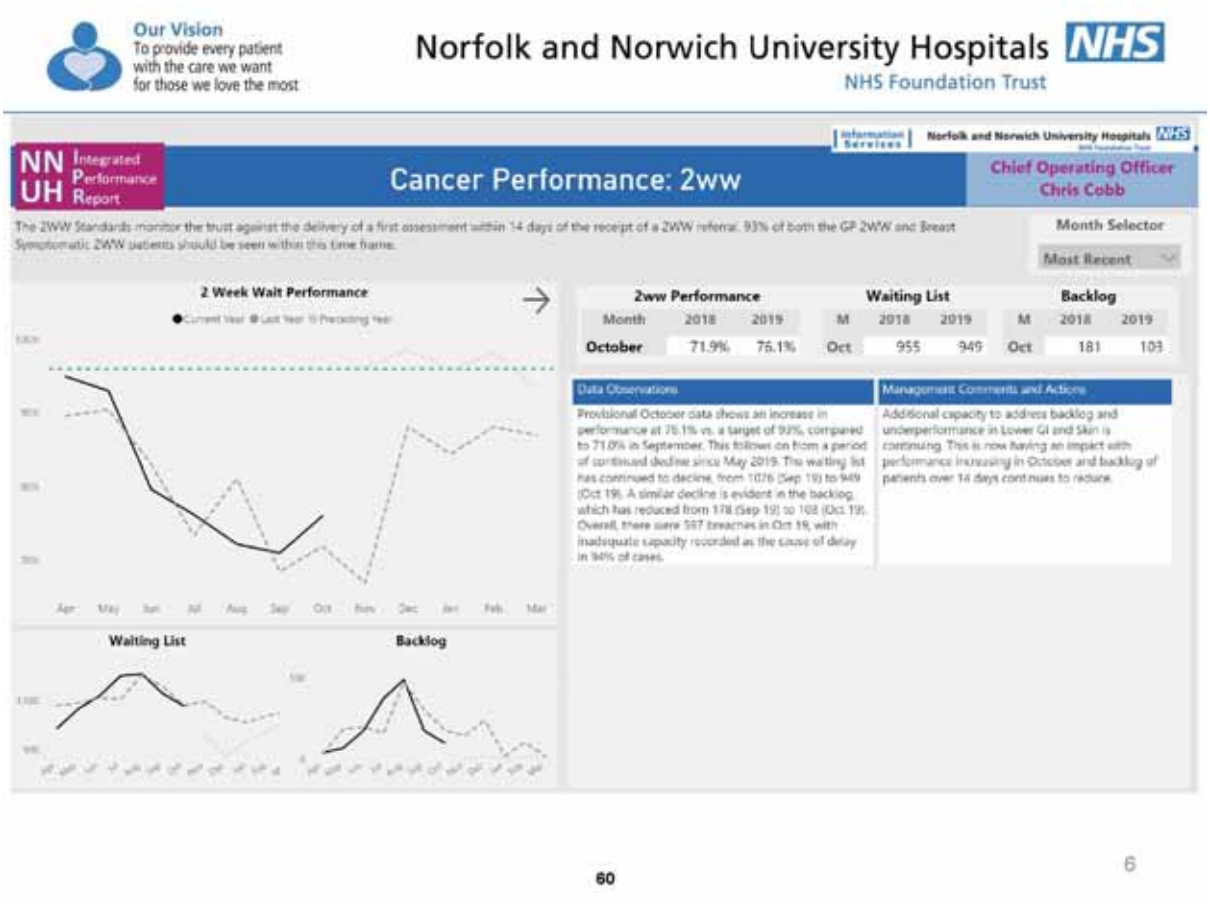


Integrated Performance Analysis

A monthly integrated performance report is produced by the Trust which provides details of how the Trust is performing on key targets such as infection control, cancer waiting time targets, the A&E target, and the 18 week RTT target, plus finance and staffing issues.

It is shared widely with the Trust Board, Management Board, the Council of Governors and with staff. The aim is to keep everyone informed on how the Trust is performing and describe our progress towards meeting targets or introducing new quality initiatives.

Example of a summary slide from the integrated performance report:



During the year, we have been meeting with our regulator NHS England and NHS Improvement to review our performance and have focused on the Trust's improvement plans, financial position and long term strategy.

KPIs, Risk and Uncertainty

The Trust has a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust.

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register. A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents.

Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a High Risk Tracker – reported to both the Board of Directors and Management Board through the Integrated Performance Report.

The Hospital Management Board oversees the identification and mitigation of key risks arising from or relevant to the operation of the Trust. Each of the Management Board committees and governance sub-boards have Terms of Reference and they report regularly to the Management Board on areas of risk or issues that require escalation.

There are eight Governance roles across the Divisions. These Leads will play a key role in promoting a safety first culture, and disseminating and best practice learning across all staff groups.

At board level, the Board Assurance Committees will review the adequacy and effectiveness of the structures, processes and responsibilities within the Trust for identifying and managing key risks;

The Board has established the following Committees of the Trust:

- Audit Committee;
- Quality and Safety Committee;
- Finance, Investments and Performance Committee;
- People and Culture Committee
- Nominations and Remuneration Committee;
- Committee in Common (meeting as part of N&W Hospitals Group)
- Charitable Funds Committee.

For more information, see the Annual Governance Statement on page 123.

CQC Inspection report

In April 2020, the CQC report was received which rated the Trust as Requires Improvement overall. The inspectors recognised the sustained and significant improvements that had been made in patient care and recommended that the Trust was removed from special measures. This happened in May 2020 after confirmation by NHS England and Improvement.

The CQC praised many aspects of care from End of Life Care which is rated as Outstanding, Outpatients which is rated Good and notable improvements in Urgent and Emergency Care and Surgery. The domains of Effective and Caring are rated as Good, and the Safe, Responsive and Well-led domains are rated as Requires Improvement.

This was an improvement from the previous report and represents a huge amount hard work, innovation and professionalism from staff.

The Requires Improvement rating shows the Trust still has improvements to make and marks good progress on the journey to outstanding. Other highlights in the report include good examples of innovation across the Trust; the positive impact being made by the Older Persons Emergency Department, and a focus on research and development as well as the creation of a quality improvement faculty.

Emergency Department
Over the year, a programme of improvements and modified processes at the front door have been implemented which have started to result in improvements in ambulance handover times. Improvements to patient flow and discharge have also been made.

The CQC undertook an unannounced inspection of the Emergency Department in December 2020, triggered by the Trust not meeting the four hour target and issued an enforcement notice after breaches of infection control procedures, staff shortages and delays in triage.

The Trust took immediate action with dedicated staff supporting patient triage available 24/7, improved infection control measures, an increase in nursing numbers and recruitment of eight new consultants due to join in Spring 2021.

Quality Improvement

The five year Quality and Safety Improvement Strategy details some of the ways in which the organisation will embed a culture of continuous quality improvement. It is focused on developing capacity and capability for teams so that Quality Improvement (QI) becomes where staff are able to listen to patients and implement changes that make a real difference to patient care and experience and also test and implement change ideas to improve staff experience. Rather than being a short-lived trend, QI is a consistent part of our culture that gives us and the people we serve confidence about the long-term sustainability of the quality of care.

We want to ensure that everyone in our local community who may use our services has absolute confidence that our care and treatment is safe, effective and completely patient centred.

Our definition of quality encompasses three equally important elements of care: Patient and staff experience, Safe systems and Effectiveness Our Quality Strategy underpins our quality objectives to continually improve patient experience, safety and effectiveness of care.

- It will ensure that challenges facing the Trust are met without compromising quality of care
- Ensure that lessons are learned when things go wrong and meaningful actions taken
- Allow us to recognise when quality is not as good as it should be and empower staff to change it for the better
- Help teams and individuals see the contribution they make to improving quality
- We will demonstrate delivery of national and locally defined quality priorities by clearly defining and measuring what we aim to achieve by when

Our **Quality and Safety Improvement Strategy** describes our strategic intent for Quality Improvement (QI) and sets an ambition to build a culture of learning and continuous quality improvement at all levels.

- Our **staff will feel empowered** to be creative and innovative, always looking for ways to improve their services and the care provided.
- Our **leaders create the conditions and commitment to QI** that is shared across the organisation
- The **focus on quality and safety first** will be a consistent part of our culture, **from ward to Board**

Our aims:

- Reduce the level of patient harm from failures in care and failure to rescue
- Evidence that we are listening and responding to patients and their carers/ families
- Evidence that we are adhering to evidence based good practice
- We will be rated as an 'outstanding ' organisation with a culture of continuous quality improvement
- Improved scores in key questions national patient and staff surveys
- Improving response rate and feedback real-time patient and carers surveys
- Increased response rate from children, young people and their families
- Evidence that themes from serious incidents and complaints and mortality reviews and utilised to prioritise our improvement programmes.

Quality improvement Capacity and Capability

Building capacity in our staff is vital if the aims outlined in our strategy are to come to fruition. Whilst we want to create a movement, success will be limited if we are empowering and enabling staff to take control of these improvement projects without the skills to bring their plans to fruition. In order to achieve our aims, we are investing in the education and training of our workforce.

Our first cohort of staff have enrolled with the NHS Improvement QSIR College. This programme develops candidates to a level where they are assessed and accepted as associate members of the QSIR Teaching Faculty and go on to skill up people within our own organisation and wider health system. Our aims include delivering the QSIR training programme to staff and building a support network for staff undertaking QI projects.

Staff completing improvement work will be supported throughout their project they will then be expected to become 'champions for quality improvement' themselves.

There is an understanding that support given to achieve improvement is then shared with peers, through learning and development. This will enable the network of expertise to expand throughout the organisation.

Equality of service delivery

A core element of our services is respect for dignity, protection of vulnerable patients and of human rights. This is reflected in the specialist work of our Learning Difficulties and Safeguarding team. Through a series of Trust policies and protocols, awareness raising, input on the wards and through staff training the dignity and autonomy of patients is enhanced. This is illustrated, for example, in relation to the deprivation of liberty safeguards, reporting of female genital mutilation, protection against domestic abuse and facilitated decision making for patients with dementia. Regular reports on these issues are received and reviewed through the Trust's Caring and Patient Experience Governance Sub-Board.

The patient experience team has worked **on improving engagement with local, seldom heard communities** through social media, organising virtual events focusing on listening to our minority groups/communities and carers. Support has also been given to our Women and Children's division to improve engagement with children and young people by increasing feedback opportunities (see more information on page 41)

Improvements in end of life care

The Palliative Care Team at NNUH was a finalist in the HSJ End of Life Care Award at the Patient Safety Awards 2020. It comes after personalised end of care plans were developed by the NNUH and have been adopted across Norfolk and Waveney after becoming a beacon of best practice.

The team have overseen a number of initiatives to improve the quality of end of life care at NNUH, including the introduction of a seven day a week palliative care service and an individual plan of care for end of life (IPOC) to guide best practice.

They have ensured that syringe drivers are always available to patients who need them and improved end of life training at the Trust. Extra support has also being given to families with a carer passport, open visiting, glide-away beds and comfort packs so that they can stay overnight and the introduction of Butterfly Volunteers to the hospital. The changes have resulted in an improvement in national end of life audits for the Trust.

Learning disabilities

A specialist nurse was appointed two years ago for children and young people with learning disabilities and autism. This role leads the improvement of effective, accessible quality care delivery for children and young people with learning disabilities and/or Autistic people, working across the Trust and liaising closely with schools, family advocacy groups, other hospitals and community services.

The aim of the role is to support the delivery of equitable healthcare, by providing specialise advice, co-ordinating care, supporting staff understanding and improving the support to families through better processes and education.

There are approximately 350 new referrals for children each year, providing bespoke care planning for children and their families though outpatient appointments, surgery and emergency admissions. A rapid risk assessment tool has also been rolled out for emergency and elective areas so that appropriate adjustments can be put in place to improve patient safety. There is also a hospital team supporting adults with learning disabilities.

NNUH Norfolk Centre for Interventional Radiology opens

This project was supported by:

In September 2020, NNUH opened the doors to the £7m Norfolk Centre for Interventional Radiology (NCIR) which quadrupled the number of interventional suites, placing NNUH among the foremost centres in the UK for interventional radiology.

In turn this will transform the Trust into a national beacon of excellence and a regional training centre in this field.

NCIR Project Manager Ray McFee said: “It is really rewarding to see this Centre open. Years of planning, designing and building this unit have come to fruition. What has been created here is an interventional radiology facility housing some of the most advanced technology in the world. As a trust we have taken a quantum leap in terms of the technology we have put in place.

The Centre sits on the roof of the east block and houses the two freestanding robots and a further two ceiling mounted Artis-Q C-Arms. They are at the centre of the new 1,450sqm space, which will comprise of four large treatment rooms, a fully kitted out 16-bed recovery unit, nurse bases, an anaesthetic room, offices, staff rest rooms, pre-assessment bays, prep rooms, scrubs, toilets and a main reception with waiting area.

Such has been the popularity of the unit that a recruitment drive had to be cut short due to the large numbers of interested people wanting to join NNUH to enhance our interventional radiology research portfolio.

Long term trend analysis

The NHS Long Term Plan, published in January 2019, spells out how new service models will be designed in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. There will be wider action on prevention to help people stay healthy, more online services to avoid visits to hospital and greater digitilsation of patient records. These elements will feature in plans to refresh our strategy during 2021 as we engage with patients, public, staff and partners.

We are also part of an Integrated Care System which is formalised from April 2021, building on the progress already made. ICSs bring together local organisations in to deliver the integration of primary and specialist care, physical and mental health services, and health with social care. They also will have a key role in working with Local Authorities to make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

The launch in 2019 of the Acute Services Integration Programme established two joint services - a single clinical team runs the Norfolk and Waveney Urology Service across the James Paget University Hospital, NNUH and the Queen Elizabeth Hospital at King's Lynn which has already led to successful consultant appointments in the Urology Service; and JPUH and NNUH run the Norfolk and Waveney Ear, Nose and Throat service.

During Covid-19 we worked more closely together and are now working together on other projects such as a joint clinical strategy, aligning policies and guidelines and the Electronic Patient Record, which is expected to transform services in the longer term, making paper a thing of the past, improving efficiency and experience for patients and staff and providing more information for primary care professionals, universally saving time.

With the planned digital improvements this would also mean that patients would only have to give their medical history details once to access the care they need, rather than multiple times as can sometimes be the case. Closer working and the development of standardised pathways, guidelines and training, will also improve services for patients. It will provide more opportunities for staff and will help support increased efficiency and help clinical teams to solve practical issues such as balancing workloads, additional capacity, recruiting to vacancies and supporting on-call rotas.

Covid-19 pandemic

The hospital's services radically changed during the Covid-19 pandemic. In a few short weeks during March and April 2020, we carried out most of our outpatient consultations by telephone or video call, created a second emergency department, moved our cancer centre to the Spire Norwich and became a regional surge centre for patients needing intensive care.

Like all acute hospitals across the country, the Trust already had plans in place to expand critical care capacity to meet potential surges in demand for local patients with coronavirus needing this level of care. The regional surge centre has created extra capacity on top of this to support patients from across the East of England.

The second wave of the pandemic which peaked in January 2021, saw demand soar. The Trust's normal capacity of 20 critical care beds was expanded to 80 as the hospital experienced high levels of pressure as it moved to Local Covid State 5 with up to 350 patients needing hospital care for Covid-19. Over the course of the year, we saw nearly 2400 patients recover from Covid-19 and sadly over 650 patients died.

During this time, our staff made a fantastic, collective team effort in stepping up to the incredible demands that were placed upon them during these extraordinary times. Many staff had to move into new roles and quickly adapt to new teams and working environments.

The impact of the Covid-19 pandemic is immense in terms of the loss of elective work and the scale of the task in tackling the backlog. It has left a legacy of longer waiting times and a significant increase in the waiting list – nearly 60,000 patients.

Our focus has moved to the restoration of elective surgery following the end of the second wave of the pandemic in April 2021.

Cancer patients treated offsite
During the pandemic, an agreement between NNUH and Spire Healthcare has enabled hundreds of Norfolk NHS patients with cancer to receive treatment in Spire's Norwich hospital, allowing NNUH to focus on caring for people with COVID-19.

The partnership between Spire Healthcare and the Trust was made possible under a national agreement, which Spire, alongside the whole of the independent sector, has signed to make its staff, equipment and facilities available to the NHS to help alleviate the pressure caused by the pandemic.

Support from Norwich Research Park
At the start of the unfolding COVID-19 pandemic in March 2020, the six organisations that constitute the Norwich Research Park, (Earlham Institute, John Innes Centre, Quadram Institute Bioscience, The Sainsbury Laboratory, University of East Anglia and NNUH came together to collaborate on an immediate response. Since then some of these collaborations have become closer partnerships, enabling the east of England to reduce the impact of COVID in the local community.

COVID-19 PCR Testing for Pillar 1
At the outset of the COVID-19 pandemic the NHS microbiology laboratories on the NRP had only very limited PCR testing capacity for the whole of Norfolk and Waveney. NNUH and University of East Anglia (UEA) sought and developed additional PCR technologies for Pillar 1 capacity, in collaboration with colleagues at Earlham Institute (EI). This new capacity was established in the haematology research facilities to substantially increase testing capacity for health and care organisations in the Norfolk and Waveney Sustainability and Transformation Partnership.

The test was approved for clinical use and has remained in use throughout 2020/21. Over 100 biomedical staff from across the NRP responded to a call for volunteers to support extended hours for PCR testing. As a result, patients in Norfolk and Waveney had their PCR results returned within 24 hours throughout the first wave whilst other areas were waiting as long as seven days.

Laboratories across the NRP were able to offer additional testing support for neighbouring hospitals including East Suffolk and North Essex NHS Foundation Trust and West Suffolk Hospital.

NNUH and UEA staff also succeeded in establishing an antibody assay before to the introduction of assays across the NHS. This continues to be used for an ongoing research project into the presence of antibodies in care home residents.

The Earlham Institute and NNUH are now offering NHS workers a more reliable test to curb COVID transmission rates in the region. LAMP tests need only be taken once a week, require a saliva sample rather than a nose and throat swab, and positive results doesn't require a confirmatory PCR test. LAMP offers much higher testing capacity than the PCR platform.

Covid Research

RECOVERY study
NNUH researchers took part in the national trial aimed at identifying treatments for COVID-19.

The RECOVERY trial (Randomised Evaluation of COVID-19 Therapy) was led by researchers in Oxford and tested several medications that are safely used for other conditions and have shown promise in helping to treat patients with the new strain of coronavirus in other countries.

Since the launch of RECOVERY (Randomised Evaluation of Covid-19 Therapy), 53 patients at NNUH have been enrolled onto the study.

The first significant results from the study have been published, which found that the use of the steroid dexamethasone cut the risk of death by a third for patients on ventilators and reduced deaths by a fifth for patients on oxygen.

SIREN study
NNUH also joined Public Health England's national study investigating Covid-19 immunity.

The SIREN (SARS-CoV-2 Immunity and Reinfection Evaluation) study aims to find out whether previous coronavirus infection in healthcare workers results in future immunity to reinfection.

The Novavax vaccine trial
The Novavax vaccine trial is a randomised controlled trial where half of the participants will receive two shots of the vaccine and the other half will receive two shots of a placebo

NNUH played its part in the vaccine trial, which has reported that the Phase 3 trial in the UK has been 89.3% effective. It was launched at NNUH in 2020, with support from the National Institute for Health Research (NIHR).

More than 500 participants from NHS, Norwich Research Park and local community took part in the trial in Norfolk, which was run at the NNUH-run Clinical Research Facility at the Quadram Institute.

Proud to be playing our part in important Covid-19 research

Researchers at NNUH are proud to be playing their part in a national trial that has helped identify the first drug to improve survival rates in certain Covid-19 patients.

Since the launch of RECOVERY (Randomised Evaluation of Covid-19 Therapy), 53 patients at NNUH have been enrolled onto the study, which is run by researchers in Oxford and is funded by the National Institute for Health Research (NIHR).

The first significant results from the study were published yesterday, which found that the use of the steroid dexamethasone cut the risk of death by a third for patients on ventilators and reduced deaths by a fifth for patients on oxygen.

Dr Eleanor Mishra, NNUH Respiratory Consultant, said: “This is a very significant development and we are proud to be playing our part in this significant study, which is testing medications that are safely used for other conditions. The use of low dose dexamethasone is going to reduce mortality worldwide, as this is a cheap and readily available drug.

This is now available for treating patients on oxygen or who require ventilation at NNUH because of Covid-19.”

Development and Performance

Four hour standard
Meeting the four-hour performance standard remains an issue with NNUH being one of the busiest hospitals for emergency admissions in the region. To improve our performance, the Board agreed to an external team coming in to support staff in autumn 2020 as they looked to identify improvement initiatives and ensure a programme of work was put in place to facilitate these effectively.

The team from PRISM IMPROVEMENT was on site for five months, assisting teams in ED, AMU and the Operations Centre, as they progressed through a number of work streams in line with our three priorities of addressing:

1. Admission avoidance
2. Demand management
3. Discharge processes.

This important piece of work was designed to improve patient experience and flow through the hospital. It is a whole-trust issue as capacity throughout the trust impacts on the Emergency Department and affects patients moving to the wards in a timely manner.

It is part of the Safer, Better, Faster: Emergency Pathways programme, that the teams across the hospital have been putting into practice to support patient flow through urgent and emergency pathways across the hospital.

In March 2021, the IMT (Incident Management Team) which was set up to manage our handling of the Covid-19 pandemic was restructured to better reflect the work that now needs to go on with all divisions represented at the daily meetings, which look at real time data showing how the hospital is performing.

Team members look at the real-time situation in

- ED
- Bed capacity
- Electives
- Each division
- Average length of stay
- Infection Prevention and Control
- 62-day waits (over 104 days)
- Financial position

A number of work streams have been created, including digital, to bring about improvements. They are designed to meet the requirements of the seven new national standards which are being introduced in April 2021. It follows a pilot scheme in 14 hospitals across the country and is broadly supported by clinicians. These standards better reflect the patient journey and what should be achieved for patients.

The challenge for the Trust is that this will need to be a whole hospital approach; how do we move patients across the whole hospital.

Cancer
The number of cancer patients waiting 104 days increased in the first wave reaching 250 patients in July 2020. Between July and September we were able to reduce that number and this has been maintained by utilising day case capacity. Patients waiting over 104 days also increased at end of December 2020 due to reduction of capacity as the second wave of the pandemic started to surge. Surgery for P2 patients (required within a month) was temporarily suspended on the main NNUH Site and moved to the Spire Hospital.

Electives
The effects of the pandemic will be felt for very many years and we expect the waiting list will continue to grow because were unable to see and treat routine patients during the first and second waves of the pandemic. Staffing and beds were needed to treat patients with Covid-19 as we became a surge centre, accepting very sick patients into our expanded critical care facilities from around the region.

In March 2021, our focus has moved to recovery with elective care restarting as we tackle the huge backlog of cases – more than 60,000 patients on the waiting list who need our care and 10,000 of those have been waiting for more than 52 weeks.

In terms of patients waiting for elective procedures, we review our waiting lists in order to prioritise clinical need and prevent harm to those patients who are waiting. Each patient has been contacted by the hospital to discuss their condition and to determine if their symptoms indicate that they should be seen sooner.

New ward block opens
One of the major projects to address capacity is the new ward block which opened in September 2020. The new £14m, 100-bed ward block opened with level one being utilised in the first instance for the new Acute Medical Unit. During the pandemic, the other two floors were also used to create extra capacity, including space to treat patients needing critical care.

The new AMU space provided 34 additional assessment unit beds for emergency patients. These included four six-bed bays, four rooms suitable for mental health patients and four standard side rooms. Each bay has its own bathroom so patients don't have to leave their bay, which adheres to new Infection Prevention and Control standards.

As well as the new ward block, a highly specialised negative pressure isolation unit (NPIU) was also built and equipped with the latest technology to treat patients ready to take the region's sickest patients

Interventional Radiology expansion
In September 2020, the £7m Norfolk Centre for Interventional Radiology (NCIR) welcomed its first patients.

The NCIR is the first in the country to house two Siemens Artis Pheno C-Arm robots and will quadruple the number of interventional suites, placing NNUH among the foremost centres in the UK for interventional radiology. In turn this will transform the Trust into a national beacon of excellence and a regional training centre in this field.

Interventional radiology is a minimally invasive alternative to open surgery that uses radiological image guidance such as x-ray, ultrasound and CT to diagnose and treat a wide range of conditions and patients from specialities including renal, urology, oncology, vascular, obstetrics, gynaecology and respiratory.

The new 1,450sqm space will comprise of four large treatment rooms, two recovery wards with side rooms, nurse bases, anaesthetic rooms, offices, staff rest rooms, pre-assessment bays, prep rooms, scrubs, toilets and a main reception with waiting area.

Isolation Unit
Following the second wave of the pandemic, a revised pathway for the management of risk assessing and admitting patients has been agreed which includes the use of our new Hoveton isolation unit for actively positive Covid-19 patients.

The new pathway comes into effect from the end of March 2021 with the activation of the £4m highly specialised isolation unit in use.

The nine-bed unit offers two intensive treatment beds and seven high dependency beds, in individual en-suite rooms. To prevent cross contamination of any virus clean air is pumped into the rooms before being passed through a filter and expelled out on the roof.

Second surgical robot
Two new surgical robots are helping to double the number of robotic-assisted surgeries to 600 thanks to a £1m donation from the Norfolk and Norwich Hospital's Charity.

The robots offer more precision for surgeons and help to reduce the time spent in hospital for patients. For the last four years the hospital has been using one robot for urological surgery and 18 months ago it began carrying out robotic colorectal procedures at weekends. This robot has been replaced by two newer models.

The second robot was installed in September 2020 for complex urology and colorectal procedures and will in the future also be used for some gynaecology, thoracic and head and neck surgery.

Imaging equipment
One of the biggest equipment replacement programmes at NNUH took place in 2020/21.

The £8m project replacing vital imaging equipment saw the change-out of four MRI scanners and a CT scanner. A new CT scanner is also being added in the Radiology department to enable the replacement of the existing CT scanner, before providing increased capacity.

The scheme follows 'Aged Assets' government funding that was announced last year, as well as benefiting from Adapt and Adopt Covid-19 funding.

The MRI and CT machines that are being replaced are more than 13 years old. The new equipment will provide a number of benefits, including improved quality of imaging, patient safety improvements, efficiencies, and improved patient and staff experience.

Kidney dialysis centre
A state-of-the-art renal dialysis unit celebrated its first anniversary in early March 2021, having provided a vital service during the pandemic providing routine dialysis for patients away from the main hospital site.

The purpose-built Norfolk and Norwich Kidney Centre is run in partnership with Diaverum, a national specialist provider of renal dialysis services. The new unit is exclusively for patients requiring dialysis and the renal dialysis unit at Cromer and District Hospital remains on its current site.

Some renal dialysis treatment still takes place within NNUH for emergency cases, those too unwell to attend the community based service and for chronic dialysis patients when they come into hospital for other treatments.

Expansion at Cromer & District Hospital
A new cancer care and support centre at Cromer and District Hospital is due to open in summer 2021 in partnership with Macmillan Cancer Support.

The centre – funded by Macmillan and the N&N Hospitals Charity - will enable patients, many of whom currently travel to Norwich, to have their treatment and access support services closer to home.

The North Norfolk Macmillan Cancer Support Centre will include:

- Six chemotherapy treatment chairs with capacity to treat up to 36 patients a day.
- Three new clinic rooms and two new minor procedure rooms, creating an additional 10,000 outpatient appointments annually.
- A Macmillan cancer information and support centre.
- The new unit will also free up space in the main Cromer Hospital building to deliver an extra 600 surgical procedures in dermatology, urology, vascular surgery and pain management.

The number of people living with cancer is growing and predicted to rise from 2.5million today to four million by 2030 in Norfolk, around 6,000 people are diagnosed with cancer each year. There are approximately 35,300 people living with cancer in the county.

Mobile cancer care unit
In order to expand cancer services, an innovative partnership between Cancer charity Hope for Tomorrow and the N&N Hospitals Charity has enabled chemotherapy and other cancer drug therapies to be delivered in a mobile cancer care unit.

The new service was launched in January 2021 visiting market towns around Norfolk to deliver chemotherapy services to patients closer to home whilst replicating the hospital environment.

Breast cancer care
The £800,000 Boudicca Appeal to create a dedicated breast cancer unit at NNUH has raised more than £400,000 thanks to donations from members of the public, groups and businesses.

Equipment is already in place and this includes a Stereotactic mammography system which uses low-dose x-rays to help locate a breast abnormality and remove a tissue and is less invasive than surgical biopsy.

Also now being used is a Hologic LOCalizer guidance system so that very small breast cancers can be more accurately and less invasively identified during diagnosis and surgery, improving the patient's experience and further reducing the need for multiple visits to hospital. The main patient waiting area is also being transformed to provide a calm environment for patients.

Bringing cancer care closer to home with new mobile treatment unit

This project was supported by:

An expansion of cancer services in Norfolk has begun with the launch of a pioneering mobile treatment unit.

The Mobile Cancer Care Unit (MCCU) will hit the road from January 2021, thanks to an innovative partnership between the Norfolk and Norwich University Hospitals NHS Foundation Trust and cancer charity Hope for Tomorrow.

The project started in Fakenham and will bring cancer treatments closer to people's homes to improve patient experience.

The mobile unit is owned and maintained by Hope for Tomorrow and will be provided along with a Nurses' Support Vehicle (NSV). The NNUH staffing costs will be covered by the Norfolk and Norwich Hospitals Charity for the first three years, which has supported funding two registered nurses, a driver, pharmacy support and booking team.

All other costs associated with the MCCU and NSV, such as running costs and maintenance, are covered by Hope for Tomorrow, who receive no government funding and rely purely on donations to keep these units operating.

The vehicle houses a mobile chemotherapy day unit with space for four recliner chairs, infusion pumps, a kitchen area and patient toilet.

Our Financial Performance

The COVID-19 pandemic led to a significant change in operational planning processes for the NHS.

The NHS Chief Executive wrote to all Trusts on 17 March 2020 outlining the 'next steps' on the NHS Response to COVID-19. The 'next steps' included the suspension of the operational planning process for FY20/21 and a fundamental shift in financial governance and business rules within the NHS for an initial period of 1 April 2020 to 31 July 2020. The focus of the COVID-19 response was to achieve simplification and certainty; resilience and continuity; to support the wider economy; and to increase our speed of response whilst maintaining appropriate financial governance and control.

This period was subsequently extended to the full financial year ended 31 March 2021.

The Trust created two key financial plans for this period in line with the 'next steps' guidance.

The first plan covered the six months to 30 September 2020, which assumed a breakeven financial position after reflecting the NHS 'block', top-up and COVID-19 funding arrangements for this period. This plan was achieved. Accordingly, the Trust planned for, achieved, and reported a break-even position for the first six months of the financial year, in line with the wider NHS expectation for the provider sector.

The second plan was for the six months from 1 October 2020 to 31 March 2021. This plan assumed a deficit of £11.4m after reflecting the revised block, top up and COVID-19 funding arrangements for the second half year along with activity recovery expectations. The Trust reported an outturn position for this period of a surplus of £7.2m.

Thus, the reported financial position for the full year was a surplus of £7.2m compared to a full year plan of a deficit of £11.4m.

The overall surplus and improvement on plan was supported by the national response to the pandemic funding arrangements and driven by operational underspends resulting from the impact of the second wave of COVID-19. The second wave caused a pausing of the activity recovery plans, particularly elective activity, resulting in an underspend of the associated operational costs.

Financial Improvement

Throughout the financial year, the Trust has been active in developing efficiency plans responsive to different pandemic/operational scenarios. For the year ended 31 March 2021, £7.6m of efficiency savings was delivered. There has been a focus on capacity planning and productivity improvements alongside the expected activity recovery plans. An enhanced governance and delivery programme with inbuilt quality and safety safeguards underpins this.

Cash Management

The NHS cash regime was reformed as at 1 April 2020. This extinguished all DHSC interim revenue and capital loans as at 31 March 2020 and replaced it with the issue of Public Dividend Capital –which allowed repayment of that historic debt. This meant that the DHSC loans as at 31 March 2020 of £195.1m were 'repaid' following the issue of new Public Dividend Capital of the same amount.

As part of the NHS response to the pandemic, the funding flows were structured to be supportive with certain income streams being in advance at year-end. This, along with the timing of capital cash funding inflows and an increase in capital creditors has resulted in closing cash of £68.9m.

Capital Expenditure
We invested £62.8m in new and replacement capital assets during the year (19/20: £35.8m). The most notable investments were:

- General construction projects linked to the response to COVID-19 - £14.5m
- COVID equipment – £2.8m
- Isolation unit and HDU facility – projects linked to the response to COVID-19 - £9m
- CT and MR replacement – £7.9m
- IT devices refresh - £4.7m
- Other digital investments - £8.8m

Overseas operations
The Trust does not have any overseas operations

Charitable Funding
We are fortunate to be supported by the Norfolk and Norwich Hospitals Charity and The Cromer Community and Hospital Friends Charity. In addition, we are again fortunate to receive support from many external charities and organisations including The Big C and Macmillan. In 2020/21, we benefitted from £2.3m of charitably donated assets (2019/20: £3.8m).

Operational Future
The Trust is now heavily focused on the restoration of services following the impact of the pandemic during 2020/21, as well as remaining prepared for any further rise in Covid-19 prevalence over the next 12 months.

We are experiencing high levels of elective demand, and prolonged waiting times in the aftermath of the acute pandemic which have created risks for delivery of the Trust's performance targets for cancer, 18-weeks and diagnostics, leading to extended waiting times and use of expensive temporary or outsourced capacity.

The Incident Management Team (IMT), which was set up to manage our handling of the pandemic, has been restructured to better reflect the work required to meet performance standards and to improve the patient journey across the whole Trust. All Divisions are represented at the daily meetings looking at real-time data showing how the hospital is performing, including ED, bed capacity, electives, Divisional performance, average length of stay, Infection Prevention and Control, 62-day waits (over 104 days) and our financial position.

Work streams, including digital, have also been created to bring these improvements about, and will help capture data for NHS England and Improvement. These issues are covered in the performance section on page 36 which describes our Better, Safer, Faster: Emergency Pathways Improvement Programme.

We are working closely with system partners to plan and deliver locally against NHS England's priorities for the 2021/22 year ahead, with key areas of focus for us being:

- Looking after the health and wellbeing of staff, helping them to recover and taking action on recruitment and retention
- Continuing to deliver the Covid-19 vaccination programme and continuing to meet the needs of patients with Covid-19
- Building on what we have learned during the pandemic to transform the delivery of services, and accelerate the restoration of elective and cancer care
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.

Whilst delivering against these priorities, the Trust will continue to make improvements in both the quality of services and effective use of resources for the benefit of patients.

NHS England has set out a financial framework that will apply for the first six months of 2021/22 that provides clarity over funding arrangements and supports the Trust, along with system partners, to deliver these priorities.

Financial Accounts 2020/21

The full accounts are attached at the end of this document.

Social and community report

We aim to be at the heart of the local community serving a large population in a rural area. We touch the lives of many people as patients, visitors, members, fundraisers, volunteers and employees. Local people can get involved in a number of ways, principally through our large membership scheme, but also through our ward assurance audit programme, patient panel or as a volunteer.

Patient and family feedback is vital to help us improve the care we provide and we collect the views of patients and families in several ways outlined on the following pages:

Patient, carer and family Feedback

We consistently gather feedback from our patients, carers and communities in a variety of ways. This includes more traditional methods of PALS (Patient Advice and Liaison Service) and complaints but also through our Friends and Family survey collecting responses from across our in-patient, out-patient and emergency areas. Over the course of the Covid-19 pandemic, Friends and Family survey feedback was received virtually in most cases due to infection prevention and control measures implemented across the Trust where areas were decluttered and leaflets removed.

We continue to work closely with Healthwatch Norfolk on the feedback received through their website. However, the visits that used to take place on regular basis to listen to patients and families have not taken place through the pandemic. Feedback was previously shared and published to the Healthwatch website.

Feedback is received and analysed via social media and online outlets such as Care Opinion, Facebook, Twitter and similar. We respond directly and take action where necessary as well as sharing the mostly complimentary comments with our wards and clinics – this is a great morale booster and shows staff the impact of their care. We have created digital engagement plans to reach out to the seldom heard groups including young carers and continue to organise virtual events to allow feedback to be shared for us learn and improve from. We have also attended community groups and events to build rapport and provide opportunity to offer a space for engagement – this has been done virtually during Covid-19 restrictions.

Over the last year the new Patient Experience team has started work on meeting the priorities in the strategic aspiration for the patient engagement and experience which is:

“NNUH is an outstanding organisation with exceptional patient and carer experience where people feel listened to, action is taken and we work in partnership with patients and carers, especially those who are seldom heard, to continually improve.”

Our ambitions for patient engagement and experience:

- Working in partnership with patients is the norm – there is a strong Patient Voice including those who are seldom heard
- Services and pathways are co-designed with patients, staff and other stakeholders
- Feedback, whether complimentary or critical is proactively sought, coordinated, analysed and used to make improvements – ‘you said, we did…together’

- All staff feel engaged, confident and empowered to proactively listen, respond and act - from the top and embedded throughout the organisation
- Volunteers support the patient experience to be outstanding through innovative roles and opportunities

The patient experience team have worked **on improving engagement with local, seldom heard communities** through social media, organising virtual events focusing on listening to our minority groups/communities and carers. Support has also been given to our Women and Children's division to improve engagement with children and young people by increasing feedback opportunities.

The Patients' Panel has grown and is 13 members strong. We are aiming to recruit new panel members to have a panel of 20 members in total. The panel members have adapted and continued to work virtually/via Teams and are embedded across the organisation on committees and supporting Quality Improvement projects for example Transforming Outpatients Committee, Infection Control Committee, Clinical Support Services PPI Forum, Carers Forum and Digital Health work streams.

The Trust has been awarded the Carer Friendly Tick Award- Health (November 2020) in recognition of the work done in identifying and supporting carers. The Carers Forum has been re-instated and had their first meeting in January 2021 after being paused due to Covid restrictions. It follows on from the publication of the Carers policy. The Carers forum is focusing on reviewing and re-setting of the priorities for 2021/22 and are working to increase carer representation within membership.

Relative Liaison Service

A relative liaison service was set up over the pandemic with an aim to improve patient and family experience and wellbeing by maintaining a line of communication during their time in hospital. This will also to enable the nurses and other clinicians to focus on direct patient care by reducing the call volume to the wards. The service was made up of re-deployed staff and has been well received by families. Following the success of the service during the first lockdown, a similar team was set within our Critical Care Complex to support the families of the patients. During the second lockdown, a total of 297 patient's families were supported by the relative liaison teams.

Volunteer work to improve the Patients' Experience

We are proud to have a vibrant volunteer community supporting a broad spectrum of areas within the hospital and who provide an immeasurable contribution to the quality of care received by our patients and their families as well as the working life of our staff. We have over 600 volunteers (across eight sites) providing around 3,000 hours of help throughout the Trust every week and we also benefit from the support of volunteers from many external voluntary, community and social enterprise (VCSE) organisations who are able to provide more specialised help.

People volunteer with us for many different reasons. They may be our recovering patients or retired with time on their hands, some are parents at home with a few spare hours to fit around their children, and some may be wishing to gain the confidence to return to work after a break. Students volunteer to gain valuable experience before embarking on medical studies or other hospital-related careers, and people with learning difficulties or physical and mental health disabilities find volunteering a rewarding way to participate in the work place while feeling valued for the work they do.

The flexible nature of volunteering enables many volunteers to take on more than one role, this offers them a more varied volunteer experience and maximises their potential to make a positive impact throughout the Trust. Our volunteers are trained to support a huge range of areas.

On wards they can provide assistance at mealtimes, companionship to patients without visitors, stimulation for patients with dementia and activities and music to encourage movement. In addition, a team of volunteers carry out audits and surveys gathering patient experience data from our inpatients on iPads. They also collect card surveys from our outpatient clinics and conduct telephone surveys with patients the day after discharge.

A team of Bleep buddies carry bleeps and can be contacted by staff hospital-wide. They respond to ad-hoc requests for errand running, note collecting, patient escorting and wheelchair pushing duties. Another team of volunteers support our school of medicine assisting them with registering students and providing refreshments on exam days.

Fundraising volunteers have been assigned to our fundraising manager and assist her with all kinds of fundraising events and activities and a team of happy welcoming faces provide an extremely knowledgably meet and greet service on our outpatient reception desks.

We also provide volunteer support in some more specialist roles:

End of Life Butterfly Volunteers
We are very proud to work in partnership with the Anne Robson Trust, to bring ‘Butterfly Volunteers’ to the Norfolk and Norwich University Hospital. The role of the Butterfly volunteer is to provide compassionate care and emotional support at end of life for patients across the hospital. The volunteers provide support to patients and their loved ones who have been recognised as being in the last days and hours of their life and can just sit with a patient, offer gentle hand massage or provide a respite break for the families.

Settle in Service
Our ‘Settle-in’ volunteers meet patients as they return home and carry out some simple checks around the home. Duties include making a cup of tea, unpacking patient’s bags, checking the central heating is working and ensuring there are some basic grocery supplies such as bread and milk in the cupboards. Volunteers carry out simple environment risk assessments around the home, offering advice to patients to prevent falls and signposting to other community services, thus increasing the patient’s confidence in returning home. The service dovetails into our Volunteer Driver Service which had enabled us to streamline the discharge process and cut down on delays getting patients home.

Volunteer Drivers
A team of volunteer drivers have access to two wheelchair accessible vehicles provided by our charity. Our volunteer drivers cover the whole of Norfolk and Waveney and are available Monday to Friday to discharge our patients to their homes in comfort. The service is also able to diversify and has assisted our occupational therapists by delivering enablement equipment, our pharmacy by delivering prescriptions and our cancer services by delivering chemotherapy.

NNUH volunteers receive long service awards

More than 50 volunteers at NNUH have received long service awards from the Trust.

Fifty three volunteers who have helped the Trust for more than five years received their awards.

Sam Higginson, NNUH Chief Executive, hit the road with Jamie Goodman, Volunteer drive co-ordinator, to deliver the awards to Janice Beck and Margaret Leggatt, the two longest serving volunteers.

Janice has volunteered at NNUH for 15 years, meeting and greeting patients and their families.

Margaret was one of the first volunteers recruited for the Big C centre when it was built. She has volunteered for 20 years in the Breast Clinic, supporting specialist nurses and patients.

The 82-year-old from Lenwade said she was looking forward to returning to the hospital when the Covid-19 pandemic was over.

“I know it is very busy at the moment and I was very touched to receive a visit from the Chief Executive and was really appreciated. I could not have had better treatment when I had cancer and I have been working with cancer patients and providing emotional support since 2000.”

Older Peoples Medicine
In OPM Volunteers provide a wide range of enrichment activities for patients on wards including puzzles, interactive games on smart screens and tablets, memory box activities and reminiscence exercises. OPM volunteers are able to support older patients across all areas of the hospital, not just OPM departments. They also support the Older People's Emergency Department where they will meet, reassure and accompany patients to further investigations for the duration of their visit. They also offer support to the dementia support team by calling patients' next of kin to discuss and complete 'This is Me' booklets. These booklets can help tell staff and visitors about patients' backgrounds, likes and dislikes and enable a more person-focussed approach to care and support.

Pets As Therapy Dogs
Research provides evidence that dogs can have a positive effect on our patients' wellbeing and assist a speedier recovery. The companionship of a dog and their handler can decrease loneliness, stimulate conversation, encourage movement and social interaction. The hospital is supported by twelve Pets as Therapy volunteers who visit ten different wards. The visiting PAT team includes Anne and her Mini Dashund Lily, Diane and her German Shepherds Yoda and Juke, Jon and his Poodle Ginger Beer, and Sophie with her Bijon Freise Minty. Feedback from the wards is extremely positive, the PAT dogs lift the mood of some of our long stay patients - they allow our patients with dementia to reminisce about having a dog of their own and staff morale is always greatly improved.

Emergency Department
A successful funding bid to NHSE this year has enabled us to recruit a volunteer coordinator specifically for Emergency Services on a secondment basis. Roles are being developed and volunteers recruited to support patients who may be alone and anxious, patients who are elderly and confused, patients who are homeless or even those at end of life. They will also support staff in a wide range of tasks such as providing refreshments, stocking up clinical areas, taking telephone calls, finding wheelchairs, basic admin tasks and collecting patient feedback.

Investing in Volunteers
Similar to "Investors in People" the voluntary services team have successfully been accredited with the Investing in Volunteers (IiV) award (renewable every three years). The process requires an organisation to produce an initial self-assessment then carry out any service developments identified before they receive a three-day visit from an assessor. The assessor is required to scrutinise evidence based practice and interview a selection of volunteers and staff. Those interviewed represent a range of specialities, ages and lengths of service, ranging from those who have volunteered for 15 or more years to those recently recruited (within the last six months) and includes a diverse range of volunteers and staff. NNUH are the only hospital in the country to receive the accreditation for a fifth time.

Membership scheme
As a NHS Foundation Trust, we have a membership scheme with over 16,000 public members. Members receive a copy of our magazine The Pulse and they are invited to talks on health topics and events such as our open day and fete. Members also give their views on health priorities and other issues. More information about membership is given in the Council of Governors' section of the Director's report on page 56.

Health Overview and Scrutiny Committee

The Health Overview and Scrutiny Committee is part of Norfolk County Council and its role is to scrutinise the local health service, ensuring that patients and the public are properly involved in any changes to services. The committee has examined issues such as ambulance turnaround times at A&E and discharge from hospital, looking at the arrangements in our hospital and others locally.

Healthwatch

Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the patient is strengthened and heard by those who commission, deliver and regulate health and social care services. Our patient experience team works closely with Healthwatch to gather patient feedback.

Norfolk & Norwich Hospitals Charity

Despite all the difficulties of this last year, 2020/21 has been another very successful and important period for the Charity.

Financials:

Our draft accounts are yet to be formally audited but they show total income >£3.5m (one of our highest annual totals ever). Grant approvals are also up – with £1.8m expenditure in the year and we carry forward £4.6m of approved grants. Inevitably some recipients have not been able to use their grants this year (due to the pandemic disruption) but the funds are committed for future use – for educational courses, new equipment, enhanced facilities – all to the benefit of patients.

We have been notified of 20 donations through Legacy giving this year – to everyone who remembers us in their Will, and to their families, we are really grateful.

Major Projects:

We are actively using our assets to have the best possible impact and a series of major projects are coming to fruition with support from the Charity:

- this year the mobile chemotherapy unit, Interventional Radiology Unit and surgical robot all started treating patients, all supported by Charity funding;
- enhanced staff facilities have also been provided, including a 'red zone' staff rest area, external bench-tables, staff kitchenette and 25 new cooled water fountains – to keep staff refreshed;
- great progress has also been made in constructing the new cancer care and support centre at Cromer and District Hospital. This was made possible through a £1.8m donation from the N&N Hospitals Charity in partnership with Macmillan Cancer Support and it is due to open in 2021.

Covid-19 & the support of our community

This has been a year like no other and the Covid-19 pandemic placed significant pressure on the Trust, its staff and patients. Staff faced long days spent in PPE, a hospital split into segregated areas, multiple uniform changes, along with the mental toll of so much uncertainty, fear, separation, stress and sadness.

The Charity became a conduit for channelling the care and support of our community to our staff and patients. We created 'pop-up' staff rooms with donated kitchen appliances, fridges and coffee machines. I-pads enabled communication when visiting was restricted whilst gifts of meals sustained staff. The flow of gifts in kind and offers of help was truly unprecedented and hugely appreciated.

Our thanks go to everyone who has helped this year and it is invidious to choose individuals but examples include:

- Army veteran, 96-year-old Brian Garrad raised more than £2,235 by walking 70 laps around his garden – covering over 10 miles in a month – inspired by Captain Sir Tom Moore.
- Nine-year old Phoebe Davison climbed 1,300 flights of stairs in a week, raising £505.
- Sue Gresham completed a 125-mile virtual walk while shielding at home, raising more than £2,500.
- Hughes Electricals donated microwaves, kettles and fridges for staff rest rooms.

When circumstances and national policy permits, we hope to properly recognise the generosity of all our donors, supporters & fundraisers.

Boudicca Breast Unit
Thanks to overwhelming support from our local community for our Boudicca Appeal, the Charity funded the equipment needed to establish a same-day service for patients suspected of having breast cancer.

"This brings us completely into the state-of-the-art in terms of what we can deliver to our patients. It is the latest technological advance and enables us to see a lot more patients a lot more quickly. The new machine also makes biopsies a lot more tolerable for patients and we can diagnose more quickly." Dr Arne Juette – Consultant Radiologist

The Boudicca Appeal will continue – to fund ongoing service development for this group of patients.

£1 million Grant Funds Surgical Robot
A £1m grant from the Charity means more patients benefitting from cutting-edge surgery at NNUH. The grant has supported development of robot-assisted surgery at NNUH, which now has two 'state of the art' devices. These enable surgeons to achieve greater precision and reduce the time that patients need to spend in hospital. These robots will assist in up to 600 surgeries a year – particularly in complex urology and colorectal procedures but also expanding in future intro gynaecology, thoracic and head and neck surgery. The generosity of people donating to the Charity is making a tangible difference – improving the lives of our patients.

Next Steps and Looking to the Future
The N&N Hospitals Charity is actively using its assets to have the best effect for patients, across all the services of the Trust, whether in Norwich, Cromer or elsewhere in the County. We have significant plans for further expenditure – to purchase additional diagnostic equipment for cancer and cardiology patients, support for developing stroke services, and enhancing care in paediatrics and maternity.

We are increasingly working with corporate and business partners. If your business might like to work with our Charity, please do contact our Charity Director – John Paul Garside at charity@nnuh.nhs.uk

We are very grateful for the generosity of all our supporters so that we can do even more for the patients of Norfolk. Next year marks 250 years since the opening of the N&N Hospital (1772-2022). If you would like to receive information about our anniversary events, have suggestions or would like to be involved – 'celebrating the past – preparing for the future' please contact us at 250@nnuh.nhs.uk

To find out more about the Charity or to sign-up for our Newsletter please visit www.nnuhcharity.org.uk or keep up to date with us on twitter @NNUHCharity #NNUHCharity1

The N&N Hospital's Charity 2020/21:

Environment and sustainability

Here is a summary of the work being undertaken to improve sustainability and reduce the Trust's impact on the environment:

- In 2020/21 the Trust has reduced its carbon emissions by nearly 3,500 tonnes. This has been accomplished by procuring grid electricity on a Renewable Energy Guarantees of Origin (REGO) certificated Clean Renewable Tariff.
- The Trust's Environmental Arts Manager has been working in partnership with South Norfolk Council, Easton and Otley College, the woodland trust and other specialists in arboriculture. This year we have planted 150 trees in various forms around the hospital site. Tree species were chosen very specifically to cope with our 'Urban Heat Island' site and rising temperatures of global warming.
- Mott MacDonald was appointed by NNUH this year to carry out a feasibility study for a site wide decarbonisation of heat strategy for the acute hospital site. Among others, the study also considers solar photovoltaic (PV) applicability as well as phasing options and recommendations to mobilise the heat decarbonisation strategy over the next 5 years. The NNUH is a significant user of heat and power, consuming circa 36.3 GWh of gas, equating to over 8,200 tCO2 emissions, per annum.
- The Trust has signed up to the NHS plastics pledge, launched in Autumn 2019

Anti-bribery legislation

In order to ensure the NHS (including our Trust) provides a transparent view of how taxpayers' money is spent, new guidance has come into force which outlines key areas of potential conflict and guides staff on how to manage them

From 1st June 2017, Managing Conflicts of Interest in the NHS came into effect, introducing consistent principles and rules for managing actual and potential conflicts of interest, providing simple advice to staff and organisations about what to do in common situations and supporting good judgement about how interests should be approached and managed

The guidance is supported by an updated Trust policy: Conflicts of Interest and Business Conduct Policy and area on the staff intranet which was accompanied by a communications campaign with staff.

Arrangements to prevent slavery and human trafficking

The Norfolk and Norwich University Hospital supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it, and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses.

Steps taken to date include:

Our arrangements:
People

- We confirm the identities of all new employees and their right to work in the United Kingdom, and pay all our employees above the National Living Wage
- Our Freedom to Speak Up: Raising Concerns Policy, Provides a platform for our employees to raise concerns about poor working practices
- We undertake awareness training to support our staffing teams to understand and respond to modern slavery and human trafficking. Including how to identify potential victims and the impact that each employee at the NNUH can have on keeping present and potential future victims of modern slavery and human trafficking safe.
- Trust staff will contact and work with the Procurement department when looking to work with new suppliers, so that appropriate checks can be undertaken.

Safeguarding:
Our commitment to ensure no modern slavery is reflected in a number of our policies and procedures. These include our Adults and Children Safeguarding Policy and the Procurement Strategy.

Suppliers/tenders:
The Trust complies with the Public Contracts Regulations 2015 and uses mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurement, which exceed the prescribed threshold, whereby bidders are required to confirm their compliance with the Modern Slavery Act.

Our procurement team and contracting team are qualified and experienced in managing healthcare contracts and have received the appropriate briefing on the requirements of the Modern Slavery Act 2015, which includes:

- Confirming compliance of their plans and arrangements to prevent slavery in their activities and supply chain.
- Implementing any relevant clauses contained within the Standard NHS Contract.
- We will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.
- We will adopt best practice advice by The Chartered Institute of Procurement and Supply.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year 2020/21.

Self-soothe support for Children's Emergency Department patients

A sensory and self-soothe project has been launched in the Children's Emergency Department at NNUH to provide support to children and young people with learning disabilities, autism or mental health needs.

A bespoke pack of activities and resources are being given to young patients to support with distraction, grounding techniques and sensory needs when they attend ED for emergency or urgent care.

This was made possible thanks to the support of Starlight Charity and the N&N Hospitals Charity.

Fiona Springall, Children and Young People's Learning Disability and Autism Specialist Nurse, said: "On average each month the Children's ED sees 30 young people with mental health needs and other 15 with learning disabilities and/or autism. These resources will help us support this cohort of patients, to reduce their anxiety levels and develop their engagement while in our care."

"For children with Autism Spectrum Condition, their ability to perceive and interact with the world around them is affected; often combined with sensory sensitivities, focus on routine and alternative means of social communication and interaction. For these young people arriving in an unfamiliar, overstimulating environment, such as the Emergency Department, can have a detrimental impact on their confidence and wellbeing."

Each pack will contain three items, selected bespoke to each individual patient's needs. This could vary from fidget spinners, slime, musical toys or a sensory chew.

"Children with mental health needs are often hesitant or frightened to attend hospital, feeling they are going to be judged for not having a physical health need and this fear of rejection is sadly something they commonly feel in their day-to-day lives," said Kieron Loane, Deputy Mental Health Operational Manager.

The packs will provide the child with appropriate distraction and sensory resources, to enhance their confidence and build trust with the hospital staff and environment.

Approval of the Performance Report

I confirm my approval of the Performance Report:

Sam Higginson
Chief Executive **Date: 11 June 2021**

Accountability Report

Directors' Report

The Board of Directors has overall responsibility for the operational management of the Trust and is charged by statute with ultimate responsibility for the Trust's corporate affairs in both strategic and operational terms. It is responsible for the design and implementation of agreed priorities, objectives and the overall strategy of the Trust.

The composition of the Board of Directors is specified in our Constitution to have a majority of independent Non-Executive Director members and the Board comprises six Executive Directors and eight independent Non-Executive Directors (including the Chairman).

In accordance with the Trust's Constitution, the Non-Executive Directors are appointed by the Council of Governors, typically for a three-year term of office and they usually serve two such three-year terms unless otherwise determined by the Council of Governors. One of the Non-Executive Directors is nominated by the University of East Anglia.

This year the Trust has also been pleased to welcome an Associate Non-Executive Director attached to the Board through the NHS NEXT Directors scheme for 'supporting tomorrow's non-executives'.

The Foundation Trust Code of Governance recommends that NHS Foundation Trusts should identify one of its Non-Executive Directors as Senior Independent Director (SID). The Board has identified Ms Sandra Dinneen as Senior Independent Director.

The Board meets in public every other month and otherwise as required and in accordance with Standing Orders. The Board Agendas are formulated to ensure that time is devoted to strategic, operational and financial matters and there is a strong focus on the quality and safety of clinical services for patients. The Board has approved a Scheme of Delegation of authority and a Schedule of Matters Reserved for decision by the Board. The Trust's Constitution sets out a process for resolution of any conflict between the Board and Council of Governors in the unlikely event that the Chairman cannot achieve such resolution.

Who is on the Board of Directors?

Executive Directors

Chief Executive

Sam Higginson was appointed as Chief Executive of the Trust from October 2019. Sam joined NNUH from Cambridge University Hospitals NHS Foundation Trust where he was Chief Operating Officer. Previously Sam was Director of Strategic Finance for NHS England and Director of Strategic Development at University College London Hospitals NHS Foundation Trust. Sam started his career working with Unicef as a logistics officer co-ordinating the airlift of emergency supplies in Sudan, followed by organising medical teams for a charity in areas of Africa and Afghanistan. He joined NHS London in 2008 after four years on the HM Treasury Health Spending Team. Sam leads the executive team responsible for the overall leadership of our hospitals.

Chief Operating Officer
Chris Cobb was appointed as Chief Operating Officer in January 2019. Prior to becoming COO, Chris was Divisional Operations Director for the Division of Medicine. As COO, Chris is responsible for the operational performance of the Trust and chairs our Divisional Performance Committee.

Medical Director
As Medical Director, Professor Erika Denton is responsible for providing professional strategic medical advice to the Board and leadership on clinical quality and safety and clinical research. Erika has been a consultant radiologist at the Trust since 1999. Erika was appointed to the role of Associate Medical Director at NNUH in 2016 and Medical Director in July 2018. Erika chairs our Clinical Safety and Effectiveness Governance Sub-board, Mental Health Board and Research Oversight Board.

Chief Nurse
Professor Nancy Fontaine was appointed as Chief Nurse in August 2018 and is responsible for professional leadership of nurses, midwives, AHPs, Pharmacists and Bio-Scientists across the Trust. As Director for Infection Prevention and Control and Executive lead for Quality, Safety, Patient Experience and Engagement, the Chief Nurse is responsible for providing professional clinical advice to the Board and for leading non-medical research and education. Nancy chairs our Patient Experience and Engagement Governance Sub-board.

Chief Finance Officer
Roy Clarke was appointed to the Board as our Chief Finance Officer in April 2020. Roy has 22 years of healthcare experience in primary, secondary and tertiary services and before coming to our Trust played a key role in the successful construction, commissioning and occupation programme for a new £200m specialist hospital.

Chief People Officer
Paul Jones was appointed as Chief People Officer in August 2019. Previously Paul had most recently served as the Chief Human Resources Officer, helping open a new state of the art teaching hospital for Women and Children in the Middle East. He has more than twenty years' experience as a Human Resources Director, working for hospitals including Oxford University Hospitals NHS Foundation Trust, Kings College Hospital NHS Foundation Trust, Royal Berkshire NHS Foundation Trust and the Cambridge and Peterborough NHS Foundation Trust.

Non-Executive Directors

Chairman
David White was appointed as Chairman in June 2019. David joined NNUH from East Suffolk and North Essex NHS Foundation Trust – where he was Chairman from 2015. David began his career as a social worker in London before becoming a Director of Social Services then moving to East Anglia as Chief Executive of Suffolk Health Authority in 1994. He went on to spend four years as Chief Executive of Thurrock Council before joining Norfolk County Council, where he held the role of Chief Executive from 2006 until his retirement in April 2013. David has lived in Norfolk with his family since 2010.

David is Chairman of both the Board of Directors and of the Council of Governors and of the Board's Nominations and Remuneration Committee and Council's Appointments & Remuneration Committee.

Dr Geraldine O'Sullivan was appointed as a Non-Executive Director from 1 November 2016 and was reappointed from November 2019. Geraldine is a Consultant Psychiatrist, who was previously the Executive Director of Quality and Medical Leadership, and before that Co-Medical Director, of Hertfordshire Partnership University NHS Foundation Trust. Geraldine is a Member and Fellow of the Royal College of Psychiatrists. Geraldine is Chair of the Quality and Safety Committee, and is a member of the Audit Committee and Nominations & Remuneration Committee.

Professor David Richardson is Vice Chancellor of the University of East Anglia. David was appointed as Non-Executive Director from September 2014, reappointed by the Council of Governors in September 2017 and again in April 2020. David is a Microbiologist with particular research interests in the biochemistry of environmentally and medically important bacteria. David is a Board member of the Anglia Innovation Partners LLP and Quadram Institute Partners Board. David is Chair of our People & Culture Committee and a member of the Nominations & Remuneration Committee.

Julian Foster was appointed as Non-Executive Director in June 2019. Julian is a chartered accountant and corporate treasurer. He was Executive Finance Director of Broadland Housing Association and has held senior finance director roles in growing housing association groups in the Eastern region over the last 20 years. After graduating from Trinity College, Oxford, Julian worked in investment banking until moving to the social housing sector. Julian is Chair of the Trust's Audit Committee and is a member of the Finance, Investments & Performance Committee, Charitable Funds Committee and Nominations & Remuneration Committee.

Dr Pamela Chrispin was appointed as Non-Executive Director from January 2020. Pam has worked in the NHS for more than 30 years and was previously Medical Director of the East of England Ambulance Service, Medical Director at West Suffolk Hospital and Deputy Medical Director at East Anglian Air Ambulance. Pam is a member of the Trust's Quality & Safety Committee, Finance, Investments & Performance Committee and Nominations & Remuneration Committee.

Sandra Dinneen was appointed as Non-Executive Director in January 2020. Sandra was Chief Executive at South Norfolk Council, Head of Economic Development at Norfolk County Council and is currently a board member for Historic England. Sandra is a member of the Trust's Finance, Investments & Performance Committee, Audit Committee, People & Culture Committee and Nominations & Remuneration Committee. Sandra is the Trust's nominated Senior Independent Director.

Joanna Hannam was appointed as Non-Executive Director from January 2020. Joanna has lived in Norfolk with her family for 30 years, was Head of Customer Services and Communications at Norfolk County Council, Executive Director of the Health Improvement Programme at Norfolk Health Authority and was a lay member at Norwich Clinical Commissioning Group. Joanna is a member of the Trust's Quality & Safety Committee, People & Culture Committee, Nominations & Remuneration Committee and chairs the Charitable Funds Committee.

Tom Spink was appointed as Non-Executive Director in June 2020. Tom is an operations director from the engineering and aerospace industries. He has held various key roles at Aviva including CEO of the General Insurance business in Turkey, and began his current role as Group Procurement Director in 2013. Tom was previously a non-executive director at the East of England Ambulance Service NHS Trust. Tom is Chair of the Trust's Finance, Investments and Performance Committee and a member of the Nominations & Remuneration Committee and Charitable Funds Committee.

Changes during the Year
In addition to those noted above, there were a number of changes to the membership of the Board during the year:

- Mr How stood down as Non-Executive Director in May 2020.

Division of responsibilities
There is a clear division of responsibilities between the Chairman and Chief Executive. The Chairman is responsible for:

- providing leadership to the Board of Directors and the Trust;
- facilitating the contribution of the Non-Executive Directors to the success of the Trust in the delivery of high-quality healthcare;
- ensuring effective communication with the Council of Governors;
- the annual evaluation of the performance of the Board and its committees and implementing any action required following such evaluation.

The Chief Executive is responsible for:

- working with the Chairman to ensure the development of strategy that is supported by the Board as a whole;
- overseeing operational implementation of the strategic objectives of the Trust;
- creating a framework of values and objectives to ensure the delivery of key targets, and allocating decision-making responsibilities accordingly;
- ensuring effective communication with employees and taking a leading role, with the Chairman, in building relationships with key external partners and agencies.

Independence of Non-Executive Directors
The Non-Executive Directors bring wide and varied experience to the Board. They also play a crucial role via the assurance committees of the Board.

There is full disclosure of all Directors' interests in the Register of Directors' Interests. The Register is held by the Board Secretary and is publicly available on our website (www.nnuh.nhs.uk).

Any actual or potential conflicts of interest are dealt with in accordance with procedures set out in the Standing Orders for the Board of Directors. The Chairman has not declared any significant commitments that are considered material to his capacity to carry out his role. The Board considers that the Chairman and the Non-Executive Directors satisfy the independence criteria set out in the Foundation Trust Code of Governance.

As required by the Code of Governance, the Board has considered Professor Richardson's role on the Board, given that the University of East Anglia has a material business relationship with the Trust. The Board has considered whether this could affect, or appear to affect, Professor Richardson's independence as a Non-Executive Director.

The Board noted that Professor Richardson's role as the University Vice Chancellor does not require a direct operational relationship with the Trust and, when this is viewed in conjunction with the safeguards against conflicts of interests as set out in the Board's Standing Orders, the Board considers that Professor Richardson satisfies the criteria for 'independence'.

In accordance with Regulations overseen by the Care Quality Commission, Foundation Trusts are required to ensure that all directors meet the requirements of the 'fit and proper persons test'.

Annual checks are conducted against national registers and through a process of annual declarations. The Board can accordingly confirm that all its director level appointments meet the 'fit and proper persons test'.

The Board's Committees
The Board makes a distinction between management responsibility (led by the Chief Executive) and independent assurance responsibility (led by the Non-Executive Directors).

In accordance with our Organisational Governance Framework, the Board has established a number of committees of the Board responsible for obtaining assurance in defined areas most particularly Audit, Quality & Safety, Finance, Investments & Performance and People & Culture. Terms of Reference allocate specific responsibilities between the committees. The Board has also established a Nominations and Remuneration Committee and a Charitable Funds Committee, which reports to the Board acting for the Trust as Corporate Trustee.

During 2020/21 the Board has also established a further committee known as the Committee in Common. This arrangement is mirrored in the two other acute hospital trusts in Norfolk and the three Committees in Common meet together on a monthly basis to enhance co-ordination and efficiency in services across the acute hospital sector. The Trust is represented at meetings of these Committees in Common by the Chairman, Chief Executive, director of Strategy and Joanna Hannam, as a second Non-Executive Director.

Audit Committee:
In accordance with the NHS Foundation Trust Code of Governance, the Audit Committee membership consists only of Non-Executive Directors. The Committee is chaired by Julian Foster with Geraldine O'Sullivan and Sandra Dinneen also as members. The external and internal auditors regularly attend Committee meetings and directors and senior managers also attend as required. The Chair of the Audit Committee meets regularly and separately with the External Auditor and the Head of Internal Audit.

The Committee continuously reviews the structure and effectiveness of our internal controls and risk management arrangements. It oversees an agreed programme of external and internal audit and monitors progress to ensure that any remedial action is taken by management in any areas of identified weakness.

The Trust's external auditors, KPMG LLP, were appointed by the Council of Governors in 2016 and reappointed in 2021 following a formal tender process and in accordance with recommendation from the Audit Committee. The fees for the external audit are set out in note 6 of the financial statements.

Auditor Independence and Non-Audit Services
The Audit Committee reviews and monitors the external auditor's independence and objectivity and considerations of avoiding conflicts of interests formed a specific consideration taken into account in appointing the external auditors. The Trust has a policy by which any non-audit services provided by the external auditor are approved. During 2020/21 KPMG LLP have not been commissioned to provide any services to the Trust in addition to undertaking the external audit of financial statements and any assurance work on the Quality Report.

KPMG LLP is also the external auditor of Norfolk and Norwich Hospitals Charity of which the NNUH Foundation Trust is the Corporate Trustee. The fees in respect of this engagement in 2020/21 are set out in note 6 of the financial statements.

The Chair of the Audit Committee confirms the independence of the external auditors to the Council of Governors at its meeting where the Annual Report and Accounts are presented and also reports any exceptional issues to the Governors during the course of the year should this be necessary.

Statement on disclosure of information to auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which KPMG LLP (the Trust's external auditor) is not aware. They also confirm that they each have taken all reasonable steps in order to make themselves aware of any relevant audit information and to establish that KPMG LLP knows about that information.

Code of Governance and associated disclosures

The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code and has been in place in its revised form since 2014. The Code requires certain disclosures to be made by Foundation Trusts and information is included in this section to demonstrate compliance with the Code and its disclosure requirements.

i) Directors:

- A section of the Annual Report above reports specifically on the Board of Directors, its role and composition. It confirms that the Board considers all of the current Non-executive Directors (NEDs), including the Chairman, to be independent. Through a formal process, the composition of the Board was revised during 2019/20 to increase the number of independent Non-Executive Directors, thereby strengthening the independent majority on the Board.
- All appointments to the Board have been the result of open competition. The Directors Report details the experience of members of the Board and includes information about the standing Committees of the Board, the membership of those Committees, and attendance at meetings.
- An NHS foundation trust's board of directors is responsible for all aspects of the operation and performance of the trust, and for its effective governance. This includes setting the corporate strategy and organisational culture. All the powers of the Foundation Trust can be exercised by the Board of Directors and the Board has a formal schedule of matters specifically reserved for its decision. Other matters are delegated to the Executive Directors and other senior management.
- The Board of Directors is collectively responsible for taking actions which legally bind the Trust. All members of the board of directors have collective responsibility as a unitary board for every decision of the board. The Board of Directors meets regularly and held eleven formal meetings in 2020/21.
- The Chairman of the Trust is Chairman of the Board of Directors and Council of Governors and leads both groups on strategy and monitoring. As detailed above, there is a clear distinction between the roles the Chairman and the Chief Executive.
- Independent professional advice is available as required to the Board or its standing committees and the Trust is a member of the national NHS risk-pooling schemes which provide cover in respect of legal proceedings and other claims against its Directors.
- Meetings of the Board of Directors are routinely open to the public. Governors are encouraged to attend public Board meetings and arrangements are in place for governors to report to the Council of Governors on Board meetings they have attended.

- In line with national guidance on social distancing during the Covid 19 pandemic we have needed to restrict physical access to meetings. To ensure as much openness and transparency as possible however facilities to attend meetings by video/teleconference have been made available and the papers from meetings of the Board are made available via the Trust's website.
- In order to facilitate governor oversight of the role of the Non-Executive Directors, the Board and Council have established a structure whereby designated governor observers attend meetings of Board committees. This practice has been in place since February 2019 and involves systematic reporting to the Council.

ii) ***Governors***:

- The general duties of the Council of Governors are to represent the interests of the Trust's members as a whole and the interests of the public; and to hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors.
- The Council of Governors meets formally four times a year. Details of the composition of the Council of Governors and attendance at meetings are contained within the Council of Governors section of the Annual Report.
- Meetings of the Council of Governors are routinely open to the public. In line with national guidance on social distancing during the Covid 19 pandemic we have needed to restrict physical access to meetings. To ensure as much openness and transparency as possible however facilities to attend meetings by teleconference have been made available and the papers from meetings of the Council are made available via the Trust's website.

iii) Board Independence:

- As detailed above, the Board considers that all the Non-executive Directors who have served during the year are independent according to the principles of the Code. This includes Professor Richardson who, as Vice-Chancellor of University of East Anglia, is appointed to the Board to reflect the Trust's status as a University Hospital Trust hosting the Norwich Medical School.
- Independence is kept under review and is based on whether each Director is independent in character, judgement and behaviour. Also considered are factors such as participation and performance on both the Board and Board Committees.
- Non-Executive Directors (NEDS), including the Chairman, are not NHS employees and do not contribute to the NHS pension scheme in their NED role. Non-executive Directors have confirmed their willingness to provide the necessary time for their duties.
- Appointment of the NEDS is made by the Council of Governors in accordance with standard terms and conditions.
- In addition to the process for maintaining the Register of Interests (detailed below) every meeting of the Board and Board Committees starts with an item for Declaration of Interests relating to any item scheduled for discussion or consideration at the meeting.
- The Chairman holds meetings with the Non-executive Directors without the Executive
- Directors being present. The Senior Independent Director (SID) also meets with the other Non-executive Directors without the Chairman being present.

iv) Policy for Raising Matters of Concern

Arrangements have been put in place by which the Trust's employees may in confidence raise matters of concern. These arrangements are covered in the Trust's Freedom to Speak-Up Policy commonly known as a "Whistle-blowing Policy" and the Trust has appointed a full-time Freedom to Speak-Up Guardian.

v) Board performance

The Board of Directors oversees performance through receipt and scrutiny of a monthly Integrated Performance Report (IPR). The IPR includes standard quality and safety metrics, details of operational performance against relevant national targets and updates on workforce issues and the financial position. The action being taken to reduce identified high level risks is also detailed. The IPR incorporates issues and areas of note/concern highlighted by the Management Board and governance sub-boards.

The meetings of the Board of Directors are managed to ensure that actions are followed up and the Board's reporting requirements are adhered to.

During the course of the year, the Board reviewed its capacity, and that of the management team, to address the current and future challenges facing the Trust, notably the ongoing work to strengthen financial governance and business planning processes.

During 2020/21 the Board undertook a review of its performance including the effectiveness and reporting of its Assurance Committees. This included a questionnaire process co-ordinated by the Board Secretary. Following this review the Board confirms the following in relation to its roles, structure and capacity:

- the Board is satisfied that its Directors are appropriately qualified to discharge their functions;
- the Board is satisfied as to its own balance, completeness and appropriateness to the requirements of the Foundation Trust;
- the Board's Committee and governance structure is appropriate and its progress and efficacy is regularly reviewed;
- the Board considers that it has an appropriate balance of expertise and experience and it has access to specialist advice, as required;
- the Chair of the Audit Committee is a Non-Executive Director with recent and relevant financial experience;
- the Board maintains its Register of Interests which is publicly available on the Trust's website:
  - Professor Richardson has declared his role as Vice-Chancellor of the University of East Anglia;
  - Dr Chrispin declared her role as Deputy Medical Director with East Anglian Air Ambulance;
  - Mr White declared his position as Trustee on the RG Carter Pension Committee;
  - Ms Dinneen declared her role as Strategic Project Advisor – Priscilla Bacon Hospice Care Ltd;

- Professor Fontaine declared her position as Patron of the Anne Robson Trust; and
- Professor Denton declared her position as Partner in Colney Radiology Group LLP.

These Board members have accordingly taken no part in decision of matters that related to the relationship between relevant parties and the Trust. Otherwise the Board can confirm that there are no material conflicts of interest on the Board;

The process for appraisal of Board members is that performance evaluation of the executive directors is undertaken by the non-executive directors and Chief Executive. The appraisal of NEDs is carried out by the Trust Chairman for report to the Appointments and Remuneration Committee of the Council of Governors. The appraisal of the Chairman is co-ordinated by the Senior Independent Director with input from governors and directors.

NHS Improvement has issued guidance which encourages '*all providers to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years".* The Board last commissioned a review by PWC of Board Capacity, Capability and Effectiveness (report November 2018). External assessment of the Trust against the Well-led Framework was conducted by the CQC (report April 2020) resulting in a rating in the Well-Led Domain of 'requires improvement'. During 2020/21 the Trust commissioned an external review of its Financial Governance from RSM, which also provides internal Audit services to the Trust. That Financial Governance review reported in October 2020 and follow-up actions are overseen by the Audit Committee, Finance, Investments and Performance Committee and Trust Board.

vi) Compliance Statement

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The Board of Directors considers that it complies with the main and supporting principles of the Code of Governance. During 2020/21 the Audit Committee reviewed the Trust's Organisational Framework for Governance and compliance against the Code of Governance. In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

A1.1 The Schedule of Matters Reserved for Decision of the Board is an appendix to the Board's Terms of Reference. It does not include a statement with regard to the roles and responsibilities of the council of governors or resolution of any potential conflict between the Council and Board. These matters are addressed elsewhere in the Trust's governance documents – specifically the Terms of Reference for the Council of Governors, Standing Orders and the Trust's Constitution as approved by Monitor/NHSI when authorising the Foundation Trust.

A.5.12 The Trust issues on its website copies of papers for meetings of the Board of Directors, including agendas and minutes. Papers for meetings of the Board that are held in private for reasons of personal confidentiality, commercial confidence or other reason are not circulated.

D.2.3 Since November 2019 national guidance ("*A remuneration structure for NHS provider chairs and non-executive directors")* has been in place and applied by the Council of Governors https://improvement.nhs.uk/resources/remuneration-structure-nhs-provider-chairs-and-non-executive-directors The Council of Governors accordingly does not consult external professional advisers to market test at least once every three years. See the Remuneration Report for more detail.

The following provisions require a supporting explanation, even in the case that the Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is provided to avoid additional unnecessary duplication.

Table of supporting explanation for required disclosures:

Code of Governance **reference**	**Summary of requirement**	**Disclosure**
A.1.1	There should be a schedule of matters specifically reserved for its decision. The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	A formal and Board-approved Schedule of Matters Reserved is in place. See Board of Directors and Council of Governors sections for details on respective roles and decisions. Detail of the Council's role and mechanism for resolving any potential conflict between Board and Council is detailed in the Council terms of Reference, Standing Orders and the Trust's Constitution.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See Directors' Report.

Code of Governance reference	Summary of requirement	Disclosure
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Council of Governors section.
Additional requirement of FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	See Council of Governors section.
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	See Directors Report
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience.	See Board of Directors section.
	Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors section.
Additional requirement of FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	See Board of Directors section
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See section relating to Nominations & Remuneration Committee.
Additional requirement of FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A - open advertisement for Chairman and Non-Executive Directors.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See section relating to Independence of Non-Executive Directors
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	See Council of Governors and Foundation Trust Membership sections

Code of Governance reference	Summary of requirement	Disclosure
Additional requirement of FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).	N/A Governors have not exercised this power.
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See section on Board Performance.
B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	N/A External review conducted in 2018/19. See Board Performance section for further detail.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	See Director's Report and Annual Governance Statement.
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See Audit Committee section and Annual Governance Statement.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See Audit Committee section and Annual Governance Statement
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the	N/A Council of Governors appointed new External Auditor from 2020/21 audit

Code of Governance reference	Summary of requirement	Disclosure
	council of governors has taken a different position.	as recommended
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See Audit Committee Section
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A No Director was released in 2020/21.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	See Council of Governors section.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See Foundation Trust Membership section.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	See Foundation Trust Membership section.
Additional requirement of FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and	See Foundation Trust Membership section.

Code of Governance reference	Summary of requirement	Disclosure
	• a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	
Additional requirement of FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.'	Registers of Interest declared by Directors and Governors are maintained in accordance with a Standard Operating Procedure approved by the Audit Committee and are publicly available on the Trust's website.

Main Activities of the Audit Committee during the Year Ended 31 March 2021
The Audit Committee met on 4 occasions during the year ended 31 March 2021. The focus of the Committee was on:

- governance, risk management and internal control;
- internal audit;
- external audit;
- other assurance functions;
- financial reporting.

During the course of the year the Audit Committee received audit reports from the internal auditors, RSM, in accordance with an agreed Audit Plan and including regular reports on follow-up of recommendations from previous audits. The Audit Plan for 2020/21 included audits relating to Business Continuity Planning, Workforce Policies, Emergency Department Standard Operating Procedures, Bank and Agency Usage, Payroll, Risk Management, Complaints, Accounts Payable, MI and Reporting, Consultant Job Planning, Data Security and Protection Toolkit, Financial Governance Review Follow-up and Deep Dive into Waiting List Initiative Processes.

The Committee received regular reports from the Local Counter Fraud Service including reviews with regard to processes in place to identify and manage risks associated with fraud. The Committee has also reviewed plans for strengthening systems for risk management in the Trust.

The Financial Accounts of the Trust for 2019/20 were reviewed by the Auditors and presented to the Committee in May 2020. In accordance with the established annual cycle, financial performance for 2020/21 is subject to external audit review during April and May 2021, for review of the Accounts by the Committee in May 2021.

Nominations and Remuneration Committee:
The Board Nominations and Remuneration Committee has a membership consisting of Non-Executive Directors and the Chief Executive. It is Chaired by David White. The other members of the Committee are Geraldine O'Sullivan, Julian Foster, Pam Chrispin, Joanna Hannam, Sandra Dinneen, David Richardson, Tom Spink and Sam Higginson. The Secretary to the Committee is the Board Secretary.

The Committee has duties and responsibilities that are detailed in agreed Terms of Reference, reflecting the provisions of the FT Code of Governance. It meets as required and no less than twice a year. During 2020/21 the Committee has met on 4 occasions. In accordance with its Terms of Reference, the Committee reviews the size, structure and composition of the Board of Directors and makes recommendations to the Council of Governors with regard to the recruitment of Non-Executive Directors.

In the case of Executive Director vacancies, the Committee is responsible for identifying suitable candidates to fill vacancies as they arise. During the period of this report the Committee oversaw the process for substantive recruitment of Mr Sam Higginson as Chief Executive. In each case these appointments were achieved with the assistance of recruitment agents, following a national recruitment search and following an open and competitive recruitment process.

The Committee considers levels of remuneration for executive directors and other senior posts that come within the Committee's remit, by reference to other organisations and NHS Foundation Trusts in particular.

During 2020/21, following consideration of national NHS pay-awards, the Committee reviewed and approved revision to remuneration for the executive directors, as reported in the Remuneration Report.

In the case of Non-Executive Director vacancies, the Committee is responsible for advising the Council of Governors on the relevant qualities and attributes required to supplement those already on the Board. The Committee has reviewed the schedule of Non-Executive terms of office and has made appropriate recommendation to the Governors accordingly.

Quality and Safety Committee:
The role of the Quality and Safety Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning quality and safety matters. The Committee has a membership of 6 Board members, including three Non-Executive Directors, Chief Executive, Chief Nurse and Medical Director. The Committee met on 10 occasions during 2020/21.

The Committee has an agreed annual cycle of business and a Work Programme of reports to be received at future meetings. During 2020/21 the work of the Committee has obviously been influenced by the pandemic, and it's reporting schedule has reflected Covid-related risks and priorities. Due to pandemic precautions, all meetings of the Committee have been held remotely and the programme of pre-meeting clinical visits had to be suspended. The Committee has focused on quality and safety related issues arising from operational pressure and disruption caused by the pandemic. The Committee has also scrutinised risks identified through our risk management process, notably those relating to prolonged waiting times and our mobilisation as a regional Covid surge centre.

Matters considered by the Committee during 2020/21 have included the operation of the Trust's clinical governance systems and processes, including our procedures for learning from incidents and examining mortality rates. The Committee has also received regular updates concerning the Clinical Quality Impact Assessment (QIA) process which is used in the Trust to protect quality and safety whilst making financial savings and productivity improvements.

During 2020/21 the Committee has also overseen the development of strategic initiatives to promote quality and safety in clinical care notably in the fields of mental health, maternity, research, and dementia care.

Finance, Investments and Performance Committee:
The role of the Finance, Investments and Performance Committee of the Board is to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning the Trust's financial position, capital schemes and delivery of contractual standards. The Committee has a membership including three Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer, Chief People Officer, Director of Strategy Chief Information Officer and Chief Nurse.

This year the Committee has received regular reports on the rapid work undertaken on the Trust's estate to accommodate the urgent changes necessitated by our pandemic response. The Committee has also sought to support and obtain assurance with regard to other areas of Trust activity and achievement of broader Strategic Objectives, where possible. This has involved particular focus on operational performance, Use of Resources, cost improvement plans, operational and financial planning and actions in response to the Financial Governance Review. The Committee has considered the analysis of the Drivers of the Trust's Deficit and its Draft Financial Strategy. Increasingly reports to the Committee have concerned the Trust's response to growing waiting lists of patients whose treatment has been delayed by the pandemic.

People and Culture Committee
The People and Culture Committee of the Board was established in October 2018 to provide assurance to the Board that the Trust has appropriate and effective strategies and plans in place relating to workforce, education, organisational development and culture. The Membership of the Committee includes three Non–Executive Directors, Chief Executive, Chief People Officer, Chief Operating Officer, Chief Nurse, Medical Director and the Chiefs of Division.

Matters considered by the People and Culture Committee during 2020/21 have included: Freedom to Speak-Up; Staff Survey Actions; PHE Report - disparities in risks and outcomes of Covid-19 for BAME staff; Covid-19 Workforce Restoration; Leadership Strategy; Workforce CIP programme; Equality, Diversity and Inclusivity; Medical Engagement Survey; Flu Vaccination Campaign; National People Plan; Corporate Risk Register; Internal Audit Reports and Gender Pay Gap Report.

Attendance at meetings of the Board of Directors
The Board meets in public bi-monthly and otherwise as required and in accordance with Standing Orders.

During this year the Board of Directors met on 11 occasions. Attendance at meetings of the Board and its Committees was as shown below:

	1 April 2020	29 April 2020	27 May 2020	3 June 2020	24 June 2020	5 August 2020	7 October 2020	4 November 2020	2 December 2020	3 February 2021	3 March 2021
Mr David White	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Roy Clarke[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Cobb	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Erika Denton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ms Sandra Dinneen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Nancy Fontaine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Julian Foster	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Joanna Hannam	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Samuel Higginson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Tim How[2]	✓	✓	X								
Mr Paul Jones	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Dr Geraldine O'Sullivan	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Prof David Richardson	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Mr Tom Spink[3]				✓	✓	✓	✓	✓	✓	✓	✓

[1] Mr Clarke was appointed as Chief Finance Officer in April 2020.
[2] Tim How stood down as Non-Executive Director in May 2020.
[3] Tom Spink was appointed as Non-Executive Director in June 2020.

Attendance at meetings of the Audit Committee
The Audit Committee meets quarterly and met on 4 occasions during the year.

Members	27 May 2020	30 Sept 2020	18 Nov 2020	31 Mar 2021
Mr Julian Foster (Chair)	✓	✓	✓	✓
Ms Sandra Dinneen	✓	✓	✓	✓
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	✓	✓

Nominations & Remuneration Committee
The Nominations and Remuneration Committee meets routinely twice a year and otherwise as required. The Committee met on 4 occasions during the year.

Members	1 April 2020	24 June 2020	5 August 2020	4 November 2020
Mr David White (Chairman and Chair of Committee)	✓	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	✓	✓	✓
Ms Sandra Dinneen (Non-Executive Director)	✓	✓	✓	✓
Mr Julian Foster (Non-Executive Director)	✓	✓	✓	✓
Mrs Joanna Hannam (Non-Executive Director)	✓	✓	✓	✓
Mr Samuel Higginson (Chief Executive)	✓	X	✓	✓
Mr Tim How (Non-Executive Director)[1]	✓			
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	✓	X
Professor David Richardson (Non-Executive Director)	✓	✓	X	X
Mr Tom Spink (Non-Executive Director)[2]		✓	✓	✓

[1] Tim How stood down as Non-Executive Director in May 2020
[2] Tom Spink was appointed as Non-Executive Director in June 2020

Quality and Safety Committee – meeting and attendance
The Quality and Safety Committee met on 10 occasions during 2020/21.

Member	21 April 2020	26 May 2020	16 June 2020	28 July 2020	29 September 2020	27 October 2020	24 November 2020	26 January 2021	23 February 2021	30 March 2021
Dr Geraldine O'Sullivan (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Erika Denton (Medical Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Joanna Hannam (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Sam Higginson (Chief Executive)	✓	✓	✓	**X**	✓	✓	✓	✓	✓	✓

Finance, Investments and Performance Committee – meeting and attendance
The Finance, Investments and Performance Committee met on 12 occasions during the year as follows:

Member	22 April 2020	27 May 2020	17 June 2020	20 July 2020	29 July 2020	30 September 2020	28 October 2020	25 November 2020	27 January 2021	24 February 2021	22 March 2021	31 March 2021
Mr Tim How (Chair of Committee and Non-Executive Director)[1]	✓	✓										
Mr Tom Spink (Chair of Committee and Non-Executive Director)[2]			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Mr Roy Clarke (Chief Finance Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Cobb (Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Mrs Sandra Dinneen (Non-Executive Director)	✓	✓	X	✓	✓	✓	✓	X	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Mr Julian Foster (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Simon Hackwell (Director of Strategy)	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Mr Sam Higginson (Chief Executive)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Jones (Chief People Officer)	X	✓	X	X	✓	✓	X	✓	X	✓	✓	✓
Mr Anthony Lundrigan (Chief Information Officer)[3]			X	✓	✓	✓	✓	✓	✓	✓	✓	✓

[1] Mr How stood down as Non-Executive Director and Chair of the Committee in May 2020.
[2] Mr Spink was appointed as Non-Executive Director and Chair of the Committee in June 2020.
[3] Mr Lundrigan joined as a member of the Committee in June 2020.

People and Culture Committee – meeting and attendance
The People and Culture Committee met 6 times during 2020/21. Attendance was as follows:

	28.05.20	18.06.20	24.07.20	26.10.20	25.01.21	29.03.21
Board members						
Prof David Richardson (Chair and Non-Executive Director)	✓	✓	✓	✓	✓	✓
Chris Cobb (Chief Operating Officer)	X	X	X	X	X	X
Prof Erika Denton (Medical Director)	✓	✓	✓	✓	✓	✓
Sandra Dinneen (Non-Executive Director)	✓	X	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	X	✓	✓	✓	X	✓
Joanna Hannam (Non-Executive Director)	✓	X	✓	✓	✓	✓
Sam Higginson (Chief Executive)	X	✓	✓	✓	✓	X
Tim How (Non-Executive Director)	X					
Paul Jones (Chief People Officer)	✓	✓	✓	✓	✓	✓
Divisional members						
Dr Richard Goodwin (CoD - Clinical Support Services)	✓	X	X	X	X	X
Dr Tim Gilbert (CoD – Medicine and Emergency Services)	X	X	✓	✓	X	✓
Dr Caroline Kavanagh (AMD - Emergency and Urgent Care)	✓	X	X	✓	X	✓
Dr Tim Leary (CoD - Surgery)	✓	✓	X	X	X	X
Jo Nieto (CoD - Women and Children)	✓	X	X	X	X	X

£6.5m children's theatres to be built at NNUH

Building work begins in February 2021 on a £6.5m dedicated children's theatre complex.

Due to be completed over two phases, in phase one we will provide a twin paediatric theatre suite, a six-bay recovery unit, as well as associated supporting facilities. The unit will also be fitted out with new clinical equipment to contemporary standards. Combined with the new facilities this will create a high standard of children's surgical capacity to meet the needs of NNUH younger patients, both now, and well into the future.

Next week early works will be carried out to prepare the site for development starting with cordoning off the area. Demolition and site clearance work will begin the following week commencing Monday 15 February.

The complex will help meet increasing demand on services and deliver an improved experience to patients and carers, including a reduction in waiting times. It will also improve staff experience by enabling them to offer new services in a purpose-built environment for children, which will serve the Norfolk and Waveney community well into the future.

Construction of the twin-theatre development is phase one of a two-phased ambition to deliver a three-theatre complex, with associated recovery and a Children's Day Procedure Unit (DPU).

Council of Governors

The Council of Governors is chaired by David White who, as Chairman of the Trust, acts as a link between the Council and Board of Directors. Directors regularly attend meetings of the Council of Governors and feedback from the Council is a standing agenda item on meetings of the Board of Directors so that the Board is informed of the views of our Members as represented by the Governors.

The Council of Governors is responsible for representing the interests of Foundation Trust members and partner organisations in the governance of the Trust. The Council receives regular reports from the Chief Executive and other Board members on relevant operational and strategic matters. The Council of Governors has a number of specified statutory responsibilities which it has satisfied during the course of the year. In particular the Council has:

- received the Trust's Annual Report and Accounts;
- expressed views for consideration by the Directors in preparing the Trust's strategic plans;
- appointed the external auditors;
- confirmed the substantive appointment of the Chief Executive Sam Higginson;
- reappointed Non-Executive Director Professor David Richardson;
- reviewed remuneration of the Non-Executive Directors and recommended no change and review of the position in 2021;
- confirmed the appointment of Mr Tom Spink as Non-Executive Director.

The term of office for Governors is three years and the appointment of both staff and public Governors is by election by the members. Elections are held on an annual basis to fill any vacancies on the Council. These elections are administered on our behalf by an independent organisation (Mi-Voice) and in accordance with the election rules set out in our Constitution. We promote elections through mailings to members, media coverage and through the Trust's social media channels. The Trust receives a good level of interest from the local community and staff in filling these vacancies and they are usually contested. As at March 2021 the Governors were:

Public Governors

• Erica Betts	Breckland
• Jane Bevington	Norwich
• Peter Bush	Norwich
• Diane DeBell	Norwich
• Nina Duddleston	Breckland
• Carol Edwards	North Norfolk
• Ines Grote	Great Yarmouth and Waveney
• Jackie Hammond	Broadland
• Peter Harrison	South Norfolk
• Chris Hind	South Norfolk
• Mary Pandya	Rest of England
• **Shirley Ricketts**	**Broadland**
• **Matthew Roe**	**North Norfolk**
• **Joy Stanley**	**Breckland**
• **Joanna Tuttle**	**Broadland**

Staff Governors

- Leanne Miller — Clinical Support
- Katie Cullum — Nursing and Midwifery
- Terry Davies — Contractors and Volunteers
- Clare Stubbs — Nursing and Midwifery
- Richard Smith — Medical and Dental
- Annie Cook — Admin and Clerical

Partner Governors

- Tracy Williams — Norwich Clinical Commissioning Group
- Alison Thomas — Norfolk County Council
- Mark Hitchcock — University of East Anglia

Changes during the year:

The following Governors left the Council of Governors in 2020/21:

- **Rob Boyce — Clinical Support**
- **Sheila Ginty — Nursing and Midwifery**
- **Shelagh Gurney — Norfolk County Council**
- **John Nolan — Medical and Dental**
- **John Rees — Broadland**
- **Jane Scarfe — South Norfolk**

A copy of the Register of Interests declared by the Governors can be found on our website at www.nnuh.nhs.uk.

Performance of the Council of Governors and its Committee
During the year, the Governors have been regularly briefed on a wide range of matters affecting the Trust including:

- the management of services in the light of the Covid-19 pandemic;
- the plan to refresh the Trust's strategy in 2021, working with the public, governors, and staff;
- joint working with the Norfolk and Waveney STP and the move towards greater collaboration with partners;
- major developments on the hospital sites, such as the new ward block, the new interventional radiology unit, and the replacement of imaging and radiotherapy equipment;
- our performance against national standards;
- the Staff Survey and Action Plan.

Governor representatives observe our Board Assurance Committees to inform them regarding the work of the Non-Executive Directors.

Attendance at formal meetings of the Council of Governors

The Council of Governors held four scheduled formal meetings in 2020/21. Attendance at Council meetings was as set out below:

		2 April 2020	14 May 2020	30 July 2020	29 October 2020	4 February 2021
1	Mrs Erica Betts	✓	✓	✓	✓	✓
2	Mrs Jane Bevington	✓	✓	✓	✓	✓
3	Mr Rob Boyce[1]	X	X	✓	X	
4	Mr Peter Bush	✓	✓	✓	✓	✓
5	Ms Annie Cook	✓	✓	✓	✓	✓
6	Mrs Katie Cullum	X	X	✓	✓	✓
7	Mr Terry Davies	X	X	✓	✓	✓
8	Prof Diane DeBell	✓	✓	✓	✓	✓
9	Mrs Nina Duddleston	X	✓	X	✓	✓
10	Mrs Carol Edwards	✓	X	✓	✓	✓
11	Miss Sheila Ginty[2]	✓	✓			
12	Mrs Ines Grote	✓	X	X	✓	✓
13	Cllr Shelagh Gurney[3]	X	X	X	X	X
14	Mrs Jackie Hammond	✓	✓	✓	✓	✓
15	Dr Peter Harrison	✓	✓	✓	✓	✓
16	Mr Chris Hind[4]					✓
17	Mr Mark Hitchcock	✓	✓	✓	✓	✓
18	Ms Leanne Miller[5]					✓

19	Mr John Nolan[6]	✓	✓	✓		
20	Mrs Mary Pandya	✓	✓	✓	X	✓
21	Dr John Rees[7]	✓	✓			
22	Mrs Shirley Ricketts[8]					✓
23	Mr Matthew Roe	✓	✓	✓	✓	✓
24	Ms Jane Scarfe[9]	✓	✓	✓	✓	
25	Mr Richard Smith[10]				✓	✓
26	Mrs Joy Stanley	✓	X	X	✓	X
27	Ms Clare Stubbs[11]					✓
28	Miss Penny Sutton[12]	✓	✓	✓	✓	
29	Cllr Alison Thomas[13]					
30	Mrs Joanna Tuttle	✓	X	✓	✓	✓
31	Ms Tracy Williams	X	✓	✓	✓	X

[1] Mr Rob Boyce stood down Autumn 2020
[2] Miss Sheila Ginty stood down in July 2020
[3] Cllr Shelagh Gurney stood down in February 2021
[4] Mr Chris Hind was elected Autumn 2020
[5] Ms Leanne Miller was elected Autumn 2020
[6] Mr John Nolan stood down in October 2020
[7] Dr John Rees stood down in July 2020
[8] Mrs Shirley Ricketts was elected Autumn 2020
[9] Ms Jane Scarfe stood down in Autumn 2020
[10] Mr Richard Smith was elected in October 2020
[11] Ms Clare Stubbs was elected Autumn 2020
[12] Miss Penny Sutton stood down Autumn 2020
[13] Cllr Alison Thomas was appointed in February 2021

Lead Governor

In accordance with the Foundation Trust Code of Governance, the Council of Governors has nominated one of its members to act as Lead Governor with particular responsibility for providing a channel of communication between the Council and NHSI in appropriate circumstances. Until November 2021 Public Governor Jane Scarfe was the nominated Lead Governor with Terry Davies, Staff Governor, as Deputy Lead Governor. Following Jane's departure from the Council, Erica Betts was selected by Council members as Lead Governor.

Appointments and Remuneration Committee of the Council of Governors
In accordance with Statute, the Council has an Appointments and Remuneration Committee. The work of the Committee is supported by the Board Secretary. As at March 2021, Membership of the Committee is:

- Mr David White (Chair)
- Mr Terry Davies (Staff Governor)
- Mrs Carol Edwards (Public Governor)
- Mrs Erica Betts (Public Governor)
- Mr Mark Hitchcock (Partner Governor – UEA)

The Committee is responsible for making recommendations to the Council of Governors with respect to the appointment or reappointment of Non-Executive Directors. This year the Committee has made recommendations regarding the appointment/re-appointment of Tom Spink and David Richardson as Non-Executive Directors.

The Committee is also responsible for overseeing the remuneration of our non-executive directors and making any recommendations for change to the Council. In 2020/21 the Committee reviewed the remuneration of the non-executive directors, in light of national guidance issued in September 2019, and have made recommended no change.

Governor development
Two Working Group meetings took place in August and September and both were well attended. Discussion focused on connections with the Non-Executive Directors, particularly when meetings are being held remotely during the Covid pandemic restrictions, plus the arrangements for governors to communicate and engage with Members.

Non- Executive Directors attend formal Council meetings on a rotational basis, to allow discussion on key areas and on the Board Assurance Committees with which they are associated.

The role of governors is to be highlighted in the Trust's Pulse magazine and to raise awareness of how to raise issues with the governors. A new Member Newsletter is also being developed to improve communication between governors and individual constituencies. Two training sessions for Governors have been arranged with NHS Providers.

Governor expenses
The Governor role is unpaid. When the Council of Governors was established it was agreed that governors were entitled to claim travel expenses for attending meetings. As meetings have been held virtually on MS Teams during 20/21, there have been no governor expenses. For comparison, in 2019/20 there were 16 governors and seven governors claimed £1,356.02

Our Membership
We have three membership constituencies: Public, Staff and Partners:

- The Public Constituency - consists of people over the age of 16 and it includes patients and their carers, as well as the general public. Most are resident within the Local Authority catchment areas of Norfolk and Waveney, although our constituency of 'Rest of England' caters for those living outside this area and reflects the broader catchment area of the Trust's specialist services and the wider range of people with an interest in the Trust;

- The Staff Constituency – includes employees who have worked for the Trust for at least 12 months. This constituency also includes our volunteers and employees of contractors who work with us, as specified in our Constitution;

- Our Partners are represented by Governors drawn from the Clinical Commissioning Groups, local government and our partner University (the University of East Anglia).

The membership has grown since we achieved Foundation Trust status and an annual recruitment campaign maintains the public membership above the 15,000 target minimum set by the Council of Governors. By the end of March 2021 we had 16,476 Public Members.

We have a Membership Strategy. We normally conduct an annual face-to-face recruitment campaign in local libraries and we were unable to carry out this task in 2020 because of the Covid-19 pandemic. This has led to a small dip in our membership numbers which we hope to make up during 2021.

Here is our public membership over the last six years.

Year	Public members
2014/15	16,937
2016/17	16,499
2017/18	17,567
2018/19	17,143
2019/20	17,225
2020/21	16,476

Our staff membership stands at 8,844, making a total of 25,320 members in total.

Communicating and involving our members
We have a programme of internal communication and engagement with staff members which includes a weekly electronic newsletter, staff intranet, in-house magazine (The Pulse), focus groups, surveys and meetings. More detail is given in the Staff Matters section of this annual report.

Public members receive our quarterly magazine, The Pulse. Prior to the Covid-19 pandemic, this publication was used to publicise events throughout the year, such as lectures, the Annual General Meeting and participation in the Patient Choice Staff Award.

For 2020/21, we have held virtual events with our AGM and staff awards held online. The AGM event was consisted of a recorded video event and a live section where people could ask questions of the senior management team and Chairman. Prior to the event, the public were encouraged to vote for their choice of topic in an online poll.

The video talks were about the work of the critical care unit, improvements to palliative care, plus a review of the year including the Trust's finances. The event also included the Inspiration Awards from the Norfolk & Norwich Hospitals Charity which recognised the support from the local community. The awards were pre-recorded with clips from the award winners as part of the AGM presentation.

Governors receive a number of briefings throughout the year, in addition to a regular programme of Q&A sessions with the Chairman, Chief Executive and other directors. These meetings are in addition to the formal meetings and provide opportunity for more detailed discussion about the Trust's services and plans.

Governors have not been able to come on the hospital site during the last year because of the risk posed by Covid-19. All meetings have been online and the judging the Trust's staff awards was also conducted as an online meeting this year.

The following is a summary of the events which have involved members and governors:

- Five governors have helped with judging the staff awards.
- The AGM took place on 7 October 2020.
- An induction event took place for new governors on 15 December 2021.

Members can contact the Membership Office by telephone on 01603 287634 or through the website or by e-mail at membership@nnuh.nhs.uk

Principle for cost allocation
The Trust is compliant with the cost allocation and charging guidance issued by HM Treasury.

Political and charitable donations
No political or charitable donations have been made by the Trust in 2020/21 financial year or previous year.

Income disclosures required by Section 43(2A) of the NHS Act 2006
During 2020/21 income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. Accordingly, the requirement of the Act has been met. Health service income amounted to £668.2m of the total income of £670.5m (2019/20 £668.2m of the total income of £670.5m).

Significant events since the Statement of Financial Position date
There have been no significant events since the Statement of Financial Position date that require disclosure.

Statement from Directors
The Directors consider the annual report and accounts taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Accounts and Statement of the responsibility of the Accounting Officer
The accounts for the year ended 31/03/2021 can be found at the back of this annual report. The statement of the responsibility of the accounting officer is on page 122.

Related party transactions
During the year none of the Board members, Governors or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation trust. Further details on related parties can be found in note 29 to the accounts.

Better payment practice Code
The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Better Payment Practice Code - measure of compliance

	Year ended 31 March 2021		Year ended 31 March 2020	
	Number	**£'000**	**Number**	**£'000**
Total Non-NHS trade invoices paid in the year	119,094	336,310	156,436	325,811
Total Non-NHS trade invoices paid within target	109,603	303,404	104,851	252,084
Percentage of Non-NHS trade invoices paid within target	92%	90%	67%	77%
Total NHS trade invoices paid in the year	3,546	72,271	3,449	48,177
Total NHS trade invoices paid within target	2,523	59,526	1,886	18,585
Percentage of NHS trade invoices paid within Target	71%	82%	55%	39%

Interest paid under the Late Payment of Commercial Debts (Interest) Act 1998
Disclosures relating to any interest paid can be found in note 11.2 to the accounts.

Annual Report on remuneration

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that Trust staff on the VSM pay scale should receive a cost of living pay award of 1.67% to basic pay, backdated to April 2020, matching the increase applied to non-medical contracts across the NHS. The Chief Executive received an uplift in salary, following substantive appointment, backdated to 1st May 2020 (this incorporated any pay award which may have been due for 2020/21). The Medical Director in addition to her managerial duties also maintains a clinical practice and received the Medical & Dental pay award of 2.8% from 1st April 2020. The Medical Director is also entitled under the consultant contract for a Clinical Excellence Award (CEA) in 2020/21.

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

The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with six months' notice. The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal without notice for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Any substantial changes relating to senior managers remuneration made during the year

No substantial changes to senior managers' remuneration were made during 2020/21, other than the uplift outlined above.

Signed by Chair of Remuneration Committee on 11 June 2021 Chairman – David White

Senior Managers' remuneration policy

Future Policy

The table below summarises each of the components of the remuneration package for senior managers which comprise the senior managers' remuneration policy.

Remuneration component	**Applicable to**	**Jurisdiction**	**Relevance to Trust's long and short term objectives**	**Amount payable**
Basic salary	All senior managers	Nominations and Remuneration Committee	Recommendations in respect of basic salary are made to the Nominations and Remuneration Committee by the Chief Executive (for executive directors) and the Chairman (for the Chief Executive) on the basis of assessment of performance at annual appraisal, and specifically achievement of agreed personal objectives that reflect the long and short term objectives of the Trust	Any increases are agreed with reference to external benchmarks and advice as required
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	N/A	Determined by the NHS Pensions Agency
Clinical Excellence Award Scheme	Medical Director only	Determined by Local Awards Committee in accordance with medical and dental employment contract; not awarded by Nominations and Remuneration Committee	Awards are determined by the Local Awards Committee in accordance with an agreed scheme that recognises clinical excellence across 5 domains. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level 9 award is the maximum that can be awarded locally.

Accompanying notes:

(1) There have been no additions or changes to the components of the remuneration package during 2020/21
(2) There are no significant differences between the remuneration policy for senior managers and the general policy for employees' remuneration
(3) The remuneration policy does not include provision for performance-related bonuses or other such schemes

Annual Report on remuneration

Service Contracts

The table below summarises, for each senior manager (Directors who are members of the Board of Directors) who has served during the year, the date of their service contract, the unexpired term and details of the notice period.

Name & Title	Date of Commencement	End Date	Unexpired Term	Notice Period
Executive Directors:				
S Higginson, Chief Executive (Appointed 21 October 2019)	21/10/2019	Ongoing	n/a	6 Months
CM Cobb, Chief Operating Officer	17/04/2019	Ongoing	n/a	6 Months
ERE Denton, Medical Director	01/07/2018	Ongoing	n/a	6 Months
NVC Fontaine, Chief Nurse	01/08/2018	Ongoing	n/a	6 Months
PD Jones, Chief People Officer (Appointed 10 June 2019)	10/06/2019	Ongoing	n/a	6 Months
R Clarke, Chief Finance Officer (Appointed 1 April 2020)	01/04/2020	Ongoing	n/a	6 Months
Non-Executive Directors:				
DR White, Chairman (Appointed 10 June 2019)	10/06/2019	31/05/2022	14 Months	3 Months
GH O'Sullivan, Non-Executive Director	01/11/2016	31/10/2022	19 Months	3 Months
D Richardson, Non-Executive Director	01/09/2014	31/08/2021	5 Months	3 Months
JA Foster, Non-Executive Director (Appointed 1 June 2019)	01/06/2019	31/05/2022	14 Months	3 Months
P Chrispin, Non-Executive Director (Appointed 1 January 2020)	01/01/2020	31/12/2022	21 Months	3 Months
S Dinneen, Non-Executive Director (Appointed 1 January 2020)	01/01/2020	31/12/2022	21 Months	3 Months
JM Hannam, Non-Executive Director (Appointed 1 January 2020)	01/01/2020	31/12/2022	21 Months	3 Months
TI Spink, Non-Executive Director (Appointed 1 June 2020)	01/06/2020	31/05/2023	26 Months	3 Months
T How, Non-Executive Director (Until 31 May 2020)	01/08/2013	31/05/2020	n/a	3 Months

The contracts of employment of the Executive Directors are for indefinite terms and are subject to six months' notice by either side. All Executive Directors are subject to periodic appraisal and are accountable to the Board of Directors for performance in those areas to which they provide executive leadership. The terms of appointment of the Non-Executive Directors are typically for 3 year terms and are subject to three months' notice by either side. There are no provisions within the contracts of employment regarding compensation for early termination for any directors.

The Trust's normal disciplinary policies apply to senior managers. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff

Nominations and Remuneration Committee

The Nominations and Remuneration Committee consists of the Chairman of the Trust, at least three other non-executive directors and the Chief Executive. During 2020/21 the membership comprised the Chairman of the Trust, (Chair of the Committee) and all of the other Non-Executive Directors and the Chief Executive (Sam Higginson).

The Committee meets as required, and at least once a year. In accordance with Monitor's Code of Governance for Foundation Trusts, the role and policy of the Committee is to monitor the level and structure of remuneration for senior managers, having considered comparative salary levels in other organisations and NHS Foundation Trusts in particular.

The Committee met four times during 2020/21, on 1 April, 24 June, 5 August and 4 November 2020. The meetings were quorate. The work of the Committee included consideration of NHS pay awards and agreed a cost of living pay award of 1.67% to basic pay for Trust staff on the VSM pay scale. This was in line with the national 1.67% pay award for staff on Agenda for Change pay scales.

Where an individual's remuneration is above the level of £150,000 per annum pro rata the Remuneration Committee's policy and practice will be in line with the requirements issued by the Cabinet Office.

The remuneration and expenses for the Trust Chairman and Non-Executive Directors are determined by the Council of Governors informed by information issued by organisations such as NHS Providers.

Disclosures required by the Health and Social Care Act

There was a total of 6 Executive Directors in office during the year and 9 Non – Executive Directors, including the Chairman. In aggregate the Directors received reimbursement of expenses of £6,176 with claims from 3 directors. In 2019/20, 20 directors had been in office, being 8 executive directors and 12 non-executive directors. In aggregate they received reimbursement of expenses of £6,333 with claims from 7 directors.

No significant awards were made to past Directors during the 12 months ended 31 March 2021.

The Governor role is unpaid. When the Council of Governors was established it was agreed that governors were entitled to claim travel expenses for attending meetings. In 2020/21 there were 16 governors and there were no claims for expenses (in 2019/20 there were 16 governors and seven governors claimed £1,356.02).

Remuneration – Audited

Name and title		12 months ended 31st March 2021					12 months ended 31st March 2020				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
		(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000
DR White, Chairman (Appointed 10 June 2019)	DR White	50 - 55	0	0	0	55 - 60	40 - 45	100	0	0	40 - 45
S Higginson, Chief Executive (Appointed 21 October 2019)	S Higginson	220 - 225	0	0	305 - 307.5	525 - 530	90 - 95	0	0	107.5 - 110	200 - 205
CM Cobb, Chief Operating Officer	CM Cobb	150 - 155	0	0	37.5 - 40	190 - 195	145 - 150	0	0	157.5 - 160	305 - 310
ERE Denton, Medical Director	ERE Denton	270 - 275	0	0	7.5 - 10	280 - 285	250 - 255	100	0	20 - 22.5	270 - 275
NVC Fontaine, Chief Nurse	NVC Fontaine	145 - 150	0	0	35 - 37.5	180 - 185	140 - 145	0	0	0	140 - 145
PD Jones, Chief People Officer (Appointed 10 June 2019)	PD Jones	140 - 145	0	0	32.5 - 35	175 - 180	105 - 110	0	0	17.5 - 20	120 - 125
R Clarke, Chief Finance Officer (Appointed 1 April 2020)	R Clarke	160 - 165	0	0	280 - 282.5	445 - 450	0	0	0	0	0
JJ Hennessey, Chief Finance Officer (Until 31 March 2020)	JJ Hennessey	0	0	0	0	0	170 - 175	400	0	0	170 - 175
PM Davies, Chief Executive (Until 30 September 2019)	PM Davies	0	0	0	0	0	115 - 120	200	0	0	115 - 120

Name and title		12 months ended 31st March 2021					12 months ended 31st March 2020				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
		(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
JM Over, Director of Workforce (Until 31 May 2019)	JM Over	0	0	0	0	0	20 - 25	0	0	7.5 - 10	25 - 30
P Chrispin, Non-Executive Director (Appointed 1 January 2020)	P Chrispin	10 - 15	0	0	0	10 - 15	0 - 5	0	0	0	0 - 5
S Dinneen, Non-Executive Director (Appointed 1 January 2020)	S Dinneen	10 - 15	0	0	0	10 - 15	0 - 5	0	0	0	0 - 5
JA Foster, Non-Executive Director (Appointed 1 June 2019)	JA Foster	10 - 15	0	0	0	10 - 15	10 - 15	0	0	0	10 - 15
JM Hannam, Non-Executive Director (Appointed 1 January 2020)	JM Hannam	10 - 15	0	0	0	10 - 15	0 - 5	0	0	0	0 - 5
GH O'Sullivan, Non-Executive Director	GH O'Sullivan	10 - 15	0	0	0	10 - 15	10 - 15	0	0	0	10 - 15
D Richardson, Non-Executive Director	D Richardson	10 - 15	0	0	0	10 - 15	10 - 15	0	0	0	10 - 15
TI Spink, Non-Executive Director (Appointed 1 June 2020)	TI Spink	10 - 15	0	0	0	10 - 15	0	0	0	0	0
T How, Non-Executive Director (Until 31 May 2020)	T How	0 - 5	0	0	0	0 - 5	10 - 15	0	0	0	10 - 15
J Fry, Chairman (Until 31 May 2019)	J Fry	0	0	0	0	0	5 - 10	0	0	0	5 - 10

Name and title		12 months ended 31st March 2021					12 months ended 31st March 2020				
		Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total	Salary	All Taxable Benefits	Annual & Long-term Performance Related Bonuses	Pension Related Benefits	Total
		(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
RM Jeffries, Non-Executive Director (Until 31 January 2020)	RM Jeffries	0	0	0	0	0	10 - 15	0	0	0	10 - 15
A Robson, Non-Executive Director (Until 30 September 2019)	A Robson	0	0	0	0	0	5 - 10	0	0	0	5 - 10

Taxable benefits cover the monetary value of benefits in kind, such as car mileage allowances where subject to income tax.

Pension related benefits have been pro-rated / time apportioned for Directors who were appointed or resigned part way through the year.

The element of remuneration relating to the Medical Director's non-managerial role is in the banding £125,000-130,000 (prior year £110,000-115,000).

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

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

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

Fair Pay Multiple

In line with the recommendations of the Hutton Review of Fair Pay, the policy of the Trust is to publish details of the band of the highest paid Director and the relationship between them and the median remuneration of its staff. This comparison involves the people in post at the year end and is based on a full time equivalent basis. The table below discloses this information.

The disclosures in respect of the highest paid director and the information in the following three tables are all subject to audit.

	2020- 21	**2019 - 20**
Band of Highest Paid Director's Total Remuneration (£'000)	270 - 275	250 - 255
Midpoint of band	272,500	252,500
Median Total (£)	29,564	28,781
Remuneration Ratio	9.22	8.77

The banded remuneration, of the highest paid director in the Trust in the financial year 2020/21 was £270-£275K (2019/20: £250-255k).This was 9.22 times (2019/20 – 8.77 times) the median remuneration of the workforce which was £29,564 (2019/20 - £28,781). In 2020/21, 0 (2019/20: 0) employees received remuneration in excess of the highest paid director. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Total Pension Entitlement

2020/21 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2021 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000
S Higginson, Chief Executive (Appointed 21 October 2019)	15 - 17.5	0 - 0	50 - 55	0 - 0	424	190	642
CM Cobb, Chief Operating Officer	2.5 - 5	0 - 2.5	30 - 35	65 - 70	599	36	667
ERE Denton, Medical Director	0 - 2.5	2.5 - 5	70 - 75	180 - 185	1,481	47	1,558
NVC Fontaine, Chief Nurse	2.5 - 5	-2.5 - 0	60 - 65	130 - 135	1,133	45	1,218
PD Jones, Chief People Officer (Appointed 10 June 2019)	2.5 - 5	-2.5 - 0	20 - 25	45 - 50	370	25	422
R Clarke, Chief Finance Officer (Appointed 1 April 2020)	12.5 - 15	27.5 - 30	50 - 55	105 - 110	533	197	739

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

2019/2020 Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2020 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2020 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2020 £'000
S Higginson, Chief Executive (Appointed 21 October 2019)	0 - 2.5	0 - 0	30 - 35	0 - 0	340	33	424
CM Cobb, Chief Operating Officer	7.5 - 10	15 - 17.5	25 - 30	65 - 70	421	147	599
ERE Denton, Medical Director	0 - 2.5	-5 - -2.5	70 - 75	175 - 180	1,399	34	1,481
NVC Fontaine, Chief Nurse	-2.5 - 0	-10 - -7.5	55 - 60	130 - 135	1,106	0	1,133
PD Jones, Chief People Officer (Appointed 10 June 2019)	0 - 2.5	0 - 2.5	15 - 20	45 - 50	333	5	370
PM Davies, Chief Executive (Until 30 September 2019)	-15 - -12.5	-37.5 - -35	65 - 70	210 - 215	0	0	0
JM Over, Director of Workforce (Until 31 May 2019)	0 - 2.5	-2.5 - 0	30 - 35	60 - 65	450	0	440

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

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

Bonus

The Trust is required by NHSI to disclose any payments that fall with the definition of "Performance Related Bonuses" and it has been determined by the Department of Health that Clinical Excellence Awards (CEA) meet this definition. As such they have been disclosed as a "Bonus". Clinical Excellence awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. Clinical Excellence Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards. These payments were previously classified within Other Remuneration. There have been no new Clinical Excellence Awards payable to the Directors in 2020/21, however one individual who has held the role of Medical Director during the period 2020/21 was in receipt of clinical excellence award as part of their remuneration packages that were determined in previous years.

Signed on behalf of the Board on 11 June 2021 Chief Executive – Sam Higginson

Staff Report

Introduction

We have nearly 10,000 staff and volunteers who are at the heart of what we do. The year has been and continues to be an exceptionally challenging time for our hospital during the Covid-19 pandemic and we are grateful for the outstanding efforts our staff. We value the contribution made by each and every staff member, and recognise that lots of our staff have had to work very differently in meeting the demands on our services.

It is because of each and every member of our team that we are able to turn our vision into reality, seeking every day to "provide every patient with the care we want for those we love the most". We are on a journey to outstanding and we want to ensure our staff feel valued and appreciated, such that they feel proud to work here and act as ambassadors for our hospital.

Analysis of average staff numbers

The information below shows the average staff numbers within the Trust from April 2020 to March 2021.

Average number of employees (WTE Basis)	2020 /2021	2020 /2021	2020 /2021	2019 /2020	2019 /2020	2019 /2020
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	1,281	707	574	1,275	691	584
Ambulance staff	-	-	-	-	-	-
Administration and estates	1,386	1,322	64	1,334	1,264	70
Healthcare assistants and other support staff	2,601	2,263	338	2,348	1,956	392
Nursing, midwifery and health visiting staff	2,493	2,293	200	2,395	2,163	232
Nursing, midwifery and health visiting learners	2	2	0	2	2	0
Scientific, therapeutic and technical staff	714	675	39	670	637	33
Healthcare science staff	365	340	25	304	283	21
Social care staff	0	0	0	-	-	-
Other	4	3	1	3	3	-
Total average numbers	**8,846**	**7,605**	**1,241**	**8,331**	**6,999**	**1,332**

Analysis of Staff costs

The tables below set out the cost and number of staff for the last two years separately analysed between those staff members with permanent employment contracts with the Trust and those who do not have a permanent employment contract.

This table shows the gross cost of staff, analysed between those who are employed on permanent contracts and others (criteria as per previous table):

	2020/21			2019/20		
	Total	Permanent Staff	Other	Total	Permanent Staff	Other
	£000	£000	£000	£000	£000	£000
Salaries And Wages	353,257	303,621	49,636	308,123	258,834	49,289
Social Security Costs	32,917	28,292	4,625	29,279	24,595	4,684
Apprenticeship Levy	1,670	1,435	235	1,504	1,263	241
Pension cost - defined contribution plans employer's contributions to NHS Pensions	40,412	34,734	5,678	36,379	30,560	5,819
Pension cost - employer contributions paid by NHSE on provider's behalf	17,653	15,173	2,480	15,829	13,297	2,532
Pension cost – other	73	0	73	42	0	42
Termination Benefits	118	118	0	2,116	2,116	0
Temporary Staff - Agency / Contract staff	10,360	0	10,360	13,779	0	13,779
Total Gross Staff Costs	456,460	383,373	73,087	407,051	330,665	76,386

Breakdown of male and female staff as at 31 March 2021

	Male	Female
Executive Director	4	2
Non-Executive Director	4	4
Other staff	1,947	7,348

Sickness Absence
As at 31 December 2020, the 12-month rolling sickness rate was 4.26%. The evidence base supports the view that the vast majority of lost days are attributable to longer term absence. Just 20% of all episodes of absence in 2020 were for durations exceeding 28 days but these absences accounted for 57% of all days lost to sickness absence.

Despite the impact of Covid-19 on sickness absence, there has been a positive improvement in sickness rates during 2020/21 and, if Covid absence is excluded, the 12-month rolling average is below 4%.

Furthermore, further evidence suggests that, statistically, a member of staff who has not resumed within the first 7 days of sickness is, more likely than not, going to be absent for between 1-3 months. Accordingly, we recognise the importance of line managers needing to 'Know Your Staff' and intervene positively in order to support a return from sickness absence and, if at all possible, to put in place interventions which prevent the need for sickness absence in the first instance.

Sickness absence data
This information is published by NHS Digital:

http://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff Turnover
For the 12 months to 31st December 2020, the staff turnover rate was 10.29%. This information is published by NHS Digital:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Diversity and Inclusion

Equality, Diversity and Inclusion (EDI) is a critical component to improvements to our organisational culture. The two Equality Standards – Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) – along with engaging with our staff networks and Equality and Diversity Group (EDGe) are part of our efforts for positive change, engagement and inclusivity which support our commitment to make the NNUH "*Our Hospital for All*."

Equality and Diversity Policy and Equality Impact Assessments
Our Equality and Diversity policy describes what is meant by Equality and Diversity and discrimination. The policy also includes the rights and responsibilities and duties placed upon the Trust, all employees and external stakeholders explaining the processes in place for addressing allegations of discrimination and to ensure that employees do not commit unlawful acts of discrimination.

We also ensure that for all new and existing policies they must be monitored and reviewed regularly to assess their equality impact. This can be undertaken using our Equality Impact Assessment Form(s) and guide.

The EIA is a way of investigating whether any of the Trust's policies (this includes project or action plans) and functions/services could affect people unfavourably and how this could be addressed. It will also show areas where the Trust needs to take action to promote equality. It improves the quality of the service that is provided to the public by ensuring that all services are accessible to everyone.

Equality and Diversity Governance
In September 2019, we replaced the HR Equality and Diversity Group (HEDGe) with the Equality and Diversity Group (EDGe) to reflect that patient, service user and customer aspects of EDI is as important a focus as workforce-related matters. The focus for the monthly EDGe meetings alternates between workforce and patient, service user and customer focus, the latter led by the patient engagement and experience team.

The group works together to identify gaps, improvements and ensures we meet EDI requirements including analysis of data to form responsive actions. It also allows each of the local divisional groups (LEDGe) to contribute and update on their local plans and initiatives.

NHS Equality Standards

Workforce Race Equality Standard (WRES)
The Workforce Race Equality Standard (WRES) is the means of helping the NHS as a whole to improve its performance on workforce race equality. The WRES has nine indicators which highlight differences between the experience and treatment of white staff and BAME staff. The data is based on financial years and is required to be published by 31 August each year.

Key indicators taken from the WRES 2020 report are:

- WRES Indicator 1 – 12% of our workforce are of a BME background and 80.9% of our workforce are White.

- WRES Indicator 2 – White candidates are 1.52x more likely to be appointed from shortlisting compared to BAME candidates

- WRES Indicator 3 – significant improvement between the likelihood of BAME staff entering the formal misconduct process compared to white staff (almost near parity - 1.15).

- WRES staff survey indicators - 35% of BAME staff have experienced bullying or abuse from other colleagues.

£8m imaging equipment replacement scheme continues

One of the biggest equipment replacement programmes at NNUH continues to be delivered, despite the challenges of the Covid-19 pandemic.

A new MRI magnet was delivered and craned into place at Cromer and District Hospital in January 2021, having been manufactured and shipped from the USA.

The hospital's old MRI was craned out of the building in November 2020, and build works to the facility will ensure that patients will benefit from improved quality of imaging, safety improvements and an enhanced experience.

The £8m project to replace vital imaging equipment will see the change-out of four MRI scanners a CT scanner at the Trust. An additional CT scanner will also be added in the Radiology department at NNUH.

The scheme follows 'Aged Assets' government funding that was announced in 2019, as well as benefiting from Adapt and Adopt Covid-19 funding.

Work has also been ongoing since November 2020 to start the reconfiguration of the Radiology department at NNUH to allow for the integration of the new CT scanner, which required the relocation of a Plain Film changing area and the department's staff rest room.

Workforce Disability Equality Standard (WDES)
The Workforce Disability Equality Standard (WDES) is a data-based standard that uses a series of measures to help improve the experiences of disabled staff in the NHS. The ten evidence based metrics enable NHS organisations to compare the reported outcomes and experiences of Disabled staff with non-disabled staff. The data is based on financial years and is required to be published by 31 August each year.

Key indicators taken from the WDES 2020 report are:

- WDES Indicator 1 – only 2.1% of our workforce have disclosed they have a disability whereas 22% of respondents to the 2019 staff survey said they had a disability or underlying health condition.

- WDES staff survey indicators - 33% of disabled staff have experienced bullying or abuse from other colleagues.

Equality Standard Actions
The WRES and WDES include some indicators which relate specifically to our Staff Survey results. Last year we focused strongly on our EDI findings as the 2019 staff survey findings indicated 35% of our BAME staff and 33% of disabled staff had experienced bullying, harassment or abuse from colleagues. We therefore ensured that two of the organisational-wide staff survey improvement objectives were related to the Equality Standards and Bullying and Harassment.

Our WRES and WDES indicators also highlight that White candidates and candidates who do not have a long term health condition are 1.52 times more likely to be appointed from shortlisting compared to BME and Disabled candidates.

We established an overarching objective for the equality standards to promote NNUH as '*Our Hospital for All'*. Interventions which looked to help us to achieve this included:

- Supporting our staff networks to become self-sufficient
- Implementing a reverse mentoring initiative
- Celebrating diverse and cultural difference through a range of events, education and activities.
- Promote the understanding of micro-aggressions and inappropriate behaviour and their impact on colleagues.
- Ensuring recruiting managers have been trained in unconscious bias training.
- Leadership programme intervention for aspiring BAME staff.
- Development of approach to ensure appropriate representation on selection panels.

All of the above interventions have been implemented and some of which are ongoing and are included in our EDI Workforce Focused Action Plan as our journey towards embedding NNUH as Our Hospital for All continues.

Staff Networks
The Trust currently has four staff networks:

- BAME Staff Network – established Nov 2018
- LGBT+ Staff Network – established Nov 2018
- Diverse Ability Staff Network – established May 2019
- Women's Staff Network – established Oct 2020

With the exception of the Women's Staff Network, our staff networks are chaired by a representative thus not led by HR. The networks have enabled shared decision making and a voice for colleagues. It has also provided them with the opportunity to consult on particular policies, as well as helped with producing new policies or toolkits including our supporting transgender staff guidelines, transgender patient care policy, health passport and attendance policy letters.

Whilst each of our staff networks are maturing, we recognise we still have a long way to go. We look to continue engaging with colleagues to create the awareness of our staff networks in order to increase membership and as a result ensure we improve staff experiences.

Disability Confident
The Trust has been successful in retaining the Level 2 Disability Confident Employer status for the past five years. This builds on and replaces the best practices of the 'Two Ticks Disability Symbol' model which the Trust previously held. Being Disability Confident provides us with an opportunity to attract, recruit and retain disabled people, whilst demonstrating commitment, action and progression.

The NNUH also hosts special schemes for recruiting employees with disabilities, such as Project Search. This is a pioneering intern programme which has led to employment for many young people. It involves NNUH working in partnership with Remploy, Serco and City College Norwich to offer students with learning difficulties and disabilities the chance to learn vital skills and prepare them for paid employment.

Employees with a long term health condition or disability receive support from the Workplace Health and Wellbeing Team, advice from Human Resources Department along with support from their line manager. Options are explored for making reasonable adjustments to the person's work activities which might include a change to working hours, duties or use of equipment. The aim is to keep the employee in work and all opportunities are explored, including redeployment.

Our Attendance Policy has a toolkit which is dedicated to support our staff with disabilities and long term health conditions which encourages managers to apply our Know Your Staff principles, putting the person before the process and:

- consult with individuals
- deal with matters confidentiality and sensitively
- consider everything that is relevant
- consider all possible options and outcomes
- implement the identified and appropriate option where they are considered to be reasonable adjustments.

The trust has an established Diverse Ability Staff Network for all staff including staff with disabilities, disability advocates, carers for relatives and managers. The purpose of the network is to provide a voice for Diverse Ability staff as well as encourage all staff within the trust to celebrate diversity. It is also to encourage our staff to understand the needs of individuals within the community to help us embed our ethos of becoming 'Our Hospital for All'.

Trade Unions

In accordance with the Trade Union (Facility Time Publication Requirement) Regulation 2017, we are required to publish information regarding 'facility' time on a government website by 31 July following the reporting period.

For the period of 1 April 2019 – 31 March 2020, NNUH reported 16 trade union representatives providing 14.71 FTE. The following table outlines the percentage of working hours these officials spent on facility time.

Percentage of working hours spent on facility time	No of Representatives
0%	5
1 – 50%	9
51 – 99%	2
100%	0

The total spend on paying employees who were relevant union officials for facility time during the relevant period was £60,462.46 which represented 0.02% of NNUH's total pay bill. The total hours on paid TU facility time totalled 3,230 which represented 4.98% of total paid facility time.

Formal and informal consultation mechanisms

Staff Engagement
One of our top priorities is to encourage the best from our staff, whilst at the same time maintaining their health, safety and wellbeing at work. Our approach to staff engagement is to involve our colleagues in discussions about key issues and this is reflected in the different ways in which we communicate and consult with staff.

Formal negotiation and consultation with our recognised trade unions is undertaken in a conversational and constructive manner with all those involved invariably wanting a common aim.

The committees where the dialogue takes place include:

- JSCC (Joint Staff Consultation Committee)
- PACS (Pay and Conditions of Service)
- LNC (Local Negotiation Committee)

In October 2020, we launched the Women's Network which was an addition to our existing staff networks; BAME, LGBT+ and Diverse Ability Networks which meet frequently to make a positive difference to individuals and our Trust.

Other communication mechanisms
Staff engagement is supported by a comprehensive internal communications programme which includes daily e-newsletters, intranet, magazine, and events. The weekly online Connected sessions, plus other Open Conversation events, are led by the Chief Executive Officer and Executive Directors talking about specific subjects. These sessions have become more accessible to staff with them being run via Microsoft Teams, with recordings being available to staff after each event. There is also a weekly Chief Executive video, plus feedback reports from the Trust Board meetings. Through these mechanisms, staff are kept up-to-date on a range of performance and finance issues affecting our hospitals.

Where there are issues affecting particular staff groups, including service changes, we hold regular meetings with those staff groups and staff side representatives, as appropriate.

NHS Staff Survey 2020
The annual National NHS Staff Survey has operated since 2003 and allows us to monitor the experiences of our staff and benchmark ourselves against other similar NHS organisations and the NHS as a whole, on a range of measures of staff attitudes and satisfaction. The results are primarily intended for use by NHS organisations to help them review and improve the experience of staff at work and, who in turn, are then feel supported to provide high quality care for our patients.

Our response rate to the staff survey 2020 was 48% with 4,309 respondents. The response rate to the 2019 staff survey was 46% with 3776 respondents.

The most recent survey covers the feedback from staff for the period September 2020 to November 2020. The results from questions are grouped to give scores in ten theme indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Ten summary indicators (referred to as themes) were created from the responses to individual survey questions. All themes are scored on a scale that ranges from 0 to 10 (the higher the 'score' the better). Scores for each indicator together with that of the survey benchmarking group (128 acute and acute & community trusts) are presented below.

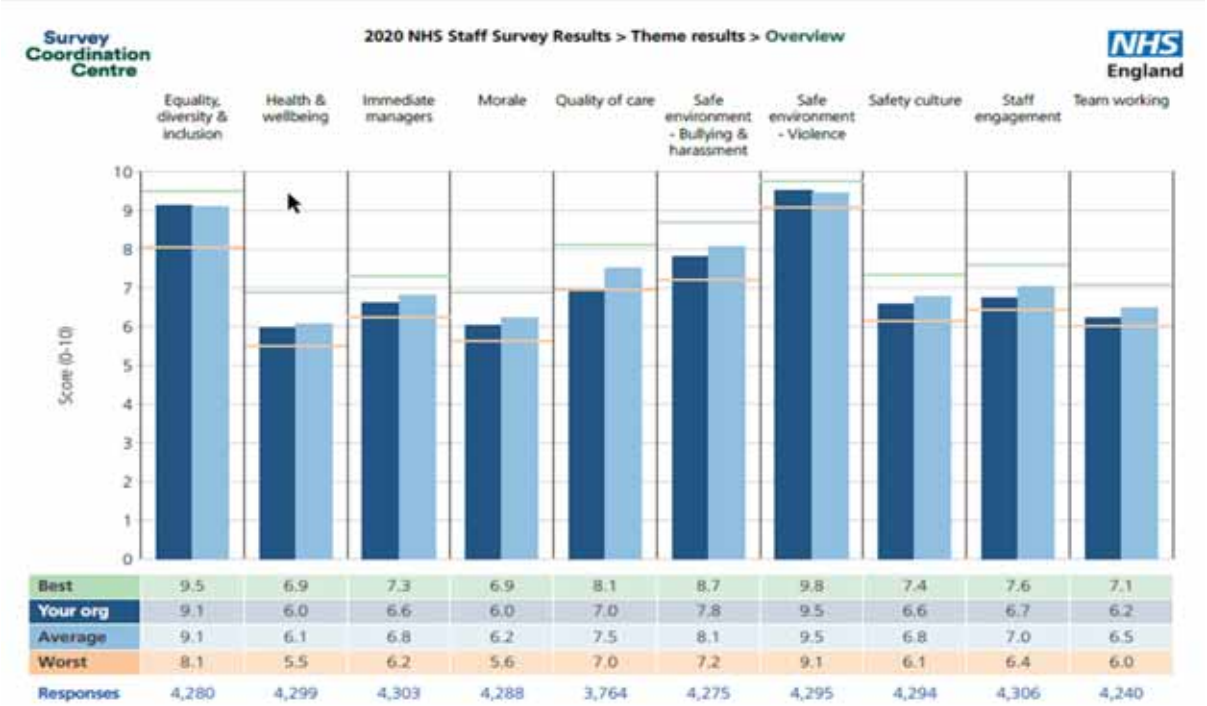
Theme	2020/21		2019/20		2018/19		2017/18	
	Trust	Benchmark	Trust	Benchmark	Trust	Benchmark	Trust	Benchmark
Response Rate	**48%**	**45%**	**46%**	**47%**	**46%**	**44%**	**47%**	**44%**
Equality, diversity & inclusion	9.1	9.1	9.1	9.0	9.1	9.1	9.1	9.1
Health & wellbeing	6.0	6.1	6.0	6.0	6.0	6.0	6.2	6.2
Immediate managers	6.6	6.8	6.7	6.8	6.5	6.7	6.5	6.7
Morale	6.0	6.2	6.1	6.1	6.0	6.0	n/a	n/a
Quality of appraisals*	-	-	5.5	5.6	5.4	5.4	5.3	5.3
Quality of care	7.0	7.5	7.1	7.5	7.1	7.4	7.3	7.4
Safe Environment - Bullying & harassment	7.8	8.1	7.8	7.9	7.7	7.9	7.8	8.0
Safe Environment - Violence	9.5	9.5	9.5	9.4	9.5	9.4	9.5	9.4
Safety culture	6.6	6.8	6.5	6.7	6.5	6.7	6.5	6.6
Staff engagement	6.7	7.0	6.9	7.0	6.9	7.0	6.9	7.0
Team working	6.2	6.5	6.5	6.6	6.4	6.5	6.5	6.5

Data from the Staff Survey National Co-ordination Centre - 11/03/2021

*Quality of appraisals was removed as a theme in 2020 staff survey.

The survey provides results for our organisation as well as comparison to the best and worst Trusts and all acute trusts (from the 128 acute and acute and community organisations).

NNUH 2020 theme scores compared to the benchmark of 128 acute trusts



Disappointingly very few responses to individual questions have shown significant improvement on 2019 results – 7 (9%) of questions have shown significant improvements since 2019. Thirty four (44%) of questions have shown significant declines since 2019 and 37 (47%) of questions have shown no significant movements since 2019 or comparisons could not be drawn.

Four of the ten theme scores are significantly worse than 2019. These are: Quality of Care, Immediate Managers, Staff Engagement and Team Working. These are the results that give us most cause for concern, and are the areas where we'll take immediate steps to address the issues raised. We will listen more to understand the issues that we need to remedy in more detail.

We will be conducting an extensive listening programme of events across the Trust from April 2021 to involve people in determining where we need to do better and what will make a real difference to staff experience

We will be working hard to ensure positive change happens and we're working with leaders, trade union partners, our diverse staff networks and other stakeholders to put in place some immediate actions.

The results from the Staff Survey 2020 have been shared organisationally and are available for all staff to view on the Staff Survey intranet pages. As well as the national reports from the NHS Staff Survey Co-ordination Centre, there are reports which provide breakdown by staff group/ division and comparison tools.

Information on the staff survey, emerging themes and proposals have been shared with various established boards and forums, including:

- People and Culture Committee
- Joint Staff Consultative Committee
- Hospital Management Board
- Trust Board
- Staff Networks (BAME, LGBT+, Diverse Ability, Woman's Network)

The Staff Survey Steering Group (SSSG) will recommence meeting and will have responsibility for the delivery of the improvement plan for 2020 Staff Survey.

Other engagement and Cultural Interventions

We continue to put on various training and bespoke interventions for our staff and leaders. These include Leading with PRIDE, Communicating with PRIDE, Rudeness Costs Lives, Unconscious Bias Training and Know your Staff.

Leading with PRIDE

At these masterclasses, managers are reminded of the importance of having effective engagement with their staff and our expectation of managers to use the 'know your staff' principles. Managers are provided with the tools for giving constructive feedback and tackling issued, building on individual team member's strengths and modelling PRIDE values as leaders.

Communicating with PRIDE
Introduced in October 2018, the Communicating with Pride Toolkits provide help and support for all – whether staff had experienced, witnessed, had to manage, or had been accused of, inappropriate behaviour.
The intent is that this empowers all of our staff to have the confidence to raise and resolve issues themselves, or with the support of colleagues. Communicating with Pride builds on the Trust's PRIDE values which detail the types of behaviour the organisation likes to see and the behaviour it discourages.

Rudeness Costs Lives
These training sessions built on the Communicating with PRIDE framework. These sought to understand the impact of incivility, recognise that rudeness exists in our workplace and gave staff and managers the knowledge to use the BUILD and ABC feedback tools in the workplace.

Unconscious Bias Training
Unconscious bias training has become a requirement for recruitment managers and was delivered from July 2019, with the audience including our Executive Directors.

Know Your Staff
Know Your Staff is our compassionate and just approach to people management. The key principles are to:

- Have an outcome focus.
- Think about the person before the process.
- Have no surprises.
- Apply discretion appropriately.
- Provide clarity, have ownership and be accountable.
- Adopt an ethos of leading through:
    - Trust, with positive
    - Relationships and
    - Engagement, knowing that you are
    - Empowered to take appropriate decisions

Local Counter Fraud Service (LCFS)
NNUH works closely with our designated local counter fraud specialist as part of the national scheme led by 'NHS Counter Fraud Authority'. This involves proactive and reactive work to ensure that precious NHS resources are not lost to fraud but rather can be spent on patient care and clinical services. This provides a clear route for concerns in relation to fraud to be reported and investigated, and development of an anti-fraud culture.

We take all necessary steps to counter fraud and bribery in accordance with guidance or advice issued by NHS Protect. This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Off payroll engagements
The Trust has a policy that all substantive staff are paid through payroll unless there are exceptional circumstances. No Board members were engaged on an interim and off-payroll basis during the period 1 April 2020 to 31 March 2021.

The table below shows the details for 2020/2021:

Off payroll engagements as of 31 March 2021 for more than £245 per day lasting for longer than six months	
No. of existing engagements as of 31 March 2021, of which:	0
No. that have existed for less than one year at the time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The trust may be able to engage contractors on an off-payroll basis, but there is scrutiny for such arrangements.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months	
No. of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure ***must*** include both off-payroll and on-payroll engagements.	6

Staff exit packages

Not Audited

Table 1:Exit Packages

	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole Numbers Only	£000	Whole Numbers Only	£000	Whole Numbers Only	£000	Whole Numbers Only	£000
Exit package cost band (including any special payment element)								
<£10,000	3	11	21	38	24	49		
£10,000 - £25,000					0	0		
£25,001 - £50,000					0	0		
£50,001 - £100,000					0	0		
£100,001 - £150,000	1	107			1	107		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**4**	**118**	**21**	**38**	**25**	**156**	**0**	**0**

- Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the Norfolk and Norwich University Hospitals NHS Foundation Trust has agreed early retirements, the additional costs are met by the Norfolk and Norwich University Hospitals NHS Foundation Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.
- This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Table 2: Analysis of Other Departures

*Includes any non-contractual severance payment made following judicial mediation and there were no payments made relating to non-contractual payments in lieu of notice.

Type Of Other Departures	Agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	21	38
Exit payments following employment tribunals or court orders		
Non-contractual payments requiring HMT approval (special severance payments)*		
Total	**21**	**38**

- As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 6 which will be the number of individuals.
- * any non-contractual payments in lieu of notice are disclosed under “non-contractual payments requiring HMT approval” below.
- **includes any non-contractual severance payment made following judicial mediation, and 0 relating to non-contractual payments in lieu of notice.
- 0 non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.
- The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report

Workplace Health & Wellbeing (Occupational Health)

This year has seen a significant increase in demand for occupational health services due to the global COVID-19 pandemic as well as the need for the department to adjust dramatically to new ways of working. The majority of work has been focused around COVID-19 within our own organisation and the other NHS Organisations who contract services from us. At the same time, we have had to maintain core elements of the Occupational Health service.

Response to COVID-19

Risk assessment

In late March 2020, the emerging evidence surrounding the Covid19 virus identified that there would be individuals who would be personally more vulnerable and have a significant risk of serious ill health should they contract the virus. It became apparent that this would impact some of the staff who worked within our organisation, and others, due to the nature of their roles and that these individuals would not be ordinarily able to comply with the governments 'stay at home' message.

This evidence led to the development of a risk matrix and risk assessment process which needed to be considered for all staff. The team spoke to literally thousands of our staff in those weeks that followed – many who needed advice and guidance surrounding their own personal health situations as well as their personal concerns for loved ones who were being placed in a 'shielding' group.

As we undertook these conversations, our focus was to protect our NHS staff and prevent them becoming our ventilated patients whilst also appreciating the need for the NHS services having sufficient staff to deliver care in a global pandemic situation. As evidence emerged and changed, so our assessments of individuals needed to be reviewed. The team had a senior nurse constantly reviewing all the changes in evidence to ensure we as a team remained knowledgeable with this ever changing situation.

These assessments were both emotive for all concerned and many staff were advised to be relocated from their original areas of work to ensure they remained protected. As the early months progressed, our Lead Consultant and a Senior Nurse worked with a technological company which enabled the risk assessment process to be undertaken electronically. The team provided the medical information and evidence base whilst using the expertise of technology to develop the tool.

Once the tool was launched, all staff could be risk assessed in minutes with outcomes of the assessment being sent to line managers and the occupational health team. This was particularly useful as restrictions following the first wave in the summer arrived to review risk assessments in preparation for shielding individuals returning and also further reviews in preparation for Wave 2 in November with the associated changes to Public Health England guidance surrounding patient pathways.

This tool became a very efficient, effective and consistent evidenced based assessment for all staff. This COVID risk assessment tool is now being used by many NHS Trusts around the country. https://rainbird.ai/case-study/assessing-covid-19-risk-for-thousands/

In addition, the department has developed Workplace risk assessments for clinical areas so that managers can assess and implement covid risk mitigation measures for individuals in their work areas to support the documentation provided by the Health & Safety team on general office/area covid risk mitigation measures.

Isolation advice and guidance
From the start of this pandemic, the team have kept up to date with the ever-changing advice from the government regarding isolation. This started in the early days with just advising when staff were returning from trips abroad, but over the year this has developed into a full in-house test and trace service for staff.

It was vital that our staff had timely advice regarding any contacts they had in the workplace from colleagues and patient contact. The team have been and continue at present to provide a 7-day service ensuring any positive staff results are contacted and if necessary ensuring contacts in the workplace commence isolation if Covid secure measures have not been in place. We have worked closely with the Infection Prevention and Control team in ensuring any ward outbreaks include staff contacts and appropriate testing has been undertaken.

Testing
Whilst not directly responsible for the staff testing service, we have worked with our Clinical Support Services team to provide governance advice and support in establishing both the swab and antibody services. We have worked in partnership with the testing team and the WHWB team have been contacting staff if positive results or any other queries in relation to the testing elements.

Increased recruitment support
Occupational health services in the NHS are a vital stage of the recruitment process of staff and the need to rapidly 'on board' staff was apparent early in this pandemic. The team have supported this process whilst changing process and guidance taking into the account that anyone coming to work in a clinical area would need to be risk assessed to ensure that their own personal health would not be at an increased risk by undertaking the role. The demand for all our NHS customers for this area of work has been significantly increased over the last 12 months.

Health & Wellbeing during the Pandemic
At the commencement of the pandemic the Head of WHWB worked with the Clinical Psychologist team within our Clinical Services Division to establish a three staged strategy for the psychological support that would be offered and anticipated needed for staff as we approached the 'unknown'. This combined many elements of work and service providers including senior nurses who were shielding offering support to staff and increased provision of employee assistance programme. The psychologist and chaplaincy teams providing a daily rota of support, plus the organisational development and training team worked with the psychologists to provide webinars to leaders to support them and these have continued throughout this year. In addition the Health and Wellbeing team providing information and support to all staff.

The dedicated 'Caring for you' intranet site was produced by our communications team so that staff could find all relevant information in one place. Of significant note, the Health and Wellbeing Practitioner team in WHWB provided a wealth of information to aid the wellbeing of our staff. It ranged from psychological wellbeing to practical elements on skin care with increased PPE wearing, practical tips to help reduce the anxiety at the end of a shift and health awareness information on what staff could do to ensure they were 'fit to fight' the virus (diet, taking vitamin D, reducing weight and health eating, exercise etc). This information was widely shared across our STP region to ensure all NHS staff received the valuable content available.

In the early stages, the Health & Wellbeing team redesigned some clinical areas that were not being utilised in their normal way to develop dedicated 'rest space' for staff. This allowed staff to have a break away from their clinical area. Due to the generosity of the general public, we were able to provide free drinks and snacks in these areas on most days. This space was very much appreciated by our staff and highlighted once again the importance of having a quiet and dedicated space available for staff.

The organisation was very conscious that we had a group of staff who had become 'shielders' – those who have individual health conditions themselves and needed to 'Stay at home' to protect them from this virus. For some they have now been 'shielding' for the best part of a year. Our HWB Practitioner has provided a range of dedicated support sessions for this group of staff. This has enabled individuals to share their experiences and frustrations, their feelings of guilt of having not been physically in the building to support their colleagues undertaking the 'frontline' work and gain support from each other.

They have shared their anxieties about returning to work and they have received meditative practices and relaxation yoga to support them. All this being undertaken by using virtual technology. Information packs have been sent to this group to prepare them for returning and also information supplied to managers so that they understand some of the concerns that staff have in this situation.

The service continues to deliver programmes to promote the health and wellbeing of our staff as well as the organisations that contract services from us.

Covid Vaccination

Building on the success of our staff flu vaccination campaigns, in November, the WHWB team became involved in planning the COVID vaccination programme. It was anticipated initially that we would be vaccinating all our staff as quickly as we could and so planning for this commenced using an IT booking system and the core staff flu vaccine flu team. A change of direction was given by NHS England with literally days before our launch that we would now commence vaccinating the 'Over 80's community' and 'Care Home staff'. This had to be done from our hospital with only a small proportion of vaccines available to our NHS staff initially. However, the team rose to the challenge and within days a dedicated hub in the hospital was created and the health and wellbeing team have been supporting both staff vaccinations and the wider community vaccinations since December 2020. The hub can vaccinate over 1000 individuals a day and has contributed significantly to the vaccination programme of the Norfolk Community.

Supporting Long Covid Staff members

Core Occupational Health Services

Core occupational health services for NNUH staff have continued over the course of this year. We have undertaken absence referrals for all our contracts, after an initial pause of immunisation services, these have now been restored since the summer and continued to provide essential protection to staff who are working in clinical environments, exposed to blood and body fluids. Our blood exposure support line continues and all staff who have such incidents are assessed and supported with any necessary treatment.

Health surveillance process have changed with remote services (as per HSE guidance) being delivered but with the assistance of technology this has been possible. In addition, the team have adapted to undertaking DSE assessments via technology – reviewing the work space and the positon of the user using video consultation methods.

Prevent influenza transmission
A full influenza vaccination campaign was undertaken from late September 2020 – November 2020 – this was shorter than normal due to the implementation of the COVID vaccination programme as well as the significant early uptake received this year. Ninety five per cent of our frontline staff received their vaccination. Due to social distancing requirements, we set up an online booking system which was extremely successful in complying with COVID secure measures as well as reminding staff of their vaccination appointment. We increased the number of nurses available to deliver the programme and invested in a further 'flu tent' so the areas could be cleaned between each staff member receiving the vaccination. The programme was also supported by over 120 local peer vaccinators in their area. This is the highest level of uptake that our organisation has achieved in this area.

Our success in this programme, was undoubtedly as a result of increased resource to ensure high accessibility of the vaccines being available to all staff, alongside strong medical and nursing leadership together with the support of a dedicated software programme and prominent communications plan.

In other aspects of work, we successfully submitted our annual review of the Faculty of Occupational Medicine SEQOHS (Safe, Effective, Quality OH Service) accreditation programme following the full five year assessment in July 2017.

As far as external business is concerned, we have been delighted to continue to our success with our current customers and gaining some significant new contracts during this last year. In fact we commenced delivery to three significant contracts despite their being a global pandemic. Our team has expanded due to the new business acquired and we have been ensuring that all team members have successful inductions so that all our customers receive a high quality service. As part of our team expansion, we have also been able to internally promote some members of the nursing team who have developed well into their new roles.

Our Consultant in Occupational Medicine, Dr Rob Hardman continues to also hold the position of Director of Quality, accreditation and audit with the Faculty of Occupational Medicine.

This is a great asset to the quality of our own team ensuring we are the forerunners of implementing any changes in guidance, legislation or good practice. Equally, the Head of Workplace Health and Wellbeing, Hilary Winch has continued to work with other regional OH leads on the regional and national streamlining project which endeavours to allow information to be transferred between NHS organisations on staff members who are moving employment in this last year.

She has been instrumental in working with NHS Improvement on consistency in standards for screening and immunisation requirements for health care workers.

In addition, she continues to lead MoHaWK (Management of Health at Work Knowledge system) for the Faculty of Occupational Medicine which is the only national OH system to support local audit and benchmarking. As part of this role, she also contributes to the management of the SEQOHS accreditation scheme.

Health & Wellbeing / Staff Experience Working Group
There have been two prominent pieces of work undertaken by sub-groups led by the Head of Workplace Health and Wellbeing over the last 12 months.

Staff Rest areas
A working group was formed to discuss ideas for improving the rest facilities available to staff. Following the initial proposal that was submitted to the estates team which included a number of indoor and outdoor suggestions, some more detailed design plans and costings are being developed with architects. Larger scale options were also included for consideration into the Estates Strategy and included a Wellness centre on the periphery of site. The improvement of rest facilities is starting to be seen as the redesign of the East Atrium has commenced.

Smoke Free NHS Estate
In line with Public Health England recommendations, we have been working to ensure we implement a completely smoke free estate. Whilst, in theory NNUH has been a smoke free site since 2005, it has not been well adhered to. By not enforcing this we have been endorsing the health risk behaviours and as a leading healthcare provider, we should instead be supporting healthy behaviours. A working party has been operational for the last two years to consider the steps that need to be taken and consider the impact of those who smoke on our site from staff, patients, visitors and contractors.

A wide range of actions have already taken place which includes:

- A review of the staff policy with staff engagement forums taking place
- Developing new signage for the site
- Liaising with all contractors on site and full communications plan to the general public in Norfolk.
- Patients to be prescribed fast acting nicotine replacement therapy on admission to manage their nicotine addiction
- Availability of fast acting nicotine replacement therapy for visitors, staff and contractors through the retail outlets on site.
- Support for all being provided through referrals to Smokefree Norfolk

Our full launch programme could not take place last year due to the pandemic – but a soft launch was undertaken and now (after industries are returning to work following lockdown) the permanent signage will be installed as we progress through March / April 2021.

Monthly PRIDE award scheme based on our Trust Values: People-focused, Respect, Integrity, Dedication and Excellence
Each month there are up to two members of staff and quarterly there are one team who receive recognition through this scheme. Members of the staff experience working group review the monthly nominations and make decisions regarding winners. This initiative continues to be really well received.

Staff Development

Apprenticeships

During the financial year of 2020/21, we have seen 141 staff commence on an apprenticeship; 83 are existing staff and 58 are new apprentices, of these 23 are 16-18 years old. We continue to play a leading role within the region for apprenticeships and at the beginning of 2021 we won the Large Apprenticeship Employer of the Year at the Apprenticeship Norfolk Awards.

We also had a number of apprentices from the Trust who were Winners and Highly Commended in the 'Achievement in Exceptional Circumstances', 'Intermediate Apprentice of the Year', and 'Advanced Apprentice of the Year' categories.

We have supported a wide range of apprenticeship training enabling us to develop staff of all levels, from entry level apprentices through to Consultants and Senior Managers. We have been very successful in the recruitment to our Trainee Nurse Associate apprenticeship programme, with 20% joining the Trust through the Level 2 apprenticeship route and progressing onto the TNA roles, ensuring we are growing our own highly skilled nursing workforce.

As face to face contact stopped due to Covid-19, the year 2020-21 has seen all our traditional ways of liaising with schools, colleges and students being transferred to virtual platforms and social media. The Career Development team has created a library of new materials and worked with teams across the organisation to create virtual career opportunities and speciality specific promotional materials to ensure we can continue to promote careers within the NHS and social care. During 2020-2021 we delivered specialty specific 'Career Weeks' 'Career Information Days', and '1-1 Career Discussions' which were offered several times a month to support local students and the wider community.

We are working with local training providers on the development of their T-Level programmes, and Healthcare Science BTECs commencing in September 2021 to ensure students will be obtaining qualifications and work experience that will enable them to pursue careers within the NHS and social care.

Project Search

Project SEARCH is a work focused Education programme for young people aged 18 to 25 years who have a learning difficulty or learning disability. This project is a joint venture between Norwich City College, Serco and our hospital and has now been running for 11 years. Each year ten students will gain experience in three different job roles with the aim for them to gain paid employment, either at the hospital or within the wider community by the end of the programme. Since commencing in 2009, 127 students have accessed the programme.

Following the recruitment for the 2020/2021 programme, eight students started in September 2020 and have been attending various placements across Serco and the main hospital site. These include, grounds maintenance, housekeeping, post room, linen porter service and radiotherapy team in the role of radiotherapy assistant.

Step into Health
Step into Health supports members of the Armed Forces community to gain an understanding of the employment opportunities within health and social care. Our programme has developed to become a partnership offering with other regional organisations including Norfolk Community Health and Care, Serco, Norfolk and Suffolk Care Support, Norfolk and Suffolk Foundation Trust, James Paget University Hospital NHS Foundation Trust, Queen Elizabeth Hospital NHS Foundation Trust, East of England Ambulance Service, and Primary Care.

Due to Covid-19, the Information Morning in June 2020 was cancelled, however the November event was transferred to a virtual platform supported by all partners, and had 23 attendees.

Step Into Work – (Job Centre – Sector Based Work Academy)
Our work with the Department of Work and Pensions on the Sector Based Work Academy, now known as 'Step Into Work Programme', continues in partnership with Serco, and all NHS and social care partners across the Norfolk and Waveney Integrated Care System (ICS).

In response to the pandemic we created a virtual four week SITW Programme working in partnership with City College Norwich and SpingPod. It delivers the Level 1 Award in Employability Skills and online virtual work experience in which the participants learn about all NHS and social care organisations and services across the ICS System.

To date we have delivered two virtual programmes: in November 2020 we recruited 23 candidates of which 11 completed programme; January 2021 we recruited 20 participants with ten completing. Plans are now being developed for a programme beginning at the end of April 2021.

Prince's Trust
We have worked in partnership with the Prince's Trust for over ten years. However, due to Covid-19 all face-to-face work experience was paused which has impacted on the programmes we have been able to offer during 2021-2021. As an ICS we are working closely with the Prince's Trust to support a new pilot role which will be hosted by the Workforce Partnership. The role will work with all ICS partners to establish new work experience opportunities for young people in our community.

Kickstart Programme
The Government is providing funding for employers to create six-month job placements for young people (16-24 years old) who are currently on Universal Credit, and at risk of long-term unemployment. Each applicant receives a salary for a placement of up to 25 hours per week for a period of six months. Working with the Department for Works and Pensions, the Trust has been funded for 75 placements across clinical and non-clinical areas. The programme is open for applications until December 2021 and we anticipate additional placements to be requested.

Health and Safety

The Health and Safety team advises on staff safety in relation to the main risks present in a healthcare environment. The team assists with risk assessment and incident investigation as well as proactively auditing and monitoring standards and compliance across all Trust premises.

In January 2020 the Health and Safety Lead Advisor had left the Trust and a replacement for the role was recruited and joined in late May. During the interim period the management of the team was undertaken by the Head of Workplace Health and Wellbeing, Occupational Health to ensure that the team had access to guidance and coordination.

During 2020 and continuing through to 2021, the Covid-19 pandemic had taken effect and priorities alternated on a frequent basis to meet the needs and safety of staff working in administrative and clinical operations. The team also managed to continue elements of its usual service.

The main 'business as usual' projects for the year 2020/2021 were:

- Continued education and advice to staff following previous changes to waste contracts and suppliers. We aim to ensure the safety of staff, patients, the public and the environment by the safe and effective segregation and management of all classes of waste leaving our sites. This also involved interaction with the External Dangerous Good Safety Advisor including the managing and implementation of controls to mitigate any findings observed.
- Offering advice and guidance in conjunction with the Trust Estates team for safety and fire regarding major projects including building works around the sites. The team has been involved in new and existing planning processes to consider the safety of anyone affected by such works and to help ensure that relevant controls are in place for the safety of all users once works are completed. This has also started to encompass advising on future projects when they are in the early stages of the planning phase.
- Continued management of the Control of Substances Hazardous to Health (COSHH) electronic system. Including working with clinical teams on the safe storage of chemicals and ensuring the recommended Personal Protective Equipment (PPE) is available.

The main Covid-19 related projects for the year 2020/2021 were:

- Face 'Fit Testing' Clinics were managed by the team to ensure staff had well fitted Personal Protective Equipment (PPE) such as FFP3 standard face masks. An in-house team of testers was established to provide competent fit-testing to colleagues who would need to wear enhanced PPE. The first clinic was implemented from April to June 2020 and a further clinic was arranged from January to Mid-February and a roaming team currently in place for March 2021.
- The team implemented the Generic Workplace Risk Assessment to aid the Trust in delivering a COVID secure workplace in predominately administration areas. The risk assessment follows the directives set out in the Government guidance documents. To support the template, a guidance document provided additional information on the completion of the risk assessment.

- The team also provided advice, guidance and collaboration with all teams on assessments of our environments to safeguard colleagues, patients and members of the public within the Trust premises.
- Support was provided to the PPE Review Panel to ensure the continued development of our PPE/RPE processes to ensure the protection of staff and patients from infection.

Training

The Health and Safety team develops and delivers training packages as well as ensuring that there are competent trainers to cover the mandatory training needs of the organisation. The training covers topics such as fire safety, health and safety, manual handling, prevention and management of aggression, chemicals and waste.

Due to the pandemic, the provision of prevention and management of aggression (PMA) was put on hold because colleagues would need to be in close proximity to one another. As a mitigation, a copy of the training handout was provided to all colleagues that would require this training to familiarise themselves with the concept and basics of PMA. This was also supported with guidance on how to assign to the eLearning package to support the handout. Manual Handling Induction and Refresher training has continued throughout the pandemic in a covid controlled environment which also included maximising the numbers of attendees to ten colleagues.

The pandemic has shown the importance of the eLearning system as a provision of support for face-to-face training and has been vital in ensuring training can continue. The adoption of new technology has also been a positive experience which allows for Training sessions to be completed virtually via Teams, such as Medical Students and Volunteers from other organisations. The training process is regularly evaluated and reviewed to ensure it is effective.

Incidents

There are five categories of health and safety related incidents that are reported most frequently for staff. These are slips, trips and falls, needle-stick and sharps injury, patient moving and handling, verbal aggression and physical aggression.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Incidents

During the period April 2020 to March 2021 the Health and Safety Department reported a total of 19 incidents to the Health and Safety Executive as they met the schedule of RIDDOR. 18 of these were related to colleagues; 1 due to a fractured wrist and the remaining because of absences of over 7 days. There was 1 reported because of a fractured hip to a member of the public.

This is a reduction of 47.5% reporting compared to 2019/20 which had a total of 40 incidents being reported for the period. Most incidents in 2020/21 were reported in Q3 with 13 compared to 4 in Q1 and 2 in Q4. The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall incidence rate is 189 per 100,000 employees. The national incidence rate for healthcare in 2019/20 was 350.

More detail on health and safety performance is included within the Health and Safety Annual Report that is presented to the Trust Health and Safety Committee.

NHS Improvement's Single Oversight Framework

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

The Single Oversight Framework (SOF) looks at five themes:

• quality of care

• finance and use of resources

• operational performance

• strategic change

• leadership and improvement capability (well-led)

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

The Trust is in segment 3, which is described as 'mandated and targeted support'. Support needs identified in Quality of care, Finance and use of resources and Operational performance.

By way of letter dated 13 May 2020 the NHSE/I National Improvement Director confirmed:

"I am delighted to be able to confirm that……the Trust will from today no longer be in special measures. I can also confirm that the trust will move from segment 4 to segment 3 of the SOF and the regional team will be in contact with you to agree refreshed undertakings shortly. I recognise the challenges that will be facing all trusts at the present time, and this will be reflected in our agreed approach for the future.

I am pleased to note that the CQC's published report rated the Trust as remaining 'requires improvement' and 'good' in the effective and caring domains. The report showed significant improvement and the CQC referenced key improvements in relation to leadership and governance and that the Trust is taking a proactive approach to working with its partners to develop care pathways, ensure sustainability of quality improvement as well as encouraging staff development. However further work is required to ensure the effective use of resources and support will be required to ensure all executives and the wider board are focused on the financial position and challenges at the trust.

This is a time to celebrate the progress that the trust has made, and I recognise the hard work and commitment of all of your staff in delivering this outcome. Given that the trust's CQC rating is still 'requires improvement' NHS England & NHS Improvement regional
team will continue to work with you and your team to provide targeted support, that will of course take into account the extremely challenging current situation of the COVID-19 virus, and help you build on the commendable improvements that have already been made…….

It is certainly encouraging that the hard work of so many people has resulted in this very positive outcome for the local population and thank you for your unwavering commitment. I look forward to seeing the Trust's continued progress."

NHSI is consulting with regard to a new System Oversight Framework and is liaising with the Trust regarding updated Licence Undertakings.

This segmentation information is the Trust's position at 31 March 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Statement of the chief executive's responsibilities as the accounting officer of Norfolk and Norwich University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require the Norfolk and Norwich University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Norfolk and Norwich University Hospitals NHS Foundation Trust and of its income and expenditure, ***other items of comprehensive income*** and cash flows for the financial year.

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

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

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

Sam Higginson

Chief Executive **Date: 11 June 2021**

Annual Governance Statement for the year ended 31 March 2021

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Norfolk and Norwich University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors has approved a Risk Management Strategy, which sets out the Board's approach to risk management, its Risk Appetite and accountability and reporting arrangements for the management of risk within the Trust.

The Chief Nurse is the Executive Director lead for Risk Management and operational responsibility for implementation of the Strategy and Policy is delegated to other named staff. The Risk Management Strategy has been made available to all Trust staff through our documents management system, called Trust Docs.

In addition to established processes for learning from incidents and patient feedback, the focus of our risk management approach is on proactively identifying and avoiding risks, rather than simply reacting to risks which have materialised. To enhance our capacity and capability in this regard the Trust has a designated Risk Manager and an Associate Director of Quality and Safety, to oversee the system of risk management in the Trust. The Risk Management Team co-ordinates and supports risk activity across the Trust, in close liaison with the divisional and clinical teams.

The Hospital Management Board has an established Risk Oversight Committee which is tasked, through defined Terms of Reference, to enhance our arrangements for the identification and management of risk and development of the Trust's Risk Maturity. Membership of the Risk Oversight Committee includes representation from the Divisional Management Teams and the Committee reports into a regular session of the Hospital Management Board at which the Corporate Risk Register (CRR) and highest-level risks are reviewed and discussed. Reports relating to the Risk Management System and Processes form a regular item for discussion by the Audit Committee as part of its annual reporting cycle. The CRR also informs updating of the Board Assurance Framework (BAF), which documents the principal threats to achievement of the Trust's Strategic Objectives, together with key controls and assurances and any gaps in those controls and assurances.

The Trust's mandatory corporate induction programme includes information concerning both clinical and non-clinical risk, the Trust's approach to managing risk and maximising quality in patient care. In addition, a range of ongoing risk management training is provided to staff and there are policies in place which describe roles and responsibilities concerning the identification, management and control of risk. Such training covers requirements for the safe delivery of services, proper use of equipment and wider aspects of management, health and safety and quality assurance.

The Trust has arrangements in place to ensure that we learn from good practice through a range of mechanisms, including clinical supervision, reflective practice, individual and peer reviews, appraisal and performance management, continuing professional development, clinical audit and application of evidence-based practice. The implementation of guidance from the National Institute of Clinical Excellence (NICE) is overseen by the Clinical Safety and Effectiveness Governance Sub-Board.

Reduction of risk and maintenance of quality are promoted by constantly reinforcing a culture of openness and transparency and encouraging staff to identify opportunities to learn from patient feedback and to improve the care and services we provide. We have introduced a robust programme of work associated with quality improvement and reduction of risk through our Quality Programme Board supported by an Evidence Group.

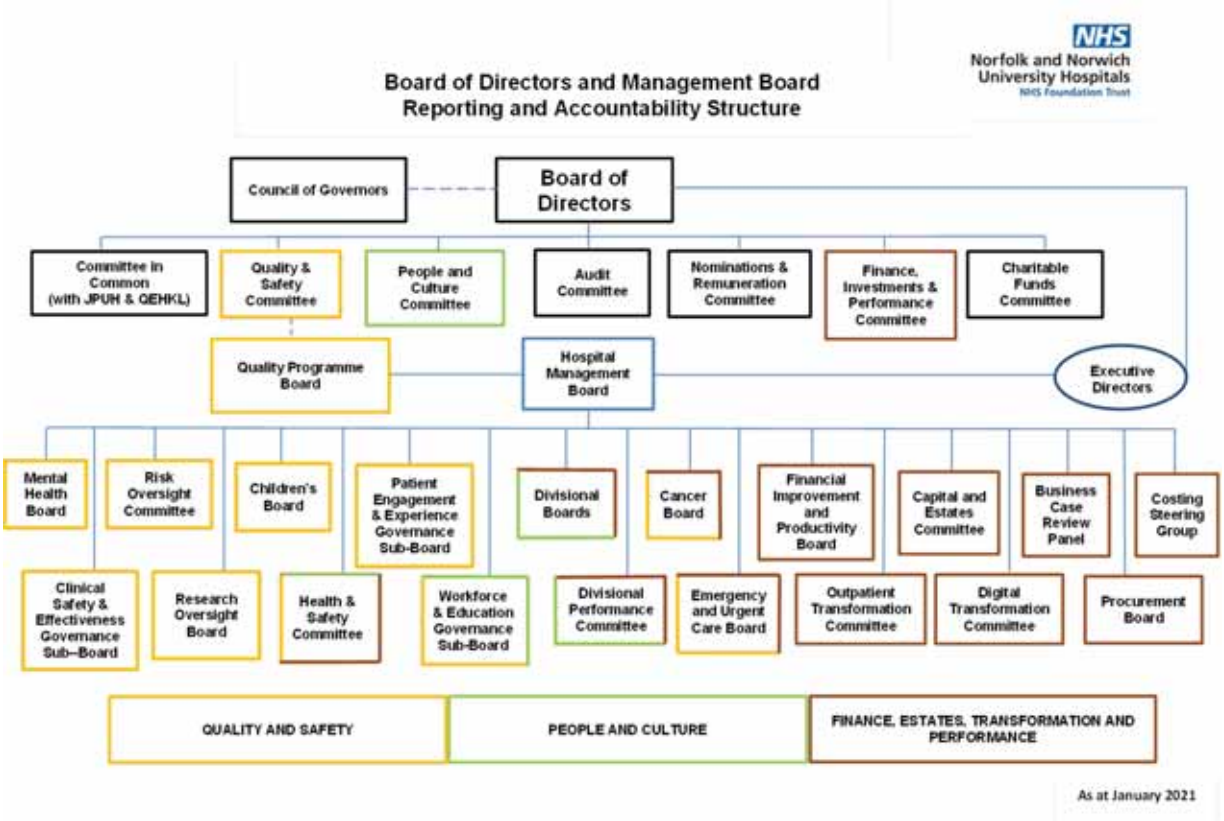
Whilst the Trust continues to mature in its approach to managing risk, the progress we have made since its last inspection was recognised by the CQC in its report of April 2020. The CQC noted specifically "*Risk management was generally more effective with an increased responsibility of the divisions in managing their risk. There were clear processes to identify, escalate and mitigate risk which was an improvement since our last inspection".*

The risk and control framework

The Board has approved a Risk Management Strategy which sets out the approach to managing risk within the organisation. The Risk Management Strategy and associated policies define the key roles, responsibilities and reporting lines in relation to the management of risk, as well as the overall governance structure underpinning this at both Board and divisional/directorate level. The Strategy details the Trust's approach to identification, evaluation, control and reporting of risk as well as a statement of the Board's Risk Appetite, which was last agreed by the Board at its meeting December 2020.

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. The Board receives regular reports which detail risk, financial and performance issues and actions being taken to reduce identified high level risks or control issues. This reporting to the Board of Directors is supported through the Trust's governance structure, as detailed in the Trust's Organisational Framework for Governance, which details the roles of the Board assurance committees, together with the Hospital Management Board, its Committees and Governance Sub–Boards.

The Board of Directors has four established assurance Committees, covering areas of Quality and Safety; Finance, Investments and Performance; People and Culture; and Audit. The Board receives regular reports from each of its Committees and the overall governance and assurance structure is as represented below:



The Board's Audit Committee has responsibility to oversee the maintenance of an effective system of integrated governance, risk management and internal control, across the Trust's activities. The Terms of Reference for the Trust's Audit Committee are based on the model contained in the HFMA NHS Audit Committee Handbook 2018, and also reflect the UK Corporate Governance Code (2018) and ICSA Guidance on Terms of Reference for Audit Committees (2020). The Committee is tasked with reviewing the adequacy of the structures, processes and responsibilities within the Trust for identifying and managing key risks.

The Board has established an Organisational Framework for Governance, which sets out the responsibilities for each of the Board assurance committees to review key risks arising within their respective areas of remit.

Each stream within our system of integrated governance is led by a Senior Risk Owner and supported by appropriate teams and management information aiding our corporate and divisional delivery:

- Clinical Governance – led by the Chief Nurse and Medical Director
- Financial Governance – led by the Chief Financial Officer
- Information Governance – led by the Chief Information Officer
- Research Governance – led by the Medical Director
- Workforce and Education Governance – led by the Chief People Officer
- Divisional Governance – led by the Chief Operating Officer

Threats to delivery of the Trust's Strategic Objectives are recorded in the BAF which identifies the assurances available to the Board of Directors in relation to the achievement of those Objectives. The Executive Director with delegated responsibility for managing and monitoring each strategic threat is clearly identified, as is the relevant Board Assurance Committee. The BAF also details the actions to be taken to provide additional assurance and to counter the identified threats.

The CQC considered the BAF and associated processes (April 2020) and reported: *"We reviewed the BAF [and] found all the threats to strategic objectives RAG rated with mitigating actions. There were clear review processes and dates documented for each at relevant review committees and management board. The BAF was discussed at trust board. Minutes showed appropriate assurance was received regarding control and mitigations."*

Internal Auditors also reviewed the BAF and reported in March 2021 *"We confirmed the BAF clearly outlines the Trust's strategic objectives and the associated threats to the achievement of these objectives……the Trust's format provides for effective oversight of the key risks to the Trust's strategic objectives." (p19)*

Information and assurance is provided to the Board through:

- scrutiny of key data and metrics reported through a monthly Integrated Performance Report – available to the Board, Governors, staff and public (via our website);
- the work of and reports from the Board's assurance committees;
- 'triangulation' of information from diverse sources including reports and presentations from clinical teams, internal and external audit, external reports and the Board programme of clinical and departmental visits.

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register. A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks.

Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a Corporate Risk Register – reported to both the Board of Directors and Management Board. High level risks are also reviewed by each of the Board assurance committees as relevant to their individual remits. This structure and process is intended to facilitate a cohesive risk management system operating from ward to Board.

The Hospital Management Board is tasked through its Terms of Reference with assisting me in effectively discharging my duties as Accounting Officer and with overseeing the identification and mitigation of key risks arising from or relevant to the operation of the Trust. It oversees the work of three Governance Sub-Boards, with areas of focus constructed so as to be consistent with the inspection regime of the Care Quality Commission under the following headings:

- Clinical Safety and Effectiveness
- Patient Engagement and Experience
- Workforce & Education

The Management Board has also established a number of other Committees to scrutinise and support areas such as Financial Improvement and Productivity, Research and Capital Planning. Each of the Management Board committees and governance sub-boards have Terms of Reference and they report to the Management Board on areas of risk or issues that require escalation.

A Divisional Performance Committee also oversees the work of our clinically-led Divisions. Our divisional structure forms a key part of our management and governance structure and each of the divisions is represented in the membership of the Management Board. During 2020/21 we have maintained a Performance and Accountability Framework to support oversight of the Divisions and the Finance, Investments and Performance Committee receives regular reports on use of the Framework.

A schedule of Executive portfolios ('Who Leads on What') is well-established and is available to Management Board and Trust staff on the TrustDocs system. It is reviewed periodically as part of the ongoing Executive Team and Board Development Programme, so that there remains clarity and assurance over capacity and capability with regard to leadership for all aspects of the Trust.

In its most recent assessment of the Trust the CQC found that *"The governance structure was effective in supporting the delivery of the current strategy and of supporting the divisions and staff to deliver high quality care."*

CQC Registration:
The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The last published report from a full inspection by the Care Quality Commission (CQC) was issued in April 2020. The overall rating for the Trust was that it 'Requires Improvement'. In its report the CQC judged the Trust to be 'Good' for the domains of Caring and Effectiveness, 'Requires Improvement' in the domains of 'Safety, Well-led and Responsiveness'.

The CQC reports identified a number of actions that the Trust 'must' and 'should' take in order to improve. Implementation of the associated action plan to implement the necessary changes has been tracked and monitored through the Trust's Quality Programme Board and the Quality and Safety Committee.

In December 2020, the CQC also undertook a focussed inspection of our Emergency Department. They identified a number of improvements from previous inspections, for example "*Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care"* and *"Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service".* The Hospital was however under pressure at the time due to the Covid pandemic and the CQC found that aspects of the Department required improvement notably in the domain of Safety. The areas in which the CQC said that the ED must improve were in relation to the processes and timeliness of triage and performance against targets such as the 4-hour wait. Their 'Requires Improvement' rating was accompanied by a Warning Notice under Section 29A of the Health and Social Care Act 2008, in accordance with which the Trust has submitted to the CQC an Improvement Plan to implement the necessary changes.

We look forward to welcoming the CQC team to the Trust again in due course, so that we can demonstrate our continuing improvement.

Other compliance issues
As part of its internal control framework, the Trust has established Business Continuity processes of Emergency Preparedness Resilience and Responsiveness. These EPRR processes are designed and maintained in accordance with NHSE guidance, with assurance oversight through the Audit Committee.

In 2020/21 the Trust's arrangements for business continuity was tested as never before through the challenges of the Covid-19 pandemic. Instead of the usual annual review against the EPRR standards, this year the national requirements were to undertake a review of the organisation's response to Pandemic Phase I & II. The associated report was reviewed by the Trust Management Board on 29 September and the Board of Directors on 7 October 2020.

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

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Such measures include staff training, policy frameworks and engagement with relevant staff networks.

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

The Trust recognises the crucial role played by its staff in delivering services to our patients and the Board has a People and Culture Committee, which is an assurance committee and strategic group, with a membership consisting of Board members and divisional leaders. The Hospital Management Board also established a Workforce and Education Governance Sub Board (WESB), chaired by the Chief People Officer and with representation from across the divisions and the Human Resources and Education directorate.

Through this governance structure the Trust ensures scrutiny of all aspects of people related issues and performance, including safe staffing, safe deployment, learning and development, cultural improvement, sickness, appraisal, mandatory training, retention, recruitment and temporary staffing. Any people related risks that arise from the divisional boards are presented at the WESB for appropriate consideration and intervention. The WESB also provides an assurance structure with regard to the 'Developing Workforce Safeguards', within its remit covering safe recruitment, skills levels, safe care and deployment (both substantive and temporary).

Significant and Strategic Risks
Threats to delivery of the Trust's Strategic Objectives are recorded in the Board Assurance Framework (BAF), the actions to be taken to provide additional assurance and to counter the identified threats.

In its assessment of the Trust, reported April 2020, the CQC found that *"The executive directors, chair and non-executive directors we spoke with all agreed on the most significant risks for the organisation. These included finance, staffing, and capacity. This was completely aligned to the trust risk register as well as the BAF. All could describe the controls in place and their individual responsibilities in addressing these concerns"*.

During the course of 2020/21 the Board and the Board Assurance Committees have reviewed the most significant risks facing the Trust, as follows:

i) **Capacity:** high levels of elective demand, and prolonged waiting times in the aftermath of the acute pandemic, have created risks for delivery of the Trust's performance targets for cancer, 18-weeks and diagnostics, leading to extended waiting times and use of expensive temporary or outsourced capacity;

ii) **Finance**: if the Trust is to deliver financially sustainable high quality services to patients, there is a need to enhance financial controls, implement operational transformation, achieve system-wide service redesign and secure support for the structural element of the Trust's financial deficit;

iii) **Covid 19 pandemic & emergency demand**: at the time of writing in May, the Trust's Operational Position is one of 'Severe Pressure' even at a point at which rates of Covid-19 infection are relatively low. The Trust faces risks associated with high levels of emergency demand, in addition to which there is the risk of further pandemic peaks or waves;

iv) **Capital:** lack of capital available for investment in services for patients and staff, creates a current and future risk especially with regard to diagnostic capacity, digital technology, staff facilities, elective capacity, education infrastructure and pharmacy.

v) **Quality:** systems, processes and teams that are insufficiently resilient and consistent in practice, or inadequate in capacity, can result in diminished standards of patient experience and quality outcomes;

vi) **Digital**: immaturity and vulnerability in the Trust's digital infrastructure creates risk to cyber security, operational resilience, quality and efficiency.

The Trust has mitigating actions in place to minimise the potential impact of these risks so far as practicably possible, with the impact of these assessed through reports to the Board and in particular the metrics set out in the monthly Integrated Performance Report. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk. Very significant challenges remain however with regard to the Trust's operational and financial sustainability in the current organisational configuration and price structure of the health economy.

Licence Undertakings:

NHSI, the independent regulator of Foundation Trusts, has previously investigated the Trust's non-achievement of national operational performance targets and quality challenges as highlighted by the CQC. Coming into 2020/21 the Trust was in Special Measures for reasons of Quality and Licence Undertakings had been in place since 2015/16.

By way of letter dated 13 May 2020 the NHSE/I National Improvement Director confirmed:

"I am delighted to be able to confirm that…the Trust will from today no longer be in special measures. I can also confirm that the trust will move from segment 4 to segment 3 of the [Single Oversight Framework] and the regional team will be in contact with you to agree refreshed undertakings shortly.…

I am pleased to note that the CQC's published report rated the Trust as remaining 'requires improvement' and 'good' in the effective and caring domains. The report showed significant improvement and the CQC referenced key improvements in relation to leadership and governance and that the Trust is taking a proactive approach to working with its partners to develop care pathways, ensure sustainability of quality improvement as well as encouraging staff development. However further work is required to ensure the effective use of resources and support will be required to ensure all executives and the wider board are focused on the financial position and challenges at the trust.

This is a time to celebrate the progress that the Trust has made, and I recognise the hard work and commitment of all of your staff in delivering this outcome. Given that the trust's CQC rating is still 'requires improvement' NHS England & NHS Improvement regional team will continue to work with you and your team to provide targeted support, that will of course take into account the extremely challenging current situation of the COVID-19 virus, and help you build on the commendable improvements that have already been made…….

It is certainly encouraging that the hard work of so many people has resulted in this very positive outcome for the local population and thank you for your unwavering commitment. I look forward to seeing the Trust's continued progress."

The Trust has subsequently agreed revised Licence Undertakings with NHSE/I. Key elements of the Undertakings are that they require the Trust to:

- work with its partners in the N&W ICS to develop and take all reasonable steps to deliver an Urgent and Emergency Improvement Plan, an Elective Improvement Plan and a Cancer Improvement Plan by 30 June 2021;
- deliver financial performance in FY20/21 as part of the STP Financial Envelope, to improve its underlying financial position in FY21/22 and to work with its partners in the N&W ICS to develop a Medium Term Financial Improvement Plan by Q3 FY21/22;
- further develop and deliver its Quality Improvement Plan (QIP) by 30 June 2021.

NHSE/I has confirmed its belief that implementation of the actions identified will ensure that relevant Licence breaches do not continue or recur.

Incident Reporting and Raising Concerns

Incident and near-miss reporting is encouraged across all staff groups and specialties across the Trust within an open culture focussed on learning and improvement. The Trust has a single web based incident reporting system which is used by all staff groups to record patient and staff safety incidents, near misses and serious incidents. The number and type of incidents reported and learning from these incidents is disseminated and monitored through the risk and governance structure and a communication route to all staff based on Organisation Wide Learning (OWL) newsletters, Safer Practice Notices and updates through the Clinical Safety and Effectiveness Governance Sub-Board.

The Trust has established a daily multi-professional Serious Incident Group (SIG) which reviews high-rated incidents or near misses, to identify and share learning, ensure any immediate safety actions are taken as well as compliance with the statutory Duty of Candour. The Quality and Safety Committee receives regular reports with regard to the rate of incident reporting in the Trust and the investigation and learning from incidents.

The Trust has a full-time Freedom to Speak-up Guardian (FTSUG) in post to support staff in raising concerns and putting forward suggestions as to how we might make further improvement in the Trust and its services. The FTSUG reports regularly to the Hospital Management Board and the Trust Board's People and Culture Committee, so there is transparency with regard to any issues of concern affecting or raised by staff.

Involvement of Stakeholders in Risk

The Trust liaises with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters. The Trust works closely with other local organisations which are part of the formal structure for NHS patient and public involvement, such as the Health Overview and Scrutiny Committee and Healthwatch.

Our Foundation Trust has a membership with approximately 17,000 public members, many of whom are actively involved with the Trust in a number of ways, including a Patient Panel and a regular programme of meetings for members about different aspects of our activities. Inevitably, such activities have been disrupted this year by the pandemic restrictions but we have sought to optimise engagement as possible, through initiatives such as digital communication, remote access to public meetings and a virtual AGM.

The members elect governors who sit on the Trust's Council of Governors and who represent the views of members when contributing to development of the Trust's forward plans and priorities. The Trust's Council of Governors receives regular updates on strategic developments in the Trust and performance against key targets and governance requirements.

The views of patients are sought in a variety of additional ways, including patient electronic surveys, nationally mandated surveys, comment cards and other activities. The Board receives regular reports on feedback from patients through the Patient Engagement and Experience Governance Sub-Board. The Trust has appointed a Lead for Patient Experience and Engagement and established a Patient Panel, to strengthen the Patient Voice in the life of the Trust and in the development of its services. The Board also receives patient feedback through a programme of Patient Stories at the beginning of public Board meetings.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

Review of economy, efficiency and effectiveness of the use of resources
The Trust's operational Plan for 2020/21 was approved by the Board of Directors following review by the Council of Governors and then submitted to and accepted by NHSEI. During the year, the Trust had to review the aims of its Operational Plan as it responded to the COVID-19 pandemic. However, Management Board continued to monitor both non-financial and financial performance against revised targets. Progress against cost improvement programmes continued to be monitored through a Programme Management Office process reporting to the Financial Improvement & Productivity Committee and the Management Board.

Assurance with regard to delivery of the Operational Plan was sought on behalf of the Board of Directors through the Board assurance committees via reports covering activity, workforce, quality, safety and finance. The process to ensure that resources are used economically, efficiently and effectively across clinical services includes Divisional Performance Reviews meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

The Trust's Internal Audit Plan is determined having regard to the Trust Risk Register and audits include objectives ensuring the economical, effective and efficient use of resources and this is applied across all audits. The findings of internal audit reports are reported to the Audit Committee and other Board assurance committees as relevant.

The Trust was subject to a Use of Resources review in December 2019 and the resulting report was published in April 2020. Overall the Trust was rated as 'requires improvement', reflecting the Trust's financial deficit and inability to consistently achieve the constitutional operational standards.

The report identified a number of areas as having scope for improvement, including initiatives to reduce length of stay, improve performance against constitutional operational standards, identify and drive transformational cost improvement programmes and review the workforce model and recruitment strategies to identify and implement innovative ways to address workforce gaps.

A formal response to the Use of Resources assessment was developed and submitted to NHSE&I, outlining the actions the Trust will take as part of our 'journey to outstanding'. The response consisted of strategic enablers running alongside a clear tactical action plan to address the specific recommendations outlined within the report.

The four key interventions identified were:

1. A detailed, independent review of the Trust's financial governance;
2. A refresh of the Trust's medium term financial strategy, in line within NHSE&I best practice guidance;
3. A review of the Trust's improvement functions with a view to enhancing the alignment of resources to drive further efficiency and transformation across the organisation through adoption of consistent governance principles. This commenced with the integration of the Use of Resources action plan within the overarching response to the CQC report and associated governance, through the Quality Programme Board; and
4. A tactical action plan, initially focussed on the recommendations, which will be supplemented by further actions, as identified.

The independent Financial Governance Review (FGR) was completed in October 2020 across five Financial Domains. The review identified 53 recommendations, 23 of which were designated as 'Must Do'. This led to the development of a detailed Tactical Action Plan consisting of 65 individual actions for completion.

An internal audit review of the Trust's progress against the recommendations has been completed in February 2021, which identified that positive progress has been made against the recommendations across each of the five domains.

The Trust has and will continue to review its position with regard to Getting It Right First Time (GIRFT), agency spend, procurement and efficiencies highlighted by the Lord Carter review, including enhancing its use of Model Hospital. Alongside working closely with local and regional partners to delivery transformational changes that support the delivery of a value for money efficient service as part of the local health economy.

Information Governance and Cyber Security
The Trust has in place a Cyber Code of Conduct and Information Governance procedures which set out the Trust's commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded.

This policy framework is supported by an information governance structure including:

- Information Governance Steering Group
- Caldicott Advisory Group
- Digital Transformation Committee

The Chief Information Officer is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors, and the Medical Director is the Trust's Caldicott Guardian. This structure is supported by a deputy SIRO (the Associate Director for Digital Health) and a deputy Caldicott Guardian (the Chief Clinical Information Officer). Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance policy and management framework.

2020/21 has seen an expansion to both the Information Governance and the IT Security/Cyber Security teams and additional resources identified to help oversee daily information governance and IT security operations. The Trust works collaboratively with other Social and Healthcare Organisations, from an Information Governance and IT Security perspective, within the Norfolk and Waveney STP to share common concerns, knowledge, skills, and learnings and support each other to ensure that there are sufficient assurances in the handling of personal and confidential information and Cyber Security.

Personal data related incidents are reported through the Trust Incident Reporting System. The lessons learnt are shared with staff members and they enable the Trust to review and continually improve its information Governance processes for the safekeeping of personal information and to ensure compliance with data protection legislation and Caldicott principles.

During 2020/21, the Trust recorded three Level 2 reportable information governance incidents. These cases have been reported to the Information Commissioner's Office (ICO) and have been concluded with no further action required. A summary of Level 1 and 2 data-related incidents reported during the year is shown below:

Category	Breach Type	Level 1	Level 2
A	Corruption or inability to recover electronic data	0	0
B	Disclosed in Error	13	1
C	Lost in Transit	0	0
D	Lost or stolen hardware	0	0
E	Lost or stolen paperwork	1	0
F	Non-secure Disposal – hardware	0	0
G	Non-secure Disposal – paperwork	2	1
H	Uploaded to website in error	0	0
I	Technical security failing (including hacking)	0	0
J	Unauthorised access/disclosure	4	2
K	Other	1	0
Total		**21**	**3**

The Data Security and Protection Toolkit (DSPT) is a NHS Digital online self-assessment tool that allows Trusts to measure their performance against the National Data Guardian's 10 data security standards. The Trust completes a DSPT self-assessment every year and for 2020/21 a number of changes were made in order to:

- Respond to lessons learned and direct feedback from users following the first year of the DSPT
- Address an Information Notice on compliance to the Network Information Systems (NIS) compliance.
- Improve the targeting of requirements to different categories of organisations

In response to the Covid-19 pandemic, NHS Digital extended the date for formal submission of the DSP Toolkit evidence to 30 September 2020. The Trust has a work-programme and an action plan in place for the successful delivery of the DSPT, however we are not compliant at this point, with the main outstanding action is around staff taking part in awareness session/training. A review was undertaken by the Trust Internal Auditors in February 2021 to validate the DSPT work programme and help provide assurance of data security and identify common problem areas. This audit review was focused on the mandatory elements for the data security standards 1, 5, 6 and 9. Areas of non-compliance with the DSPT assertion requirements were identified and an action plan with appropriate monitoring has been established.

The Trust continues to raise awareness of Information Governance and the importance of protecting personal information with its staff through a comprehensive training programme available by various means online and face-to-face. To complement this learning, relevant policies, guidance and best practice are made available to staff members via the Trust's intranet.

Data quality and associated governance

There are a number of controls in place across the Trust that provide assurance to the Board with regard to the controls in place concerning Data Quality and Accuracy of Data. The Trust has an experienced Data Quality Manager and Data Quality Team. To facilitate joint working and exchange of information, this team is closely affiliated to the Commissioning and Income Team.

The Data Quality Team maintain and manage a suite of policy documents for application across the Trust. These include a Data Quality Policy & Strategy; Patient Demographics; Referral to Treatment Access Policy and numerous Standard Operating Procedures. The Team also provide training for Trust staff and audit compliance with data collection and reporting requirements with particular regard to elective waiting time data. The Trust also retains the services of specialised and skilled coding and informatics staff to produce and analyse data and to ensure the accuracy of reporting.

Three key audit programmes are in place with regard to Data Quality:

i) *Referral to Treatment 18 Week Rolling audits*: carried out at a speciality level on a rolling basis, these audits give assurance over the accuracy of data relating to Performance Standards (focussing on RTT Standard) and adherence to policy; as well as compliance to National Rules. The audit results are reviewed through the Trust Assurance Group (TAG);
ii) *Key Systems Audit Programme*: this programme supports reporting of clinical income and provides assurance from standalone systems, to ensure the Trust is able to report correctly attracting the correct level of income from clinical activity and to ensure that information used in Service Line Reporting is accurate, valid, reliable, timely, relevant and complete. Reporting of audit results is taken through the Information Governance Steering Group;
iii) *Clinical Threshold / Individual Funding Requirement:* Weekly and monthly audit work is undertaken to confirm compliance with policy statements agreed with local Clinical Commissioning Groups.

In addition, the Data Quality Team support a monthly validation process (with particular focus on RTT clock starts, stops & coding). NNUH has been rated as having the highest quality RTT/PTL recording in the NHS amongst NHS Acute Trusts. The Trust reports consistently in the upper quartile against the Data Quality (SUS) Dashboard, performing well against both local benchmarks and significantly above the National Average. The Trust also performs consistently strongly in the Data Quality Maturity Index quarterly report. This metric confirms completeness of data.

Information to support the quality metrics used in the reporting on quality is held in a number of Trust systems, including Datix (electronic risk management system), PAS (patient administration database) Telepath (electronic pathology system) and ICNet (infection control system). The data is utilised day-to-day in the Trust's operations and, where appropriate, it is submitted to the National Information Centre, which operates national checks to ensure its reliability and accuracy. Further quality data is drawn from the reports that are produced for the Clinical Safety Sub-Board and the Patient Engagement and Experience Sub-Board.

Annual Quality Report

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

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Quality and Safety Committee and Finance, Investments & Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has met regularly throughout the year and has kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring metrics that are agreed as indicative of effective controls. The Board reviews a monthly Integrated Performance Report covering a wide range of performance metrics – these show the key relevant national priority and regulatory indicators, with additional sections devoted to safety, clinical effectiveness and patient experience. This monthly integrated summary is supplemented by more detailed briefings on areas of notable or adverse performance. The selection of appropriate metrics is subject to regular review by the Board, with changes in priorities or areas of concern reflected in that selection.

The Audit Committee has reviewed the overall framework for internal control and the Trust's Organisational Framework for Governance, and has recommended this statement to the Board of Directors.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Further assurance is provided through the CQC intelligent monitoring reports, the outcomes of the clinical audit programme, the results of reviews and inspections by external organisations and our internal audit programme.

Clinical Audit as part of the internal control framework:
The Trust has systems and controls in place to ensure that high quality clinical audits are conducted and their findings acted upon by all directorates and specialties across the Trust. There is a Trust Medical Lead for Clinical Audit and each specialty within a directorate has its own clinical audit lead. The Trust Clinical Audit Lead, the Clinical Effectiveness and Improvement Manager and specialty audit leads are responsible for developing, monitoring and reporting an annual clinical audit programme that reflects local and/or Trust issues around service quality or patient safety. The Clinical Audit Plan is subject to review by the Board's Audit Committee and Quality and Safety Committee.

All clinical audit projects are registered on an electronic system and monitored to completion and subsequent re-audit. The Medical Audit Lead is a member of the Trust's Clinical Safety and Effectiveness Governance Sub-Board which is accountable to, and reports audit activity to, the Hospital Management Board. Clinical Audit is therefore a key element of our governance arrangements for ensuring compliance with key standards and best practice.

During 2020/21 progress in implementing the Clinical Audit Plan was disrupted by the need to prioritise the Trust's emergency response to the Covid-19 pandemic, in accordance with national guidance. Progress during the year was reviewed by the Quality and Safety Committee in March 2021 and will be reflected in the priorities chosen for 2021/22.

Internal Audit as part of the internal control framework:
In addition to Clinical Audit, the Internal Audit plan is a risk based programme of reviews based on areas of management concern, emerging risks, and national and historical experience. The Plan is informed by previous internal and external audit work and discussion with the Executive Team.

The Trust's internal audit function is outsourced (to provide enhanced objectivity) and is provided under contract by RSM. The work of internal audit is overseen by the Trust's Audit Committee which agrees the audit plan and it covers risk management, governance and internal control processes across the Trust – including financial management and control, human resources and operational governance.

A report is produced at the conclusion of each audit assignment and, where scope for improvement is found, recommendations are made and appropriate action plans agreed with management. Reports are issued to and followed up with the responsible Executive Directors, and the results of audit work are reported to the Audit Committee.

During 2020/21, Internal Audit completed 10 audits resulting in a formal assurance opinion. Of these, 6 confirmed that the Board could take either substantial or reasonable assurance that effective controls are in place. In 4 areas, the result was a partial assurance report. In each of these areas, actions to implement all recommendations are identified and progress in implementing these actions is followed-up and regularly reported to the Audit Committee.

Based on the work undertaken in 2020/21 the Head of Internal Audit has concluded: *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective'.*

Significant internal control issues
During 2020/21 the Executive, Management Board and the Board of Directors have considered and reflected on the significant risks and challenges facing the Trust, as indicated and highlighted by our internal governance framework and discussion and feedback with regulators. The Board of Directors has identified the following areas of challenge which pose significant internal control issues for the Trust:

- **Waiting times for planned and elective care:**
  In common with the position nationally, the number of patients waiting for planned or elective care in the Trust has increased over the course of the last year to unprecedented levels. Restoration of services in the immediate post-Covid period is a well-documented challenge of huge importance for those patients who are waiting for unacceptably long periods.

- **Covid-19 and demand for emergency care:**
  The level of emergency demand on the NHS over the course of the pandemic has been unprecedented and it is necessary to recognise the potential for further Waves and surges in demand. This is against the background in which the Trust has really struggled in the face of increased emergency activity over the Winter. The unpredictability of future demand poses a significant risk issue for the Trust, noting that even in May at the time of writing, the Trust's Operational Position is again one of 'Severe Pressure'.

- **Financial sustainability:** The Trust has a significant underlying financial deficit**.** There is a need to enhance performance in relation to financial planning and controls but also to address the underlying strategic drivers of the deficit to ensure the longer-term financial sustainability of the Trust.

- During 2021/22, the Trust will be working in collaboration with system partners and regulators to establish a robust and effective Medium Term Financial Strategy.

- **Staff welfare:** Our response to the Covid 19 pandemic, against the background of longer terms issues affecting the Trust, has had a significant effect on the resilience, well-being and morale of our staff. It has highlighted inadequacies in our current infrastructure to support staff – including rest areas, changing facilities, catering, transport and leisure/welfare options. These issues feature prominently in feedback from staff and to ensure the sustainability of the Trust, it will be necessary to identify solutions to remedy these inadequacies.

- **Digital immaturity**: assessment against international standard criteria shows that the Norfolk & Waveney STP area is the least digitally developed of any in the NHS in England. The Trust's position in the lowest 5% of secondary care providers (scoring of 0.2/5) reveals the size of the challenge and is typified by our reliance on paper-based medical records and a plethora of separate clinical databases and applications with limited functionality and interoperability. Inadequacy of the digital infrastructure in the Trust has continued to impact negatively on the Trust's ability to achieve its potential in terms of operational efficiency, effectiveness and quality improvement. The Board has taken a number of steps to improve the position, notably through investment in an Electronic Document Management System and an E-Obs system. Ultimately implementation of an Electronic Patient Record (EPR) system will be essential and the business case for a single EPR across the three Norfolk acute hospitals is being pursued as a matter of urgency.

As confirmed below, mitigating actions are in place or in development with respect to each of these significant risk areas.

Conclusion

My review confirms that Norfolk and Norwich University Hospitals NHS Foundation Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives. Both operational and financial sustainability however remain significant risks for the Trust and its ability to achieve key performance targets, the Trust's Strategic Objectives and the timely high quality services to which we all aspire.

I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans in place or in development to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

In his 2020/21 Annual Opinion, the Head of Internal Audit concluded *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".* I have taken careful note of that opinion, in addition to those of the CQC and NHSI as referenced above. These accord with my own assessment that whilst much has been done, there is still more to do. The Trust remains resolute in its commitment to continuous improvement and to enhancing the quality of its services and its financial and operational sustainability, in order to ensure delivery of the best possible care to our patients.

Signed:

Sam Higginson
Chief Executive **Date: 11 June 2021**

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Sam Higginson
Chief Executive **Date: 11 June 2021**

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2021

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Contents

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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

In our opinion the financial statements:

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

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that revenue recognised one month pre or post year end was recognized in the wrong period and the risk that Trust management may be in a position to make inappropriate accounting entries.

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

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included:
    - Unexpected postings to cash, revenue and expenses codes.
    - Journals containing certain words in the description.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the completeness, existence and accuracy of income recognised with specific emphasis placed on cut-off. This included:
    - Review and sample testing of income recognised either side of year-end
    - Sample testing of year-end deferred income including consideration of year on year movements.

Assessing the completeness, existence and accuracy of non-pay expenditure recognised with specific emphasis placed on cut-off. This included:

- Sample testing of year-end accruals including consideration of year on year movements;
- Sample testing of invoices and bank payments pre and post year-end.

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

Annual Governance Statement

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

Remuneration and Staff Reports

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

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 122, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

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

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

Significant weakness – financial sustainability

The Trust's outturn position for 2020/21 is a surplus of £7.2 million. The £7.2 million surplus represents a £14.7 million improvement against its budget of a £7.5 million deficit. However, in the 2021/22 phase 4 financial plan, the Trust has a provisional budget plan for the second half year - pending National Planning Guidance, of a net deficit of £55m. At the time of the Audit the Trust has a draft financial strategy in place and is working with Regulators and the Norfolk and Waveney ICS to agree a final recovery trajectory in line with the requirements of its Undertakings.

The Trust's forecast deficit and future borrowing requirements are evidence of weaknesses in proper arrangements for planning effectively to support the sustainable delivery of the Trust's strategic priorities.

Recommendations:

The following recommendations are raised in light of the significant weakness reported above:

- Develop a medium-term improvement plan and as part of this obtain approval for any additional financing that is required, in line with the enforcement notifications issued.

- Develop an action plan to ensure that cost improvement targets are met.

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

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

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

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

Statutory reporting matters

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

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

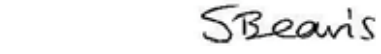
We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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



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

Foreword to the Accounts

These accounts, for the year ended 31 March 2021, have been prepared by the Norfolk and Norwich University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed……..

Sam Higginson
Chief Executive

Date: 11 June 2021

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2021

STATEMENT OF COMPREHENSIVE INCOME	Note	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Operating income	3	657,541	578,425
Other operating income	4	145,828	93,171
Operating expenses	6	(764,895)	(692,050)
OPERATING SURPLUS / (DEFICIT)		**38,474**	**(20,454)**
FINANCE INCOME AND EXPENSES			
Finance income	12	0	208
Finance expense - financial liabilities, including unwinding of discount on provisions	14	(31,306)	(34,535)
NET FINANCE COSTS		**(31,306)**	**(34,327)**
SURPLUS / (DEFICIT) FOR THE YEAR		**7,168**	**(54,781)**
Other comprehensive income			
Impairments	15	0	(2,098)
Revaluations	15	2,125	12,481
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**9,293**	**(44,398)**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2021

STATEMENT OF FINANCIAL POSITION	Note	31 March 2021 £'000	31 March 2020 £'000
Non-current assets			
Property, plant and equipment	15	349,021	268,112
Trade and other receivables	18	62,463	85,484
Total non-current assets		**411,484**	**353,596**
Current assets			
Inventories	17	13,129	11,865
Trade and other receivables	18	32,260	35,135
Cash and cash equivalents	19	68,945	13,432
Total current assets		**114,334**	**60,432**
Current liabilities			
Trade and other payables	20	(114,272)	(68,824)
Other liabilities	22	(16,734)	(14,833)
Borrowings	21	(5,037)	(199,270)
Provisions	25	(468)	(453)
Total current liabilities		**(136,511)**	**(283,380)**
Total assets less current liabilities		**389,307**	**130,648**
Non-current liabilities			
Other liabilities	22	(2,128)	(3,515)
Borrowings	21	(182,368)	(187,403)
Provisions	25	(8,087)	(4,572)
Total non-current liabilities		**(192,583)**	**(195,490)**
Total assets employed		**196,724**	**(64,842)**
Financed by (taxpayers' equity)			
Public dividend capital		290,709	38,436
Revaluation reserve		27,061	25,328
Income and expenditure reserve		(121,046)	(128,606)
Total taxpayers' equity		**196,724**	**(64,842)**

The financial statements on pages 8 to 46 were approved by the Board on 11 June 2021 and signed on its behalf by:

Signed: ……(Chief Executive) Date: 11 June 2021

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£'000	£'000	£'000	£'000
Taxpayers' equity at 1 April 2020	**38,436**	**25,328**	**(128,606)**	**(64,842)**
Surplus for the year	0	0	7,168	**7,168**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	0	(181)	181	**0**
Other transfers between reserves	0	(211)	211	**0**
Impairments	0	0	0	**0**
Revaluations	0	2,125	0	**2,125**
Public dividend capital received	252,273	0	0	**252,273**
Taxpayers' equity at 31 March 2021	**290,709**	**27,061**	**(121,046)**	**196,724**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2019	**31,909**	**14,968**	**(73,847)**	**(26,970)**
Deficit for the year	0	0	(54,782)	**(54,782)**
Other transfers between reserves	0	(23)	23	**0**
Impairments	0	(2,098)	0	**(2,098)**
Revaluations	0	12,481	0	**12,481**
Public dividend capital received	6,527	0	0	**6,527**
Taxpayers' equity at 31 March 2020	**38,436**	**25,328**	**(128,606)**	**(64,842)**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2021

	Note	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Cash flows from operating activities			
Operating surplus / (deficit)		38,475	(20,454)
Operating surplus / (deficit)		**38,475**	**(20,454)**
Non-cash income and expense:			
Depreciation	6	16,882	10,072
Impairments and reversals of impairments		7,201	0
Loss on disposal of non-current assets		250	509
Income recognised in respect of capital donations (cash and non-cash)		(8,515)	(3,805)
Decrease / (Increase) in trade and other receivables		1,272	(5,840)
(Increase) in inventories		(1,264)	(1,427)
Increase / (Decrease) in trade and other payables		41,948	(30)
Increase in provisions		3,560	2,626
Net cash from / (used in) operations		**99,809**	**(18,349)**
Cash flows from investing activities			
Interest received		16	202
Purchase of property, plant, equipment and investment property		(66,126)	(29,330)
Sales of property, plant, equipment and investment property		148	43
Receipt of cash donations to purchase capital assets		0	500
Net cash used in investing activities		**(65,962)**	**(28,585)**
Cash flows from financing activities			
Public dividend capital received		252,273	6,527
Movement on loans from the Department of Health		(195,131)	83,803
Capital element of finance lease rental payments		(186)	(182)
Capital element of PFI, LIFT and other service concession payments		(3,172)	(2,912)
Interest paid on finance lease liabilities		(3)	(8)
Interest paid on PFI, LIFT and other service concession obligations		(31,300)	(30,963)
Other interest paid		(814)	(3,361)
Net cash from financing activities		**21,667**	**52,904**
Increase in cash and cash equivalents	19	55,513	5,970
Cash and Cash equivalents at start of the year	19	13,432	7,462
Cash and Cash equivalents at 31 March	19	**68,945**	**13,432**

The accompanying notes form an integral part of the Financial Statements

NOTES TO THE ACCOUNTS

1. Accounting Policies and Other Information

1.1 Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Going Concern

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

NOTES TO THE ACCOUNTS

1.3 Interests in other entities

NHS Charitable Fund

The NHS foundation trust is the corporate trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. Since 2013/14 the Trust has chosen not to consolidate the charitable fund on the basis it is not material.

Interests in Joint Operations

The Trust has a 58% interest in a joint operation for the provision of pathology services in Norfolk known as the Eastern Pathology Alliance (EPA). The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

Accordingly, the Trust's share of operating income and expenditure is included in these accounts.

1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

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.

2020/21

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

Comparative period (2019/20)

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

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

NOTES TO THE ACCOUNTS

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.

1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

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

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

1.7 Expenditure on other goods and services

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

NOTES TO THE ACCOUNTS

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part 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.

NOTES TO THE ACCOUNTS

A valuation of the Trust's Estate was carried out in 2019/2020 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors. The effective date of the valuation was 31 March 2020.
The revaluation basis for all of the Trusts Land and Buildings was depreciated replacement cost as a Modern Equivalent Asset, with the exception of the Residential Accommodation on the hospital campus and the office accommodation within the main hospital building.
These were valued as non specialised assets, accordingly were valued on a market value for existing use.

This valuation was accounted for in the 2019/2020 accounts.

For 2020/21, the valuation has been subject to an indexation review by Monatgu Evans, to assess the valuation movement over the year to 31 March 2021. This movement has been reflected in the 2020/21 accounts, along with capital additions in the financial year.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 - Borrowing Costs. 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 have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

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

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

NOTES TO THE ACCOUNTS

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.

Private Finance Initiative (PFI) transactions

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

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

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

NOTES TO THE ACCOUNTS

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 is shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	82
Plant & machinery	1	30
Transport equipment	5	12
Information technology	1	10
Furniture & fittings	5	15

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

1.9 Inventories

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

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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.

NOTES TO THE ACCOUNTS

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

NOTES TO THE ACCOUNTS

Impairment of financial assets

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses for assets relating to Non NHS bodies are determined by reference to an unbiased probability-weighted approach using recent actual recovery experience. A separate assessment is employed for each of the main sources of Non NHS income.

Expected credit losses in relation to NHS bodies are not normally recognised. They are subject to a separate credit note risk assessment.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

De-recognition

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

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

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.

The lease liability is de-recognised when the liability is discharged, cancelled or expires.

NOTES TO THE ACCOUNTS

Operating leases

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

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

Leases of land and buildings

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

The Trust as a lessor

Finance leases

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

Operating leases

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

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:

		Nominal rate
Short-term	Up to 5 years	minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

NOTES TO THE 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.

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 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, 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.

1.15 Public Dividend Capital (PDC) and PDC dividend

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

1.16 Value Added Tax

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

1.17 Corporation Tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 2021, neither did it for the year ended 31 March 2020.

1.18 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.19 Foreign Exchange

The functional and presentational currency of the Trust is sterling. A transaction denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the dates of the transaction. At the end of the reporting period, monetary assets and liabilities denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's income or expense in the period in which they arise.

NOTES TO THE ACCOUNTS

1.20 Third party assets

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

1.21 Losses and Special Payments

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

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

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Note 1.1 Early adoption of standards, amendments and interpretations

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

1.24 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 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.

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

NOTES TO THE ACCOUNTS

1.25 Critical judgements in applying accounting policies

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

An assessment of the Trusts PFI schemes was made as part of the IFRS transition in the 2009/10 accounts, and it was determined that the PFI scheme in respect of the main Hospital building should be accounted for as an on-Statement of Financial Position assets under IFRIC 12. This required judgements to be made in order to determine the required accounting treatment. The key judgements were to initially value the hospital at the cost of construction, to attribute an asset life of 70 years and to identify the components of the hospital subject to lifecycle maintenance, that should be accounted for separately. The annual contribution to lifecycle maintenance is treated as a non current prepayment until it is capitalised consistent with the operators schedule for replacement.

A full valuation of the PFI hospital was performed as at 31 March 2020 by the Trust's externally appointed independent valuer, Montagu Evans, Chartered Surveyors.

The revaluation basis was depreciated replacement cost as a Modern Equivalent Asset.

The valuation was accounted for in the 2019/2020 accounts.

For 2020/21, the valuation has been subject to an indexation review by Monatgu Evans, to assess the valuation movement over the year to 31 March 2021. This movement has been reflected in the 2020/21 accounts, along with capital additions in the financial year.

1.26 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:

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining carrying amounts of those assets. Variation is not expected to be significant.

Judgement has been used to determine the carrying value of provisions, deferral of income and accruals for expenditure.

An estimate has been used to determine total future obligations under PFI contracts as disclosed in note 24.2, in relation to future rates of inflation. This estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2021 or 31 March 2020, or the amounts charged through the Statement of Comprehensive Income.

2. Operating segments

IFRS 8 requires income and expenditure to be broken down into the operating segments reported to the chief operating decision maker. In the case of the Trust, this has been determined to be the Executive Directors.

The Executive Directors receive segmental information for expenditure. Segments are defined as the Trust's divisions, as identified in the following table which also describes the service that each provides. The Services division deals with areas such as the commissioning of catering, portering and cleaning, as well as support functions. Expenditure on Covid-19 is reported separately to the Executive Directors as part of the pandemic incident reponse and has been included as a separate operating segment. As a result, the comparatives have been restated.

Income and assets are not reported by division, so are not analysed in the data below. Details of income by source is provided in note 3.1. The Trust's main source of income is from within the UK for the provision of healthcare services.

2020/21:

	Medicine	Clinical Support	Surgery and Cromer	Women, Children and Sexual Health	Emergency	Services	Pandemic Incident Response	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	125,142	74,494	126,808	49,269	28,434	35,413	10,124	**449,684**
Non Pay	99,591	31,461	28,371	8,115	3,175	73,196	23,241	**267,150**
Total	**224,733**	**105,955**	**155,179**	**57,384**	**31,609**	**108,609**	**33,365**	**716,834**

2019/20 :

	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	113,395	71,783	118,001	45,438	26,582	27,025	296	**402,520**
Non Pay	89,686	34,348	49,697	7,403	3,202	71,396	545	**256,277**
Total	**203,081**	**106,131**	**167,698**	**52,841**	**29,784**	**98,421**	**841**	**658,797**

Reconciliation - Pay

	2020/21 £'000	2019/20 £'000
Employee Expenses - Non-executive directors (note 6)	147	143
Employee Expenses - Staff and executive directors (note 6)	449,419	400,261
VSS & Redundancy (note 6)	118	2,116
Total	**449,684**	**402,520**

Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 6)	764,895	692,050
Less: Pay (see above)	(449,684)	(402,520)
Less: Depreciation (note 6)	(16,882)	(10,072)
Less: Consortium payments (note 6)	(17,055)	(15,718)
Less: Loss on disposal (note 6)	(250)	(509)
Less: Research and development (note 6)	(5,627)	(5,876)
Less: Education & training - notional expenditure funded from apprenticeship fund (note 6)	(1,046)	(1,078)
Less: Impairments (note 6)	(7,201)	0
Total	**267,150**	**256,277**

3. Operating income

3.1 Income from activities

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
NHS Foundation Trusts	0	11
NHS Trusts	0	2,117
CCGs and NHS England	654,377	572,089
NHS Other	0	82
Non-NHS: Private patients	1,128	1,965
Non-NHS: Overseas patients (non-reciprocal)	341	384
NHS injury cost recovery scheme (formerly RTA)	1,239	1,338
Non-NHS: Other	456	439
Total income from activities	**657,541**	**578,425**

Substantially all income from activities comes from the provision of mandatory services.
NHS injury cost recovery scheme income is subject to a provision for impairment of receivables of 22.43% (2019/20: 21.79%) to reflect expected rates of collection.
Overseas patients (non-reciprocal) income is amounts received by the Trust, where the overseas patient is liable for the cost. This occurs when there is not a national reciprocal arrangement with the country that the patient is a national of.

Substantially all income arises in the UK. There are two (2019/20: four) main customers of the Trust who each account for the majority of its income from activities. They are NHS Norfolk and Waveney CCG (68.98%) and NHS England (27.43%). In 2019/20, they were NHS England (24.05%), NHS South Norfolk CCG (20.51%), NHS Norwich CCG (22.02%) and NHS North Norfolk CCG (18.76%).

3.2 Income from activities by category

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Block contract / system envelope income	627,829	357,347
High cost drugs income from commissioners	7,621	66,534
Other NHS clinical income	1,274	134,596
Private patient income	1,469	2,349
Additional pension contribution central funding	17,653	15,829
Other clinical income	1,695	1,770
Total income from activities	**657,541**	**578,425**

3.3 Overseas Visitors (patient charged direct by the Trust)

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Income recognised this year	341	384
Cash payments received in year (all years)	55	49
Amounts added to provision for impairment of receivables (all years)	229	123
Amounts written off in-year (all years)	0	139

3.4 Income from Commissioner Requested Services

Operating income includes income from Commissioner Requested Services as follows:

	Year ended 31 March 2021	Year ended 31 March 2020
Commissioner Requested Services	655,616	575,637
Non-Commissioner Requested Services	1,925	2,788
	657,541	**578,425**

4. Other operating income

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Research and development	5,506	5,682
Education and training	26,392	25,221
Donations/grants of physical assets (non-cash) - received from NHS charities	237	1,388
Donations/grants of physical assets (non-cash) - received from other bodies	2,089	1,917
Donated equipment from DHSC for COVID response (non-cash)	6,189	0
Cash donations for the purchase of capital assets - received from NHS charities	0	500
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	8,901	0
Rental revenue from operating leases	147	220
Sustainability and transformation fund (STF)	0	12,783
Reimbursement and top up funding	53,929	0
Other:		
Staff recharges	18,378	15,431
Car parking	644	2,710
Pharmacy sales	799	1,326
Staff accommodation rentals	762	853
Clinical tests	97	238
Clinical excellence awards	465	929
Grossing up consortium arrangements	17,055	15,718
Other income	4,238	8,255
Total other operating income	**145,828**	**93,171**

5. Total operating income

Total operating Income is from the supply of services. 82% (2019/20: 86%) is income from activities and 18% (2019/20: 14%) from other operating income.

6. Operating expenses

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Services from NHS trusts	18	52
Purchase of healthcare from non NHS bodies	259	0
Employee expenses - non-executive directors	147	143
Employee expenses - staff and executive directors	449,419	400,261
Supplies and services - clinical	75,214	66,439
Supplies and services - general	14,086	21,299
Establishment	8,318	8,801
Research and development	5,627	5,876
Transport	578	582
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	26,466	25,194
Premises	23,369	21,673
Movement in credit loss allowance: contract receivables	973	1,065
Movement in credit loss allowance: all other receivables	70	120
Change in provisions discount rate(s)	113	198
Inventories written down	252	105
Inventories consumed	81,353	78,117
Rentals under operating leases	10,751	8,818
Depreciation on property, plant and equipment	16,882	10,072
Impairments	7,201	0
Audit fees payable to the external auditor*		
audit services- statutory audit	103	78
other auditor remuneration (external auditor only)	0	4
Clinical negligence	13,626	13,117
Loss on disposal of non-current assets	250	509
Legal fees	100	160
Consultancy costs	604	395
Internal audit	149	79
Education and training - notional expenditure funded from apprenticeship fund	1,046	1,078
Training, courses and conferences	1,262	1,160
Patient travel	1,631	1,718
Redundancy	118	2,116
Insurance	95	54
Other services, eg external payroll	1,486	780
Grossing up consortium arrangements	17,055	15,718
Losses, ex gratia & special payments	13	11
Other	6,261	6,258
Total operating expenses	**764,895**	**692,050**

* The engagement letter signed on 13th May 2021 states that the liability of KPMG LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £1,000k in the aggregate in respect of all such services.

6.1 Auditor's Remuneration

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Audit Fees- statutory audit	103	78
Assurance services	0	4
TOTAL	**103**	**82**

The Trust's auditors, KPMG LLP (2019/20 KPMG LLP), also audit the associated charity (Norfolk and Norwich Hospitals Charity) for a fee of £9k (2019/20 £6k).

7. Operating leases

7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Minimum lease payments	10,751	8,818
Total	**10,751**	**8,818**

Total future aggregate minimum lease payments	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Payable:		
Not later than one year	9,293	9,843
Between one and five years	33,646	35,997
After 5 years	21,898	27,766
Total	**64,837**	**73,606**

7.2 As lessor

The Trust leases the retail units at its Colney Lane site to a third party. The contract is for a period of 30 years and was entered into in 2002.

Rentals, recognised as other operating income	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Rents recognised as income in the year	87	88
Contingent rents recognised as income in the year	60	132
Total	**147**	**220**

Total future aggregate minimum lease payments	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Receivable:		
Not later than one year	87	88
Between one and five years	350	350
After 5 years	525	612
Total	**962**	**1,050**

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Salaries and wages	346,334	303,450
Social security costs	32,917	29,278
Apprenticeship levy	1,669	1,504
Employer's contributions to NHS pensions	40,412	36,379
Pension cost - employer contributions paid by NHSE on provider's behalf	17,653	15,829
Pension cost - other	73	42
Termination benefits	118	2,116
Agency/contract staff	10,360	13,779
Total	**449,536**	**402,377**

Above total excludes costs of non-executive directors.
Details on the remuneration of key management personnel can be found in note 29.

8.2 Monthly average number of people employed

	Year ended 31 March 2021 Number	Year ended 31 March 2020 Number
Medical and dental	1,281	1,275
Administration and estates	1,386	1,334
Healthcare assistants and other support staff	2,600	2,348
Nursing, midwifery and health visiting staff	2,493	2,395
Nursing, midwifery and health visiting learners	2	2
Scientific, therapeutic and technical staff	713	670
Healthcare science staff	365	304
Other	6	3
Total	**8,846**	**8,331**

The above numbers are based on whole-time equivalents.

8.3 Staff exit packages

Staff exit packages for the year ended 31 March 2021

	Number of compulsory redundancies
<£10k	3
£100k - £150k	1
	4

Staff exit packages for the year ended 31 March 2020

	Number of compulsory redundancies
<£10k	11
£10k - £25k	9
£25k - £50k	12
£50k - £100k	11
£100k - £150k	4
	47

9. 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.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

9. Pension costs (continued)

c) Scheme provisions (continued)

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10. Retirements due to ill-health

During 2020/21 there were 3 (2019/20: 3) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements are £87k (2019/20: £211k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

This note has been moved to page 85 of the annual report.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust made payments of £nil under this legislation in the year (2019/20: £nil)

12. Finance income

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Interest receivable on bank deposits	0	208
Total	**0**	**208**

13. Other gains and losses

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Loss on disposal of plant and equipment	250	509
Total	**250**	**509**

14. Finance expense - financial liabilities including unwinding of discount on provisions

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Interim Revenue Support Facility Cost - Dept. of Health	34	3,576
Finance leases	3	8
Finance Costs in PFI obligations:		
- Main finance costs	16,571	16,831
- Contingent finance costs	14,728	14,131
Unwinding of discount on provisions	(29)	(11)
Total	**31,307**	**34,535**

15. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2020	**11,563**	**220,349**	**7,864**	**76,619**	**127**	**26,969**	**870**	**344,361**
Additions - purchased	0	61,087	5,945	12,868	20	14,054	774	**94,748**
Additions - donated	0	278	1,899	85	0	57	7	**2,326**
Additions - equipment donated from DHSC for COVID response	0	0	0	6,189	0	0	0	**6,189**
Reclassifications	0	7,229	(7,755)	(5)	6	527	(2)	**0**
Impairments	0	(6,259)	0	(942)	0	0	0	**(7,201)**
Revaluation	48	(4,240)	0	0	0	0	0	**(4,192)**
Disposals	0	0	0	(3,732)	0	0	0	**(3,732)**
Cost or valuation at 31 March 2021	**11,611**	**278,444**	**7,953**	**91,082**	**153**	**41,607**	**1,649**	**432,499**
Accumulated depreciation at 1 April 2020	**0**	**4,029**	**0**	**55,869**	**80**	**15,413**	**858**	**76,249**
Provided during the year	0	7,656	0	4,653	8	4,525	40	**16,882**
Reclassifications	0	(1)	0	1	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	**0**
Revaluation Eliminated	0	(6,317)	0	0	0	0	0	**(6,317)**
Disposals	0	0	0	(3,336)	0	0	0	**(3,336)**
Accumulated depreciation at 31 March 2021	**0**	**5,367**	**0**	**57,187**	**88**	**19,938**	**898**	**83,478**
Net book value								
NBV - Owned at 31 March 2021	11,611	74,345	6,054	24,577	65	21,598	742	**138,992**
NBV - Finance lease at 31 March 2021	0	0	0	37	0	0	0	**37**
NBV - PFI at 31 March 2021	0	187,510	0	0	0	0	0	**187,510**
NBV - Donated at 31 March 2021	0	11,222	1,899	9,281	0	71	9	**22,482**
NBV total at 31 March 2021	**11,611**	**273,077**	**7,953**	**33,895**	**65**	**21,669**	**751**	**349,021**
Net book value								
NBV - Owned at 1 April 2020	11,563	45,492	7,864	15,992	47	11,527	7	**92,492**
NBV - Finance lease at 1 April 2020	0	0	0	209	0	0	0	**209**
NBV - PFI at 1 April 2020	0	159,625	0	0	0	0	0	**159,625**
NBV - Donated at 1 April 2020	0	11,203	0	4,549	0	29	5	**15,786**
NBV total at 1 April 2020	**11,563**	**216,320**	**7,864**	**20,750**	**47**	**11,556**	**12**	**268,112**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

15. Property, plant and equipment (continued)

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2019	**11,710**	**216,293**	**514**	**71,226**	**78**	**16,673**	**870**	**317,364**
Additions - purchased	0	8,932	7,455	5,266	0	10,296	0	**31,949**
Additions - leased	0	0	0	0	0	0	0	**0**
Additions - donated	0	1,889	0	1,916	0	0	0	**3,805**
Impairments	(807)	(2,255)	0	0	0	0	0	(3,062)
Reclassifications	0	105	(105)	(49)	49	0	0	0
Revaluation	660	(4,615)	0	0	0	0	0	**(3,955)**
Disposals	**0**	**0**	**0**	**(1,740)**	**0**	**0**	**0**	**(1,740)**
Cost or valuation at 31 March 2020	**11,563**	**220,349**	**7,864**	**76,619**	**127**	**26,969**	**870**	**344,361**
Accumulated depreciation at 1 April 2019	**0**	**15,273**	**0**	**54,396**	**59**	**14,184**	**854**	**84,766**
Provided during the year	0	6,156	0	2,674	9	1,229	4	**10,072**
Reversals of impairments	0	(964)	0	0	0	0	0	**(964)**
Reclassifications	0	0	0	(12)	12	0	0	**0**
Revaluation Eliminated	0	(16,436)	0	0	0	0	0	**(16,436)**
Disposals	0	0	0	(1,189)	0	0	0	**(1,189)**
Accumulated depreciation at 31 March 2020	**0**	**4,029**	**0**	**55,869**	**80**	**15,413**	**858**	**76,249**
Net book value								
NBV - Owned at 31 March 2020	11,563	45,492	7,864	15,992	47	11,527	7	**92,492**
NBV - Finance lease at 31 March 2020	0	0	0	209	0	0	0	**209**
NBV - PFI at 31 March 2020	0	159,625	0	0	0	0	0	**159,625**
NBV - Donated at 31 March 2020	0	11,203	0	4,549	0	29	5	**15,786**
NBV total at 31 March 2020	**11,563**	**216,320**	**7,864**	**20,750**	**47**	**11,556**	**12**	**268,112**
Net book value								
NBV - Owned at 1 April 2019	11,710	36,396	514	13,247	19	2,439	10	**64,335**
NBV - Finance lease at 1 April 2019	0	0	0	373	0	0	0	**373**
NBV - PFI at 1 April 2019	0	153,997	0	0	0	0	0	**153,997**
NBV - Donated at 1 April 2019	0	10,627	0	3,210	0	50	6	**13,893**
NBV total at 1 April 2019	**11,710**	**201,020**	**514**	**16,830**	**19**	**2,489**	**16**	**232,598**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

15. Property, plant and equipment (continued)

During the year assets to the value of £2,326k (2020: £3,805k) were purchased using charitable support. In addition £6,189k (2020: £0k) of equipment relating to the Trust's COVID response were donated by DHSC.

Plant and Equipment mainly consists of low value equipment with short asset lives. It is therefore considered that Depreciated Historic Cost is appropriate to be used as a proxy for Depreciated Replacement Cost and for Fair Value.

A valuation of the Trusts Estate was carried out in 2019/2020 by the Trusts externally appointed independent valuer, Montagu Evans, Chartered Surveyors. The effective date of the valuation was 31 March 2020.
The revaluation basis for all of the Trusts Land and Buildings was depreciated replacement cost as a Modern Equivalent Asset, with the exception of the Residential Accommodation on the hospital campus and the office accommodation within the main hospital building.

These were valued as non specialised assets, accordingly were valued on a market value for existing use.
The valuation has been accounted for in the 2019/2020 accounts.

For 2020/21, the valuation has been subject to an indexation review by Monatgu Evans, to assess the valuation movement over the year to 31 March 2021. This movement has been reflected in the 2020/21 accounts, along with capital additions in the financial year.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 - Borrowing Costs. 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.

The economic lives of the depreciable items of property, plant and equipment is disclosed in the table below:

	Minimum Life (years)	Maximum Life (years)
Buildings excluding dwellings	5	82
Plant and machinery	1	30
Transport equipment	5	12
Information technology	1	10
Furniture & fittings	5	15

Assets under construction are not depreciated until they are brought into use.
Land is not depreciated.

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	31 March 2021 £'000	31 March 2020 £'000
Property, Plant and Equipment	7,534	7,943
Total	**7,534**	**7,943**

17. Inventories

17.1. Inventories

	31 March 2021 £'000	31 March 2020 £'000
Drugs	4,170	4,356
Consumables	8,597	7,509
Consumables donated from DHSC	362	0
Total	**13,129**	**11,865**

17.2 Inventories recognised in expenses

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Inventories recognised as an expense in the year	139,355	128,886
Write-down of inventories (including losses)	252	105
Total	**139,607**	**128,991**

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2021		31 March 2020	
	Current £'000	Non - Current £'000	Current £'000	Non - Current £'000
Contract receivables invoiced	12,253	0	22,092	0
Contract receivables (not yet / non invoiced)	14,031	2,684	7,241	1,359
Allowance for impaired contract receivables	(2,932)	0	(1,978)	0
Allowance for impaired contract receivables (not yet / non invoiced)	(2,001)	0	(1,983)	0
Prepayments (non-PFI)	8,282	0	7,239	0
PFI prepayments:				
Lifecycle replacements	0	58,033	0	82,641
Interest receivable	0	0	16	0
VAT receivable	1,811	0	2,384	0
Clinician pension tax provision reimbursement funding from NHSE	131	1,746	115	1,484
Other receivables	685	0	9	0
Total	**32,260**	**62,463**	**35,135**	**85,484**

The significant majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Provision for impairment of receivables

	31 March 2021 £'000	31 March 2020 £'000
At 1 April as previously stated	**3,961**	**3,041**
Increase in provision	1,235	1,436
Amounts utilised	(71)	(265)
Unused amounts reversed	(192)	(251)
At 31 March	**4,933**	**3,961**

19. Cash and cash equivalents

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Balance at 1 April	13,432	7,462
Net change in year	55,513	5,970
Balance at 31 March	**68,945**	**13,432**
Comprising:		
Cash at commercial banks and in hand	95	88
Cash with the Government Banking Service	68,850	13,344
Cash and cash equivalents as in statement of financial position and statement of cash flows	**68,945**	**13,432**

20. Trade and other payables

	31 March 2021 Current £'000	31 March 2020 Current £'000
NHS trade payables	20,591	10,629
Amounts due to other related parties	5,679	5,293
Capital payables	16,247	12,233
Social security costs	9,388	8,605
Other payables	12,395	9,372
Accruals	49,972	22,692
Total	**114,272**	**68,824**

Included in Amounts due to other related parties at 31 March 2021 is £5,679k (31 March 2020: £5,293k) of outstanding pension contributions.

21. Borrowings

	31 March 2021 Current £'000	31 March 2021 Non-current £'000	31 March 2020 Current £'000	31 March 2020 Non-current £'000
Interim Revenue Support Facility - Dept. of Health	0	0	168,757	0
Capital Loans - Dept. of Health	0	0	27,155	0
Obligations under finance leases	66	0	187	65
Obligations under Private Finance Initiative contracts	4,971	182,368	3,171	187,338
Total	**5,037**	**182,368**	**199,270**	**187,403**

Details of the PFI schemes comprising the liabilities detailed above can be found in note 24.

On 2 April 2020, DHSC and NHSE&I announced reforms to the NHS cash regime for 2020/21. The announcement confirmed that in 2020/21 PDC would be issued to enable providers to repay all existing interim loans. The value of interim loans as at 31 March 2020 was £195,912k, this included interest of £781k. The loan value has been re-paid and re-issued as PDC in 2020/21.

22. Other liabilities

	31 March 2021 Current £'000	31 March 2021 Non-current £'000	31 March 2020 Current £'000	31 March 2020 Non-current £'000
Deferred Income	16,734	2,128	14,833	3,515
Total	**16,734**	**2,128**	**14,833**	**3,515**

23. Finance lease obligations

	31 March 2021 Minimum Lease Payments £'000	31 March 2021 PV of Minimum Lease Payments £'000	31 March 2020 Minimum Lease Payments £'000	31 March 2020 PV of Minimum Lease Payments £'000
Gross lease liabilities				
of which liabilities are due:				
- not later than one year;	79	79	190	190
- later than one year and not later than five years;	0	0	79	79
Finance charges allocated to future periods	(13)	(13)	(17)	(17)
Net lease liabilities	**66**	**66**	**252**	**252**
Split into:				
- not later than one year;	66	66	187	187
- later than one year and not later than five years;	0	0	65	65
Net lease liabilities	**66**	**66**	**252**	**252**

24. Private Finance Initiative contracts

24.1 PFI schemes on-Statement of Financial Position

New Hospital

On 9 January 1998 the Trust concluded contracts under the Private Finance Initiative (PFI) with Octagon Healthcare Limited for the construction of a new 809 bed hospital and the provision of hospital related services. In addition, and as a consequence of revised patient activity projections, the Trust entered into a contract variation with Octagon Healthcare Limited to extend the new hospital by a further 144 beds. This contract variation was approved by the Department of Health and was signed on 14 July 2000.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, that is being acquired through a finance lease. The payments to Octagon in respect of it have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in accounting policy 1.8.

The service element of the contract was £26,500k (2019/20: £25,200k), with contingent rent being £14,700k (2019/20: £14,100k).

The estimated value of the scheme at inception was £222,600k. Payments under the scheme commenced on 15 August 2001. In 2003/04 the Trust entered into and concluded a refinancing arrangement with Octagon Healthcare Ltd on the investment in the hospital. This resulted in an extension of the minimum term of the scheme from 30 to 35 years and a reduction in the annual charge by £3,500k per annum.

24.2 PFI schemes on-Statement of Financial Position (on-SoFP)

Total obligations for on-statement of financial position PFI contracts are:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**810,267**	**880,838**
Of which liabilities are due:		
- not later than one year;	42,529	42,483
- later than one year and not later than five years;	181,019	182,726
- later than five years.	586,719	655,629
Lifecycle Maintenance expenditure	(61,645)	(68,801)
Finance charges allocated to future periods	(561,283)	(621,527)
Net PFI, liabilities	**187,339**	**190,510**
- not later than one year;	4,971	3,172
- later than one year and not later than five years;	26,031	23,637
- later than five years.	156,337	163,701
	187,339	**190,510**

Gross PFI liabilities includes £61,645k (2019/20: £68,801k) in respect of lifecycle maintenance expenditure on the hospital PFI scheme. These are payments to replace components of the hospital infrastructure throughout the course of the PFI agreement.

Finance charges include both interest payable and contingent rent payable. Contingent rent is variable, dependent on the future rate of inflation using the Retail Prices Index (RPI). The Trust has assessed the future rate of RPI with regard to historical trends and current forward-looking estimates.

24.3 The Trust is committed to make the following payments for on-SoFP PFI obligations during the next year in which the commitment expires:

	31 March 2021 £'000	31 March 2020 £'000
16th to 20th years (inclusive)	42,529	42,483
Total	**42,529**	**42,483**

24.4 The Trust is committed to make the following payments in respect of the service element of the On-SoFP PFIs.

	31 March 2021 £'000	31 March 2020 £'000
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	26,466	25,194
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	25,959	25,224
- later than one year and not later than five years;	110,489	107,097
- later than five years.	358,116	384,272
Total	**494,564**	**516,593**

25. Provisions

	Current 31 March 2021 £'000	Non-current 31 March 2021 £'000	Current 31 March 2020 £'000	Non-current 31 March 2020 £'000
Pensions - Early departure costs	111	784	115	848
Pensions - Injury benefits	128	2,295	126	2,240
Legal claims	98	0	94	0
VSS & Redundancy	0	0	3	0
Clinician pension tax	131	1,746	115	1,484
Other	0	3,262	0	0
Total	**468**	**8,087**	**453**	**4,572**

2020/21

	Pensions £'000	Legal claims £'000	VSS & Redundancy £'000	Clinician Pension Tax Reimbursement £'000	Other £'000	Total £'000
At 1 April 2020	3,329	94	3	1,599	0	**5,025**
Change in the discount rate	113	0	0	0	0	**113**
Arising during the year	145	57	0	278	3,262	**3,742**
Utilised during the year	(240)	(53)	(3)	0	0	**(296)**
Unwinding of discount	(29)	0	0	0	0	**(29)**
At 31 March 2021	**3,318**	**98**	**0**	**1,877**	**3,262**	**8,555**
Expected timing of cash flows:						
Within one year	239	98	0	131	0	**468**
Between one and five years	952	0	0	282	3,262	**4,496**
After five years	2,127	0	0	1,464	0	**3,591**
	3,318	**98**	**0**	**1,877**	**3,262**	**8,555**

Pensions covers liabilities in respect of former staff members. Due to the nature of the obligation (pension related) there is uncertainty over the expected timing of cash flows, duration and magnitude.

Legal claims include Employer's Liability and Public Liability claims. Incidents occurring after 1 April 1999 are covered by the NHS Litigation Authority Liabilities to Third Parties Scheme.

The NHS Litigation Authority holds provisions at 31 March 2021 of £319,509k (31 March 2020; £256,935k) in respect of clinical negligence liabilities of the Trust.

The clinician pension tax reimbursement relates to clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits which will be paid for by the NHS Pension Scheme. Accordingly we have reflected the provision for this liability. It will be met in full by the NHS Pension Scheme. We have an equal and opposite asset in income accruals.

Other provisions largely consist of provisions for HMRC determinations.

25. Provisions (continued)

2019/20

	Pensions	Legal claims	VSS & Redundancy	Clinician Pension Tax Reimbursement	Total
		£'000	£'000	£'000	£'000
At 1 April 2019	2,331	79	0	0	**2,410**
Change in the discount rate	198	0	0	0	**198**
Arising during the year	1,052	54	3	1,599	**2,708**
Utilised during the year	(241)	(39)	0	0	**(280)**
Reversed unused	0	0	0	0	**0**
Unwinding of discount	(11)	0	0	0	**(11)**
At 31 March 2020	**3,329**	**94**	**3**	**1,599**	**5,025**
Expected timing of cash flows:					
Within one year	241	94	3	115	**453**
Between one and five years	954	0	0	246	**1,200**
After five years	2,134	0	0	1,238	**3,372**
	3,329	**94**	**3**	**1,599**	**5,025**

26. Financial Instruments

26.1 Carrying values of financial assets

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2021	£0	£000	£000	£000
Trade and other receivables excluding non financial assets	24,851	0	0	**24,851**
Cash and cash equivalents at bank and in hand	68,945	0	0	**68,945**
Total at 31 March 2021	**93,796**	**0**	**0**	**93,796**

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2020	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	27,863	0	0	**27,863**
Cash and cash equivalents at bank and in hand	13,432	0	0	**13,432**
Total at 31 March 2020	**41,295**	**0**	**0**	**41,295**

26. Financial Instruments (continued)

26.2 Carrying values of financial liabilities

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2021			
Loans from the Department of Health and Social Care	0	0	**0**
Obligations under finance leases	66	0	**66**
Obligations under PFI, LIFT and other service concession contracts	187,338	0	**187,338**
Other borrowings	0	0	**0**
Trade and other payables excluding non financial liabilities	104,884	0	**104,884**
Other financial liabilities	0	0	**0**
Provisions under contract	5,294	0	**5,294**
Total at 31 March 2021	**297,582**	**0**	**297,582**

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2020			
Loans from the Department of Health and Social Care	195,911	0	**195,911**
Obligations under finance leases	252	0	**252**
Obligations under PFI, LIFT and other service concession contracts	190,510	0	**190,510**
Other borrowings	0	0	**0**
Trade and other payables excluding non financial liabilities	60,218	0	**60,218**
Other financial liabilities	0	0	**0**
Provisions under contract	5,025	0	**5,025**
Total at 31 March 2020	**451,916**	**0**	**451,916**

26.3 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value of the above financial assets and liabilities.

26.4 Maturity of financial liabilities

	31 March 2021	31 March 2020
	£000	£000
In one year or less	147,961	300,740
In more than one year but not more than two years	182,252	183,759
In more than two years but not more than five years	0	0
In more than five years	590,311	657,763
Total	**920,524**	**1,142,262**

26.5 Financial risk management

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

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

26.5.1 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.

26.5.2 Interest rate risk

The Trust has borrowings in the form of PFI arrangements and a Finance Lease. For both types of borrowings, the interest rate is fixed, resulting in a low level of associated risk. Contingent rent does apply to the largest PFI scheme, as it is indexed through a twice yearly application of RPI. There is therefore an interest rate risk associated with that, though it is deemed to be low due to its comparative size and current market conditions.

26.5.3 Credit risk

Because the majority of the Trust's income 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.

The Trust's Treasury Management Policy has clear criteria, is updated regularly and advice is taken from it's investment advisers so as to ensure that there is a very low level of risk associated with cash and any deposits with financial institutions.

26.5.4 Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

27. Events after the reporting year

There have been no events after the reporting year that have had a major impact on these accounts.

28. Capital cost absorption rate (PDC)

The Trust incurs a charge on the balance of any funding received from the government. This is in the form of a PDC dividend charge that is broadly calculated as 3.5% of the Trust's average net relevant assets. In 2020/21 this equated to a £0k charge (£0k in 2019/20).

29. Related party transactions

The Norfolk and Norwich University Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.
During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Foundation Trust.
The Department of Health and Social Care is regarded as a related party. It is the parent department for DHSC group bodies. Accordingly we are required to provide a note of the main entities within the public sector with which we have had dealings. They are: Norfolk CCGs, NHS England, HMRC and NHS Pension Schemes.

Related Party Transactions	Income Year ended 31 March 2021 £'000	Expenditure Year ended 31 March 2021 £'000	Income Year ended 31 March 2020 £'000	Expenditure Year ended 31 March 2020 £'000
Value of transactions with board members	0	0	0	0
Value of transactions with key staff members	0	0	0	0
Value of transactions with other related parties:				
- Charitable Funds	484	0	2,078	0
- Other	1,235	5,625	464	2,492
- NHS Shared Business Services	0		0	523

Related Party Balances	Receivables 31 March 2021 £'000	Payables 31 March 2021 £'000	Receivables 31 March 2020 £'000	Payables 31 March 2020 £'000
Value of balances (other than salary) with related parties in relation to doubtful debts	(2,001)	0	(1,983)	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year	0	0	0	0
Value of balances with other related parties:				
- Charitable Funds	226	0	850	0
- Other	866	791	547	526
- NHS Shared Business Services	0	0	0	3

Remuneration of Key Management Personnel

The following table analyses the remuneration of key management personnel (deemed to be the Board of Directors) in accordance with IAS 24.

	Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Short term employee benefits (pay)	1,250	1,162
Post-employment benefits (employers pension contribution)	90	90

The highest paid Director in 2020/21 received remuneration of £271k, excluding pension related benefits and exit packages, for their services as Medical Director including an element relating to their non-managerial role. In 2019/20 the highest paid Director received remuneration of £250k, not including pension related benefits and exit packages, for their services as Medical Director including an element relating to their non-managerial role.

Further details on remuneration of the Board of Directors can be found in the Remuneration Report.

In addition, the Trust had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions were with HM Revenue & Customs in respect of the deduction and payment of PAYE and with South Norfolk Council in respect of rates.

The Trust has also received revenue and capital payments from the Norfolk and Norwich Hospitals Charity, the Corporate Trustee of which is the Trust. These payments are outlined below.

29. Related party transactions (continued)

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £1,303k for enhancement of the patient environment, investment in staff, additional equipment, and research (2019/20: £1,209k) from the Norfolk and Norwich Hospitals Charity.

During the year assets to the value of £8,515k (2019/20: £3,805k) were donated to the Foundation Trust, of which £237k (2019/20: £1,888k) came from the Norfolk and Norwich Hospitals Charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £247k (2019/20: £170k) to the Norfolk and Norwich Hospitals Charity for the provision of the administration and management of the charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has received payments of £30k (2019/20: £22k) from the Eastern Academic Health Science Network. The Chief Executive Officer is a member of the board of this network.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £546k (2019/20: £387k) to Norwich Research Partners LLP. The Chief Executive Officer and a Non-Executive director are members of the board of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £4,536k (2019/20:£2,105k) to the University of East Anglia and received income of £1,205k (2019/20:£442k). A Non-Executive director is the Vice-Chancellor of this organisation.

30. Third Party Assets

The Trust held £2k (2019/20: £2k) cash at bank and in hand at 31 March 2021 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

31. Losses and Special Payments

There were 1,390 cases of losses and special payments totalling £185k paid during the year (2019/20: 3,050 cases totalling £291k).

	31 March 2021		31 March 2020	
	Number	£'000	Number	£'000
Losses				
Cash losses (including overpayments, physical losses, unvouched payments and theft)	0	0	7	1
Bad debts and claims abandoned (excluding cases between FT and other NHS bodies)	1,331	19	2,999	175
Stores losses (including damage to buildings and other properties as a result of theft, criminal damage and neglect)	3	153	3	105
Special Payments				
Ex gratia payments	56	13	41	10
	1,390	**185**	**3,050**	**291**

These amounts are recorded on an accruals basis but excludes provisions for future losses.

32. Contingent Assets and Contingent Liabilities

There are no contingent assets or contingent liabilities.

Norfolk and Norwich University Hospitals NHS Foundation Trust

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