University Hospitals Plymouth NHS Trust

A YEAR LIKE NO OTHER

Annual Report and Accounts 2019/2020

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FOREWORD

Welcome

The year 2019/20 ended in dramatic fashion with the implementation of a national lockdown and a massive effort across the Trust to prepare for the COVID-19 pandemic. The year itself, however, was characterised by far more than this. It was once again a year where we saw huge efforts from our staff to provide the very best service to our patients, and some fabulous developments both within the Trust, and across the wider system of health and social care.

We had much to celebrate in 2019/20, including:

- Our ICU team winning a national Parliamentary Award for 'Care and Compassion'.
- Building stronger relationships with our local GPs to provide more joined-up care for patients.
- Embarking on a joint bid with Livewell Southwest to run complex adult health and care services in Plymouth.
- Being rated by inspectors as having improved with a #betterpicture in our CQC Report.
- Starting the planning work on our £30m Emergency and Urgent Care Department.
- Securing £5m seed funding to develop our plans for building the next phase of Derriford Hospital.
- Delivering an excellent response to the first peak of COVID-19 which ensured patients were well-cared for and staff supported.

In May we held an event to showcase learning from excellence. We called it ACE, standing for Appreciation Civility and Excellence, and it set us up wonderfully to further develop our efforts to create a positive work place culture. Around 250 people attended and took part in a joyful day of celebration and fun which perfectly encapsulated the dedication to patient care, creativity and energy of our staff. The event had a profound impact upon all who attended, lifted spirits and reminded us all of the importance of highlighting the amazing work done in our hospital, and also of the huge influence that we all have on others through our behaviour, and the fundamental importance of finding time for appreciation and thanks in our busy lives.

The same theme of excellence and improvement has been reflected in our "People First" programme, which has become a major part of how we do things at University Hospitals Plymouth. We are working as part of a national programme to embed improvement techniques and bring together clear strategic objectives at a Trust level, with the enormous wealth of creativity and ideas for improvement amongst our staff. Tremendous strides have been made during the year and the hard work that has been done to create such a strong culture of learning and improvement is set to reap dividends in the year to come.

That programme of improvement forms the bedrock of our new Trust-wide strategy **Healthier Lives: Making a Difference** which sets out our approach to providing outstanding integrated care. By valuing and caring for the wellbeing and professional development of our staff, making sure that we provide

efficient and sustainable services which are safe and of the highest quality, and by ensuring that we work with our partners in primary, community and social care across the system, we intend to integrate services to really make a positive difference to the lives of the people we serve.

We are proud to share that ambition with our partners in the City Council and in Livewell Southwest, the providers of community health services. We are currently working with Livewell and our Devon Clinical Commissioning Group to agree a new contractual framework which will form a major part of how we integrate and transform.

Our improvement and transformation received another boost in September when the government announced as part of its national programme for hospital improvement that we would receive £600m to rebuild and regenerate the Derriford site. Work is now underway to plan for what should be a very exciting project which will define the way hospital care is provided in Plymouth for generations to come.

This year also saw our most recent CQC inspection. Whilst the inspectors noted clear improvement on last year's report, and once again rated our staff as being outstanding in the way they provide compassionate care to patients, we were disappointed that our overall grading is still that we Require Improvement. The CQC set out clear challenges to us where we know we can still make improvement, and our absolute commitment is to ensure those improvements are made and that we make a huge step in 2020/21 towards our ambition to be an outstanding Trust.

In early 2020 the world became increasingly aware and concerned about the discovery of an outbreak of the COVID-19 virus in the province of Wuhan in China. In March we began preparation in earnest for the impending pandemic and, as the national lockdown was implemented, our staff have been at the forefront of the fight against the virus. At tremendous pace our teams have transformed our hospital and services, creating far greater intensive care capacity and preparing our staff to work in ways which many had never envisaged in the most challenging of circumstances.

The efforts made by those who work on the frontline, and those who support them in so many ways, has been truly outstanding and humbling. As this Annual Report is being produced we are still in the thick of the crisis and our teams continue to show the highest levels of professionalism, dedication and compassionate care, making sure that we do our utmost to support our patients and communities throughout these difficult times.

There has never been a time where our services and our people have been so important and so appreciated. Those brilliant people will continue to serve and support throughout the current crisis and beyond. We are both fortunate and honoured to be able to call them our #1BigTeam.

Ann James
Chief Executive

Richard Crompton
Chairman

OUR YEAR IN PICTURES

April 2019

On Monday 15 April, CQC inspectors visit our Emergency Department in an unannounced inspection. When the inspectors reported, we were delighted they had seen for themselves "a supportive and friendly culture within the department which was centred on the needs of patients" and that the "emergency department had a committed and well-motivated leadership team." We would like to publicly applaud and thank our emergency team for this. As our patient feedback so often tells us, this team works exceedingly hard to give great care and it is often hugely appreciated by patients and their families. Read more here.

May 2019

An outreach cancer support programme, run by the Mustard Tree Macmillan Cancer Support Centre to support prisoners at HMP Dartmoor, wins the 'Best Clinical Team' award from the Royal College of General Practitioners. Inspired by a particular patient, and determined to address the perceived inequality for prisoners, Project Manager, Annie Charles, created an outreach programme, with support from colleagues. Annie now visits the prison once a month, offering 1:1 support to individuals. These visits provide a private and confidential space for patients to speak openly about their worries and Annie provides emotional support, help with decision-making, offers a care plan and signposts to additional services.

June 2019

A very special event is held, during National Volunteers' Week, to say 'thank you' to the 200+ dedicated volunteers who generously donate their time to help our patients and colleagues, all year round. More than 80 volunteers and Deputy Lord Mayor Councillor Terri Beer attended the event. The Deputy Lord Mayor opened the event by recalling her own experience encountering volunteers: "Eighteen months ago my husband was in intensive care seriously ill and whilst waiting each morning for visiting to start, there was a volunteer who would make the family tea and provide biscuits. Quite often I recall we were all in tears for one reason or another and they provided some comforting words or allowed us just to talk."

July 2019

In February, we announced a great new partnership with Regent's Park Healthcare to reduce waiting times for specialist cardiology treatment.

Our third cath lab is now open and the first patient at the Peninsula Heart Clinic, Pamela Robertson, was absolutely delighted with her treatment: "Everyone was so nice; they made a scary experience less scary. This was my fourth procedure and I would be very comfortable coming back here in the future as everyone was so lovely."

Chief Executive, Dr Anil Ohri and Clinic Manager, David Smith from Regent's Park Healthcare commemorated the occasion with flowers and gifts.

August 2019

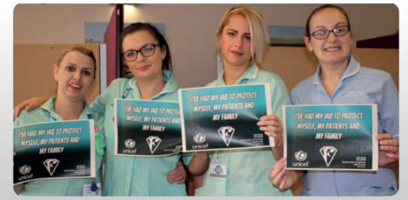
Staff in our newest MRI scanning unit welcome the first patient through the doors. "This is a significant upgrade in what used to be a mobile scanner inside a lorry," said Dr Lucy McGavin, Consultant Neuroradiologist and MRI Specialist Interest Group Lead. "The scanner is now housed in a modular build with a patient comfort unit which allows us to do a much bigger range of examinations." The scanner has been designed to have easy access for patients that have reduced mobility and is far more accessible than the previous mobile scanner. It has also been designed in conjunction with the dementia awareness team, with subtleties like types of clocks, colours of the floors and doors, all made to be dementia and learning difficulty friendly.

September 2019

We launch our Autism Service for adults who have autism to improve access to hospital services. It is currently the only specialist service for people with higher-functioning autism in an acute hospital setting in Devon. The purpose is to provide advice, education and identify resources for people with autism, carers and Trust staff, with the aim of adjusting to individual needs and therefore promoting positive healthcare outcomes. Primarily for adults with autism who do not have learning disabilities, the service is a pilot for 18 months during which data and feedback will be collected to support the continuation of the service.

University Hospitals Plymouth NHS Trust
@UHP_NHS

Staff - Protect yourselves, your patients and your family TOMORROW. The Flue, Brew and Breakfast Bap event runs from 07:30-11.30. For every vaccination, the Trust will also be donating to a @UNICEF vaccination programme for developing countries. Your one jab, goes a long way.



October 2019

We welcome more than 600 members of staff to the organisation. Incoming staff will be very familiar to Trust colleagues as they are Hotel Services staff (housekeepers, cleaners, patient catering, porters, supervisors, linen room and postal staff) previously employed by Serco, who are essential to the care provided to more than half a million people every year.

After an extensive consultation with patient representation groups and teams from across the organisation, we decided to bring hotel services in-house at the natural end of a 10-year contract with Serco.

November 2019

Around 200 guests gather in Plymouth for UHP's first Getting It Right First Time symposium. The event saw colleagues from across the south west visiting Derriford Hospital to hear examples of service transformation across a range of clinical specialties.

Lord Carter of Coles, author of the 2016 Carter review of operational productivity of acute trusts, was also in attendance, to hear how UHP has been tackling unwarranted variation.

Ratings for Derriford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Requires improvement Aug 2018
Medical care (including older people's care)	Requires improvement →← Aug 2019	Requires improvement →← Aug 2019	Good →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement →← Aug 2019
Surgery	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Good →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Critical care	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Maternity	Good ↑ Aug 2019	Good →← Aug 2019	Outstanding ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Services for children and young people	Good Nov 2016	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
End of life care	Good Jun 2015	Good Nov 2016	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
Outpatients	Good Aug 2018	N/A	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018
Diagnostic imaging	Requires improvement →← Aug 2019	N/A	Good →← Aug 2019	Requires improvement ↑ Aug 2019	Requires improvement ↑ Aug 2019	Requires improvement ↑ Aug 2019
Overall*	Requires improvement →← Aug 2019	Requires improvement →← Aug 2019	Outstanding →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement →← Aug 2019

December 2019

Our CQC Report is published. We were inspected in August and September and overall, University Hospitals Plymouth NHS Trust remains graded as Requires Improvement and we retain our rating of Outstanding for Caring. When we look in more detail at the scoreboard which compares our ratings from last year (see below), this shows a better picture: we no longer have any red for inadequate ratings and, unlike last year, we have no warning notices. The full report is published by the CQC here

January 2020
Our Pharmacy team have got together to banish plastic bags used for patients to carry medicines home from hospital. Instead, new recyclable paper bags are being used for patients' medicines, which will replace the single-use plastic bags.

The initiative came from a staff suggestion at a team 'improvement huddle' which aims to make improvements across the Trust. Staff wanted to get rid of plastic where they could, and so a new paper bag has been sourced and designed to cut down on waste. Find out more here.

February 2020
Senior Sister Ali Griffiths turns her experience of grief into positive change for bereaved relatives. Ali and a team of innovators worked together to improve the way belongings are returned to families after someone has passed away. Purple 'bereavement bags' are being rolled out across Derriford Hospital and it is hoped other Trusts across the UK will follow suit. Ali said: "This idea was born out of my personal experience of collecting my Mum's belongings. Her things were presented to me in a carrier bag. When I saw the contents and her hair on the brush, I was overwhelmed. I collapsed in a heap of sadness, and it took me a long time to get past that moment in my own grief journey." Watch Ali's story here.

March 2020
Our friends at Plymouth Argyle FC step in to help us respond to COVID-19. New arrangements come into place on Monday 30 March which see two community health services delivered at Home Park Stadium. Community Phlebotomy (for over 16s) and Community Antenatal clinics are the first services which will be relocated to the newly redeveloped main grandstand. Plymouth Argyle generously offered use of their conference room, which is unused following the suspension of the English Football League, to the local NHS to be transformed into a clinical space.

Specialist Senior Sister in the Intensive Care Rehabilitation Team at University Hospitals Plymouth (UHP), Kate Tantam, has shared stories of the kindness she's experienced during the COVID-19 outbreak.

Kate explains that staff at UHP have been pulling together to make remarkable things happen. Teams from across the Trust and external contractors have worked tirelessly to put together a new Intensive Care Unit (ICU) and continue to support the team in many different ways to support patient care.

"We've been really lucky, we've had lots of people volunteer to come and help us in intensive care and we've had lots of people who have been redeployed to help us," said Kate. "They've all come in and been keen and enthusiastic and well supported."

Kate also expressed her thanks to members of the community for their thoughtful gestures and donations. With the support of kind members of the public, the ICU team have started a 'knitted heart' scheme. Local people have been making crocheted hearts for patients in ICU so one heart can stay with the patient and another is sent to the family. The team are sending the knitted hearts to the families along with a photo of their loved one holding their own version to give them a sense of connection.

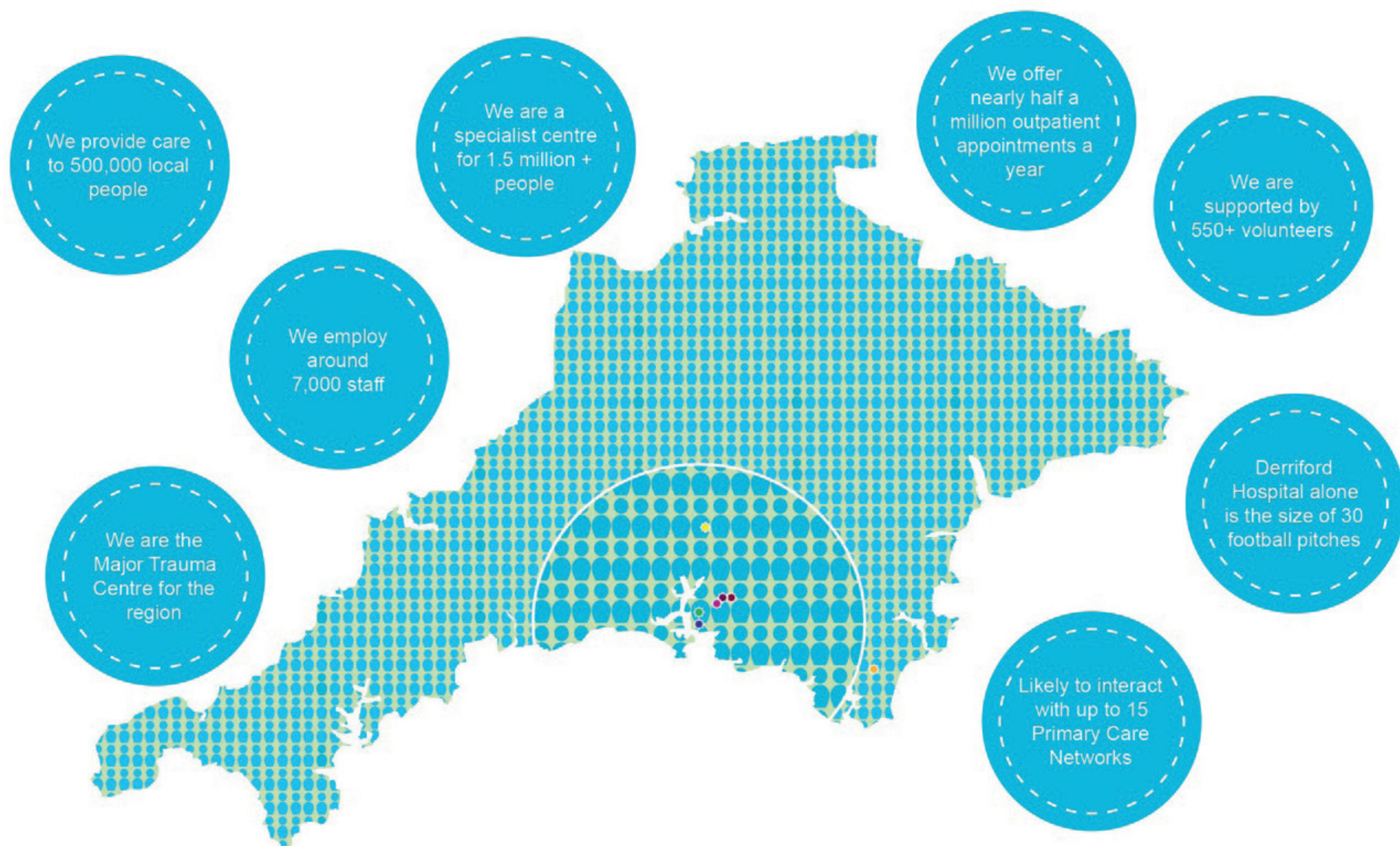
"The morale lifting gestures have just been beautiful, remarkable, humbling and just so kind," said Kate. "So thank you to everyone who has donated."

The response we have had from our local and national community, in support of us and our work has been absolutely heart-warming.

Thank you from everyone at #1BigTeam.

PROUD!

ABOUT US



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

Where our patients came from in 2019/20:

Area	Number of distinct patients	%
Plymouth	120,157	55.8
Cornwall	47,268	21.95
South and West Devon	4,905	22.25
Total	**215,330**	**100**

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

University Hospitals Plymouth NHS Trust
@UHP_NHS

A standing ovation and not a dry eye in the house after Karen's inspiring words 👏💜 #PoPStarUHP

3.53pm · 26 Jul 2019 · Twitter for Android

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

We are a teaching hospital in partnership with the University of Plymouth and working with Plymouth Marjon University. As host to the South West Medical Defence Group in a city with a strong military tradition, we have a tri-service staff of 200+ military doctors, nurses and allied health professionals fully integrated within the hospital workplace. Our Chief Executive sits on the Plymouth Growth Board, is a board member of the NHS South West Leadership Academy, is Regional Chair for Talent Board and is a member of One Plymouth.

As such, we are ideally placed to support our local health and social care system acting as a lead partner, supporting new investments to ensure people are cared for as close to home as possible and developing new collaborative practices.

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

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

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

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

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

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

During our response to COVID-19, we are also providing services at Plymouth Nuffield Hospital, the Peninsula Treatment Centre, Home Park Stadium and the Centre for Reproduction and Gynaecology West and Wales.

IVF
We served notice to Devon CCG in the summer of 2019 on the contract for all of the fertility services which require a Human Fertilisation and Embryology Authority Licence. These services include IVF, sample storage and fertility related andrology. We will continue to provide outpatient services for people with recurring miscarriage and specialist endocrinology clinics.

We took this decision, after careful consideration for operational reasons, which include our ability to sustain the service and manage space at the hospital.

After a competitive tender process run by Devon and Kernow CCGs, the contract was awarded to CRGW.

Their facility is purpose-built and close to Derriford Hospital, based next to the Peninsula Radiology Academy. We are currently working with this company to ensure the service is migrated as smoothly as possible, including the transfer of our staff. This means patients will be cared for at the new location by the same specialist team which previously worked in the Ocean Suite at Derriford Hospital.

We pride ourselves on leading with excellence and caring with compassion

Our Values
The values defining the way we do things are:

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

As part of our strategy, recognising the importance of our staff, carers and partners, we changed our first value from **Putting Patients First** to **Putting People First.**

OUR STRATEGIC CONTEXT

After a comprehensive listening and learning exercise, we revised and published our new strategy, Healthier Lives: Making a Difference, in August 2019. This set out our direction of travel for the next five years.

Our ambition, stated in this document, is simple:
To support our local and regional population leading healthier lives and, when the time comes, to support them in dying with dignity in the place of their choosing with their loved ones.

Demand for our emergency and urgent care services is rising in a way that we cannot meet under current arrangements. People have to wait too long for planned investigations and care because our beds and diagnostic equipment are needed by patients with urgent problems.

Our strategy recognises that we have to take bold steps to work in a different way in order to safeguard our specialist and acute services so they are available and accessible when people need them. It is also critical that we think not just about the need in front of us today but plan for tomorrow by continuing with our highly successful research agenda.

We live in an increasingly networked world and we recognise the role we have to play working with others to achieve this ambition: whether those others are breastfeeding mums, support networks for people with cancer, our colleagues in the community such as district nurses and GPs, social workers, city planners, local schools and universities, public health specialists or the charitable sector, such as our partners St Luke's Hospice or local charities such as Shekinah Mission. At University Hospitals Plymouth, we exist in a rich eco-system.

We are backing services delivered at a neighbourhood level through Primary Care Networks using our resources and expertise to support delivery as close to home as possible.

We recognise that health and wellbeing is about much more than healthcare. The wider determinants of health – the quality of our built and natural environment, air quality, employment opportunities, housing, education and the bonds between people in communities, are some of the rich factors which have a significant effect on our health and wellbeing.

As a hospital trust providing specialist and acute services for when people are acutely unwell, we recognise that those we see and care for are patients with us some of the time and people with their own lives all of the time. If we do our job really well, we reduce the amount of time they spend as patients and increase the time they enjoy living their lives as individual people. And when they are patients with us, we recognise the value of partnering with them, rather than an older-style paternalistic approach.

Our challenge, when faced with workforce shortages and growing demand for services on a Derriford site that cannot expand, is to work with others in a networked way to help prevent people becoming ill and ensuring that we are then able to provide the best possible care when they do.

We have an influential role as a major employer and research powerhouse. With more than 7,000

University Hospitals Plymouth NHS Trust
@UHP_NHS

Our Emergency Department is being filled with Christmas cheer, thanks to Karen Higginson and EDs own Dr Roddy Campbell

employees and volunteers, we want to support our staff in leading healthier lives and enjoying better wellbeing, including a better work/life balance. If we care for our colleagues, they will be happier and better able to care for others.

Our reach through our staff into the wider community is immense and influential. By focusing relentlessly on the wellbeing of our staff, we will encourage them to be ambassadors for better health and wellbeing with their families and in their communities. We also have a key role to play in education – both as a provider ourselves and in our relationships with local universities.

We know from our clinical outcomes and the many compliments, notes and gifts of thanks that we receive from patients and their families, that every day, through the dedication and compassion of our staff, we make a difference. Our stakeholders have told us clearly that our excellent clinical care and compassionate, professional staff are our strengths.

We have to hold onto those strengths and continue making that difference against a backdrop of a number of key challenges: financial resources are not infinite, there are national staff shortages in critical areas and demand for health and social care services is growing.

Our approach to doing this is by working with others where we can and providing the best possible specialist services when only we can. Healthier Lives sets out our approach to doing just that.

Our Journey to Integrated Care

Together, University Hospitals Plymouth, Livewell Southwest and our colleagues in primary care have come together to develop better integrated pathways to enable us to better support people to receive care closer to home, working closely with communities to identify the best ways we can do this.

Together we are on an exciting journey to integrate health and care services in Plymouth and the surrounding area through a joint bid for complex adult services, in a competitive tendering process being run by Devon CCG.

Relationship Building with Primary Care

Over the past year, under the leadership of Jonathan Cope, Associate Medical Director for Primary Care and a GP himself, we have continued to build on our progress and are constantly exploring ways to improve communication and relationships.

We have sought to bring together teams from primary and secondary care wherever possible or practical, to jointly consider how we can better work together. We have spent time ensuring that our primary care colleagues are well informed about service changes and service developments. We continue to hold regular interface meetings to discuss and agree how we can best work together. Our goal is to develop trusted relationships in order for us to more successfully deliver integrated care closer to people's homes.

We have an integrated model of care for our Diabetes service, which we plan to emulate for other services including Respiratory Medicine and Cardiology. We are working with primary care and community services to co-design these new models of working.

We are exploring what digital technology can bring to clinical services to improve efficiency and, more importantly, to improve the quality and safety of patient care. There are great benefits for us to work with primary care to enable the development of a single, accessible and comprehensive clinical record. In addition to this we are working to create a population health model to help us understand what unmet health needs exist in our communities. We are developing this in partnership with Livewell Southwest, Primary Care Networks and Optum Health, a specialist IT provider.

We have continued our twinning programme where clinicians spend time in each other's workplace, which continues to be popular. We have expanded this to include nurses and managers. We have found there has been a lot of beneficial learning that has emerged from this exercise.

Our local Sustainability and Transformation Partnerships

We have to be closely aligned to the STPs of both Devon and Cornwall, recognising that we serve communities from both counties. In Devon we are an integral part of the Devon Sustainability and Transformation Partnership (STP), which from 1 April 2020 was set up to establish an Integrated Care System, known as Together for Devon. The STP has drawn up a draft Long Term Plan, after work with its population and partners, following the parameters set out in the NHS Long Term Plan and tailored to meet the needs of Devon. This will be the blueprint as Devon becomes an Integrated Care System (ICS).

Publication of this plan has been delayed by the coronavirus pandemic. However, the following themes, have been agreed in principle. In light of the coronavirus pandemic, the plan will be subject to change. Our vision is: "Equal chances for everyone in Devon to lead long, happy and healthy lives".
Together we will:

- Work with communities to identify priorities and tackle the root causes of problems such as domestic abuse, homelessness and mental ill health
- Provide a dedicated centre for planned operations and treatments in Devon, to reduce the number of cancellations
- Coordinate care among GPs, community teams, hospitals and mental health services so that people get properly joined-up care
- Create a dedicated, major diagnostic centre in Devon to reduce waits
- Invest in computer systems and technology that can be used by all doctors and nurses, regardless of location or which organisation they work for
- Reorganise our care so that fewer people need to travel outside Devon
- Work to tackle the physical health inequalities experienced by people with mental illness, learning disabilities and/or autism
- Enhance our prevention programmes to support people to stay well, with an early focus on diabetes and hypertension
- Establish clinical networks across the peninsula so that, together, hospitals can provide the services needed – starting with cardiac services, pathology, stroke and neurology
- Improve access to psychological therapies, and put comprehensive support in place for young people up to the age of 25
- Actively promote careers in health and social care, to attract the workforce we need and to reduce our reliance on expensive agency staff
- Transform our maternity and perinatal care to give women more choices and more joined-up care
- Reduce the length of time people stay in hospital, particularly stays of over 14 days and those where there is no clinical need for people to be in hospital

Our response to COVID-19

There can be no doubt that, as we write this, just passing the first peak of COVID-19, this is an extremely challenging time for the health and care system as the pandemic has added to an already rapidly growing demand for health services.

Our staff stepped up to the ask of them magnificently and by the end of May 2020, we had treated more than 330 patients and discharged more than 240 of those.

At short notice, our staff opened new intensive care beds, moved services around to reconfigure the hospital so we had isolation wards, moved services off site to protect the most vulnerable – chemotherapy treatment for example - cared for patients, underwent upskilling training and in many cases, changed rotas and were redeployed at short notice. It truly was a #1BigTeam effort, not just with our staff but across our community. We supported care homes with testing and infection control advice, worked with GPs and our colleagues in the community and Plymouth City Council on a joined-up response.

We were also overwhelmed by the love and support shown to our staff and patients by our local communities. The generous donations and expressions of appreciation – from the bright rainbow drawings by schoolchildren to beautifully carved wooden sculptures and donations of food and gifts – have simply blown us away. We had such an abundance, we shared these gifts with the wider NHS and key workers right across Plymouth. Thank you to every single one of you who took the time to show us your love and support.

We are now working to restore the planned services that we had to postpone in order to respond to the pandemic.

Plymouth patients have confidence in their treatment and care by hospital staff

Patients continue to highly rate the doctors, nurses and allied health professionals treating them, and have confidence in the treatment they receive during their time spent in Derriford Hospital, according to a national survey published in June 2019.

The independent survey, undertaken by Quality Health and standardised by the Care Quality Commission, asked adult patients who were discharged from University Hospitals Plymouth during July 2018, after having spent at least one night in hospital, to rate various aspects of their stay and care. The results are intended for use by the CQC to monitor and regulate quality of care, as well as by NHS trusts to help improve patient experience.

"We already know that confidence in staff providing treatment remains high, thanks to our regular Friends and Family feedback," explains Lenny Byrne, Chief Nurse. "It is important to view this in the context of ever-increasing operational pressures, as it is a testament to our highly skilled and passionate colleagues."

University Hospitals Plymouth's results showed a particular reduction in the amount of noise at night created by hospital staff, which is something we had vowed to work on last year.

A total of 570 patients discharged by University Hospitals Plymouth were surveyed. There was a 47% response rate, above the national average of 45%. Read more here.

PROUD!

Our Performance

	Standard Required	What did University Hospitals Plymouth achieve?
Infection Control		
Hospital apportioned MRSA bacteraemia	0	3
Hospital onset healthcare associated Clostridium difficile	63	66
Referral to treatment times		
Incomplete pathways: Total number of pathways	27,217	29,243
Incomplete pathways: % waiting less than 18 weeks	92%	72.6%
52 week waits	0	126
Emergency Department		
We are part of a national pilot and not reporting against the 4 hour standard		
Cancer urgent referral to first outpatient appointment waiting times:		
All cancer two week wait	93%	94.1%
Two week wait for symptomatic breast patients (cancer not initially suspected)	93%	53.9%
Cancer diagnosis to treatment waiting times:		
31 day (diagnosis to treatment) wait for first treatment: all cancers	96%	94.1%
31 day wait for second or subsequent treatment: surgery	94%	89.2%
31 day wait for second or subsequent treatment: anti-cancer drug treatments	98%	99.5%
31 day wait for second or subsequent treatment: radiotherapy treatments	94%	75.9%
Cancer urgent referral to treatment waiting times:		
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	85%	72.1%
62 day wait for first treatment from consultant screening service referral: all cancers	90%	83.3%
62 day consultant upgrade wait for first treatment: all cancers	85%	68.8%
Diagnostic waits:		
% of patients waiting 6+ weeks for a diagnostic test	<1%	13.3%
Cancelled operations		
% Cancelled operations by the hospital for non-clinical reason on the day of or after admission, who were not treated within 28 days	0%	17.3%
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	N/A	2.6%
Other key standards		
% stroke patients spending 90% of their stay on ASU	80%	79.1%
Clinically unjustified mixed sex accommodation breaches	0	46
% patients receiving appropriate VTE risk assessment	95%	96.6%

NHS Clinical Activity	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Elective Spells	62,321	62,774	62,877	59,446	66,756	**70,192**
Emergency & Non Elective Spells	53,152	54,623	56,752	58,726	70,911	**58,488**
Outpatient Attendances	485,423	487,435	492,968	485,812	493,994	**518,376**
Emergency Department Attendances	92,780	94,560	97,126	100,319	106,223	**98,786**
Babies delivered	4,555	4,570	4,180	4,166	3,848	**3,874**

Our Performance table should be read alongside our increased activity and our awareness of increased patient acuity. This change in the demand, both in the volume and the level of need of patients, gives us a longer-term challenge that we are working on together with primary care, our local authority and other partners to address as a local system. Our ability to hit targets has also been impacted upon by the need to respond to COVID-19, with preparations for that starting in March 2020. Prior to the pandemic preparations, we had prioritised plans to address long waits for patients and meeting diagnostics targets. We had come close to delivery of both of those trajectories.

Our CQC Inspection

The Trust was inspected by the CQC in August-September 2019, with the report published in December 2019. We have again been rated as 'Requires Improvement' overall for our services. Our rating for each of the domains assessed by the CQC is shown below:

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

CQC Inspection Report UHP 2018

Ratings for Derriford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018
Medical care (including older people's care)	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement ↓ Aug 2018	Good →← Aug 2018	Requires improvement ↓ Aug 2018
Surgery	Good →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Good →← Aug 2018
Critical care	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016	Good Jun 2015	Good Nov 2016
Maternity	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Services for children and young people	Good Nov 2016	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
End of life care	Good Jun 2015	Good Nov 2016	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
Outpatients	Good Aug 2018	Not rated	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018
Diagnostic imaging	Requires improvement Aug 2018	Not rated	Good Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018	Inadequate Aug 2018
Overall*	Requires improvement →← Aug 2018	Requires improvement ↓ Aug 2018	Outstanding →← Aug 2018	Requires improvement →← Aug 2018	Good →← Aug 2018	Requires improvement →← Aug 2018

CQC Inspection Report UHP 2019

Ratings for Derriford Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Requires improvement Aug 2018
Medical care (including older people's care)	Requires improvement →← Aug 2019	Requires improvement →← Aug 2019	Good →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement →← Aug 2019
Surgery	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Good →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Critical care	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Maternity	Good ↑ Aug 2019	Good →← Aug 2019	Outstanding ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Services for children and young people	Good Nov 2016	Good Jun 2015	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
End of life care	Good Jun 2015	Good Nov 2016	Outstanding Jun 2015	Good Jun 2015	Good Jun 2015	Good Nov 2016
Outpatients	Good Aug 2018	N/A	Good Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018
Diagnostic imaging	Requires improvement →← Aug 2019	N/A	Good →← Aug 2019	Requires improvement ↑ Aug 2019	Requires improvement ↑ Aug 2019	Requires improvement ↑ Aug 2019
Overall*	Requires improvement →← Aug 2019	Requires improvement →← Aug 2019	Outstanding →← Aug 2019	Requires improvement →← Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement →← Aug 2019

Overall it was #ABetterPicture. The Trust no longer has any 'Inadequate' ratings and did not receive any Section 29A Warning Notices as a result of this inspection. One of the previous recipients of a Warning Notice, Diagnostic Imaging, improved from 'Inadequate' to 'Requires Improvement' in the Responsive and Well Led domains. Our Maternity service is now rated 'Good' overall and 'Outstanding' for Caring. It is also the first Maternity service in the peninsula to be rated 'Good' for the Safe domain.

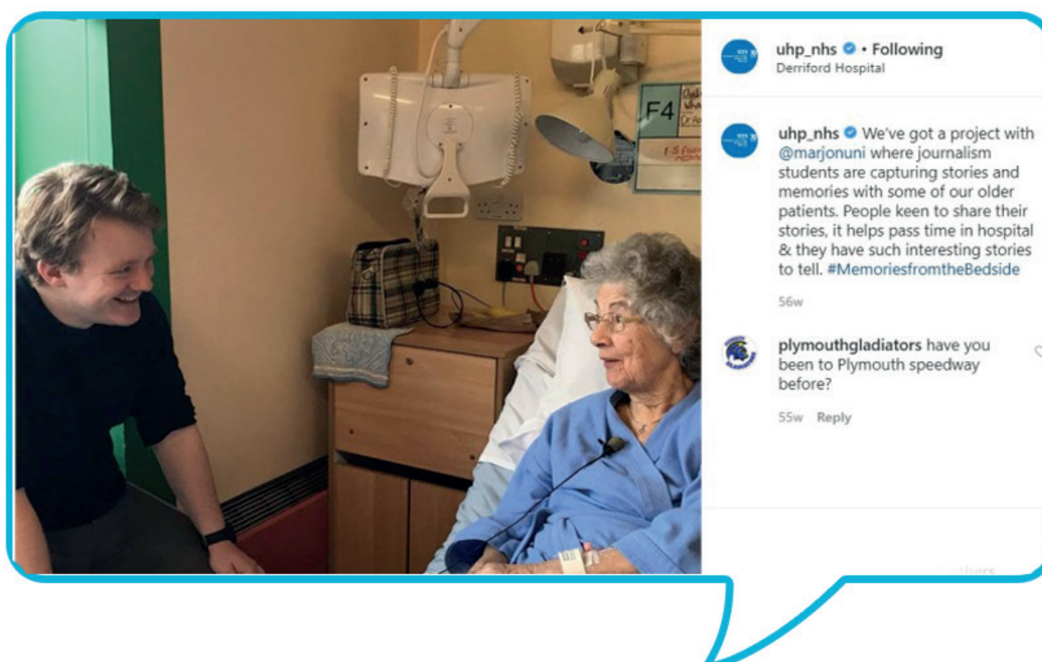
The 'Requires Improvement' rating is based upon 33 critical actions identified as Must Dos which are the focus for the organisation and the action plan. As part of the wider plan relating to ongoing CQC compliance we have also created a plan to address the Should Do actions as advised by CQC which will be implemented in tandem with the Must Dos. The Trust's action plan was submitted to CQC in February 2020. The key themes to address within our actions relate to:

- Strengthening our governance framework
- Compliance with mandatory training
- Staffing levels
- Record keeping

In line with its revised Terms of Reference, the Quality Assurance Committee will receive a monthly update on progress of delivery of the action plan with onward reporting to Safety and Quality Committee and Trust Board.

The Trust continues to be fully registered with the CQC across all of its locations without conditions and continues to monitor compliance across all of the fundamental standards.

We are on a journey of continuous improvement and we continue to monitor, review and constantly improve the quality of care across the services that we provide.



PeopleFirst

Driving our Improvement Culture

In 2019 we entered the second year of our joint programme of People First with Livewell Southwest. This programme is changing the way we work to improve the quality of care we offer, making our services safer, more effective and more patient-centred.

It helps create better services by putting the best ideas of frontline staff into action, removing waste, and focusing on what our patients really want. As part of this we are also changing the way we manage our work, to enable more purposeful team huddles that feed Care Groups (our operating divisions) and the Executive team; enabling clarity of purpose, accountability, speedier decision making and being close to the voice of frontline staff.

The Quality Academy and People First

Much of the programme is delivered through training of our 'in-house' Quality Academy. So far, more 600 staff have received some element of People First training or participated in events. In addition the Quality Academy also supports Quality Improvement training on induction of staff and during last year 2,200 staff received this training with very positive feedback.

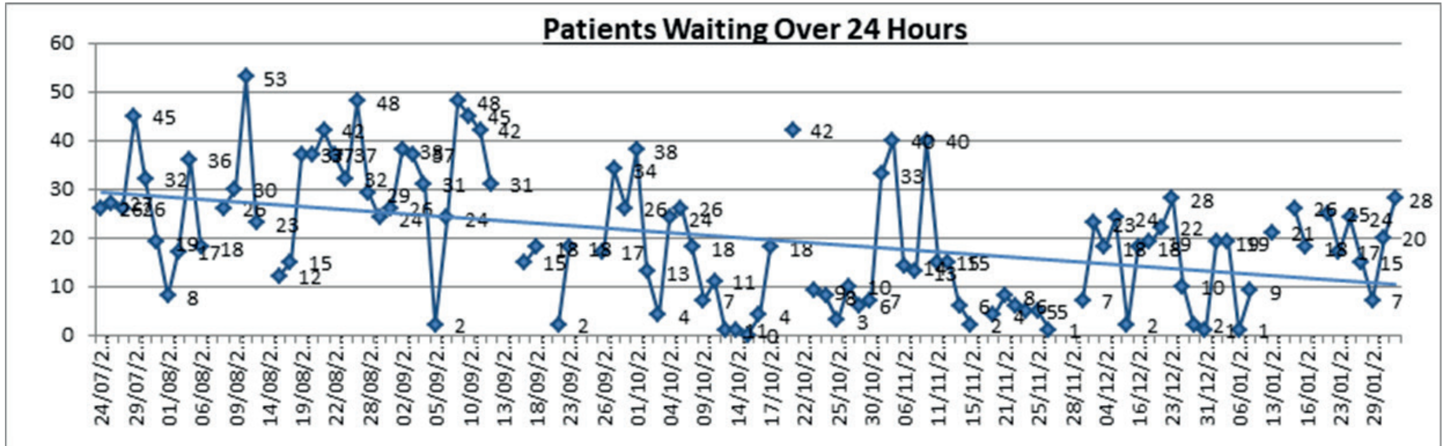
Developing capability is very much part of the programme and through the Director of Improvement we have certified six frontline practice coaches – all of whom have delivered a project with more than 10% improvement. There are a further 27 projects and learners on course for certification. We are also training staff in scientific learning using 'plan do study act' with four coaches and 56 active learners working on topics.

Real impact for patients

These five examples really highlight our approach:

More time to Care – Monkswell (Care of the Elderly Ward)

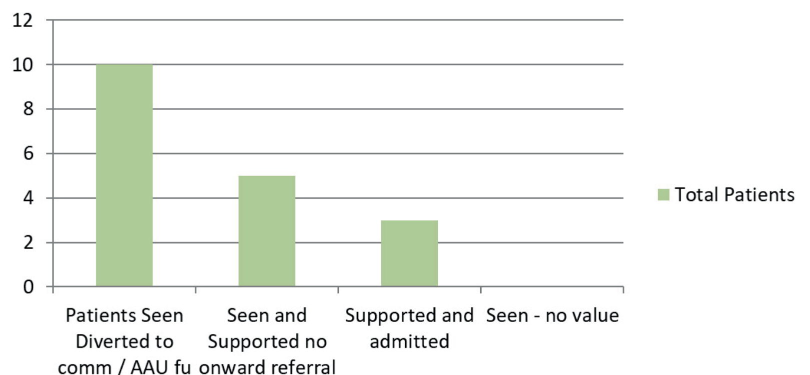
The ward staff reviewed their morning routine practices and released 20 minutes daily from Healthcare Assistant time to spend quality time with patients. They did this by understanding waste around linen/ bay supplies and using their own ideas improved the process.



Less time for To Take Away (TTA) drugs – Respiratory
The junior doctor team, pharmacy team and ward team did a study on processes to understand waste. They created an innovative on-ward pharmacy service that not only reconciled drugs but enabled 15 minute dispensing.

Fewer waits for an inpatient CT - Imaging
Through a whole series of testing improvement ideas the CT team increased the number of scans per day and reduced the numbers of patients waiting. They did this by creating better 'early bird' morning routines, clarity of patient flows and improved flow to scanners, all supported by a daily improvement huddle.

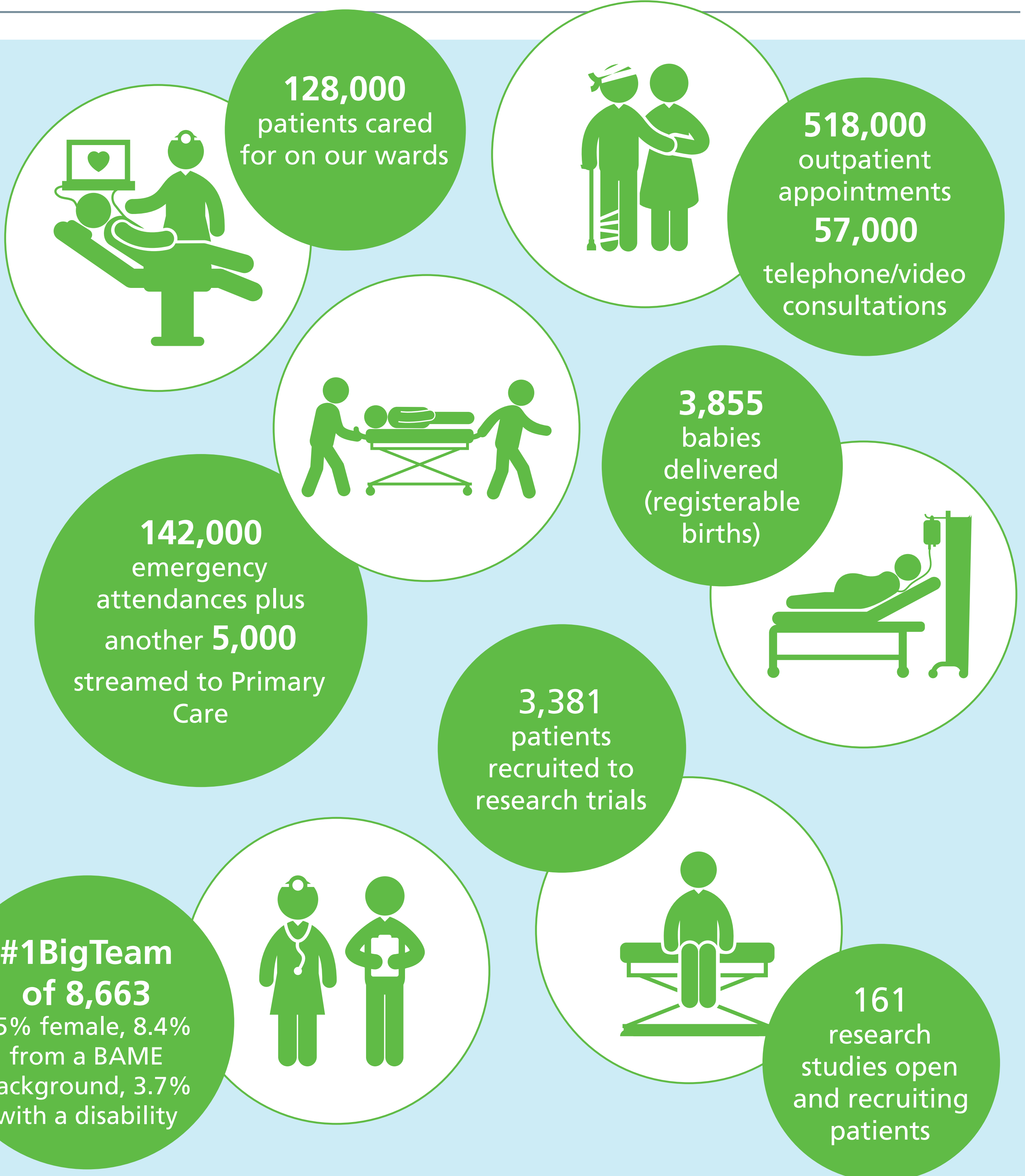
Avoiding Admissions - Cardiology
This team was shortlisted for a national award, after creating a support service in our Emergency Deptarment and ambulatory area to give on-the-spot, nurse specialist input for patients suspected with heart failure/chest pain. This reduced the number of people admitted per week by 15 and enabled much more joined-up care with the community.



Reduce time for medical ward bed – Medicine
We held a site wide improvement event to look at how we fill a bed once a patient is discharged. Lots of improvement ideas were generated and eleven were implemented, with a 50% reduction in time to fill the bed. This helps with clearer standard work and potentially less crowding in our emergency areas.

These are just a few of our examples. We will continue to build our 'culture of improvement' and the capability of teams to deliver better care for patients.

OUR YEAR IN NUMBERS



University Hospitals Plymouth NHS Trust
@UHP_NHS

University Hospitals Plymouth has been shortlisted for a Health Service Journal (HSJ) Value award. A campaign, titled '#WeCare2 - The Difference ANPs and HCSs Make' was a collaborative effort between the Communications Team and all disciplines of Allied Health Professionals (AHPs) and Healthcare Scientists (HCSs)

Improving Our Patients' Experience

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

Our Patient Council

We set up our Patient Council in 2014; this group is now well established and highly regarded. In 2018/19, the Council helped to embed the patient perspective into a wide range of improvement activities and service changes that affect patients. We appreciate Council members who act as a voice for patients and carers who use our services and work alongside the Trust as a critical friend. Our Patient Council have helped us in activities, including PLACE assessments, developing communication boxes, reducing noise at night, Carers week, and supporting patients in the Emergency Department. Please see the Patient Council report on page 27.

Patient Feedback

We hear from our patients through:

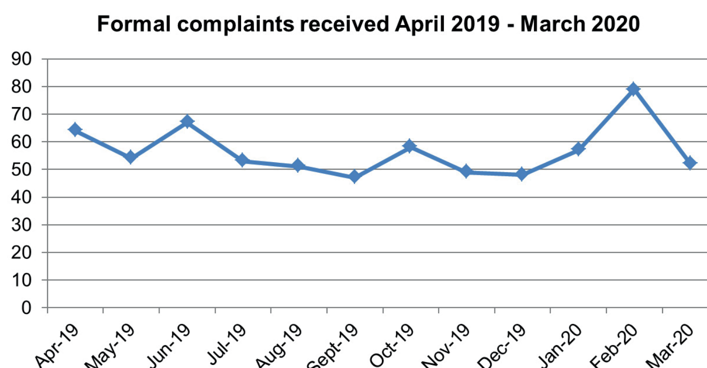
- Friends and Family Test
- Trust surveys
- CQC National surveys
- Engagement events
- Complaints
- Compliments and concerns given to our Patient Advice and Liaison Service (PALS)
- Social media and online feedback (including Care Opinion)

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

Complaints

From April 2019 to March 2020, 679 patients and relatives made formal complaints to the Trust. This represents a 4.2% decrease compared to the same period in 2018/19.

5,375 patients and relatives made enquiries to our PALS during 2019/2020. This number is an increase on



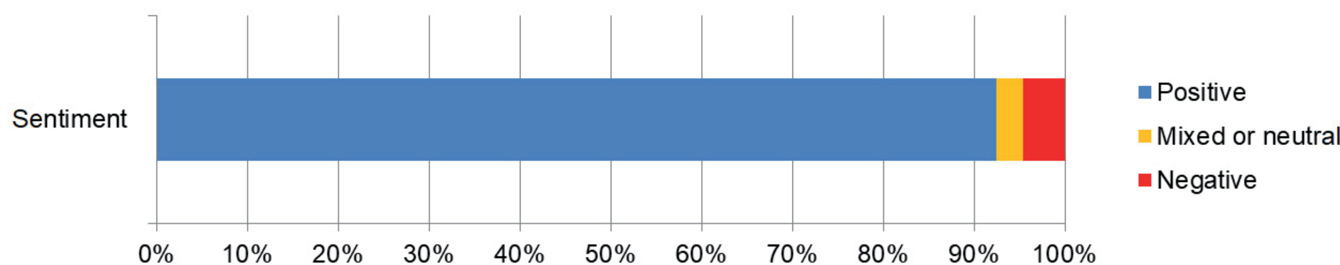
the previous year (4,982), and indicates that the Trust continues to manage concerns at an earlier stage and via appropriate routes, which our patients and families tell us is important to them.
A key measure of quality concerning how we manage our complaints is the number that are reopened because the person in receipt of the response says that we have not answered their concerns. Between April 2019 and March 2020, the Trust reopened 22 complaints at the request of patients and families. This is a reduction from 110 reopened cases the year before. Of the total number of complaints received during this period, it equates to a rate of 3.2% (15.5% last year).

We revised, updated and relaunched our Complaints Policy in November 2019, following the principles set out in legislation. We encourage our services to make early contact with patients and families to try and bring about an early resolution wherever possible, and if not, to clarify the points that we need to investigate. This then creates a bespoke response letter, making it personal and less formulaic.
Our complaints training provides support and guidance for staff who investigate or respond to complaints. Our training includes patient or family members who come and share their experiences of how the Trust responded to them when things went wrong. The CQC highlighted this as outstanding practice in their last inspection.

Complainants have the right to refer any complaint they feel we have not resolved adequately to the Parliamentary and Health Service Ombudsman (PHSO). From April 2019 to March 2020, the PHSO initiated six investigations. Of those six investigations, the PHSO partially upheld three, and three are ongoing.

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

Sentiment analysis of just under 10,000 comments made by patients over a four month period shows these to be overwhelmingly positive:



(Figures: 92.5% positive, 2.9% mixed or neutral, 3.6% negative)

Patients left over 30,000 comments throughout the year on Trust surveys and Friends and Family Test (FFT) responses:

Improving patient care

Throughout 2019/20 we continually reviewed patient feedback, complaints, compliments and other sources of external intelligence and were able to identify areas where we could make improvements. Some of our key achievements are detailed below.

Communication Boxes

People who experience difficulty communicating can find visiting hospital stressful, and with this in mind we launched and rolled out communications boxes to help our patients communicate with staff. The contents of the box include a hospital communication book, which contains pictures to explain what is going to happen, a magnification sheet, guidance for accessing interpreters, finger spelling help sheets, sign language information, a mini echotech hearing loop, dyslexia overlay sheets and other useful tools for staff and patients.

Carers

The Trust is represented on the Plymouth Carers Strategic Partnership Board, and at Improving Lives Plymouth and Cornwall Carers Partnership Board. We have completed a significant amount of work to improve the experiences of our carers, who now receive a Welcome Pack on arrival to the Trust with key information to signpost services available to them. Additionally, where appropriate, carers can now access meal and car parking vouchers.

We held a Carers engagement event as part of Carers Week in June 2019. During this week, the Patient Experience and Engagement Team held events including an awareness session for Carers on the main concourse with the Plymouth Carers Ukulele Band. We visited our wards to hand out Carers welcome packs and undertake additional survey work.

Volunteers Buggy Service

The volunteer buggy service is now fully functioning with a new buggy complete with wheelchair ramp which enables patients to board the buggy with their mobility aid.

Emergency Volunteers

We have introduced a volunteer service in our Emergency Department, where volunteers provide a listening ear and refreshments (if clinically appropriate). Patients and families have given positive feedback about this service.

Discharge
Discharge continues to be a key area of improvement, and a Discharge Project Working Group co-ordinates these improvements. Together with the opening of the discharge lounge, we are implementing a 'Help me Home' campaign aimed at patients, families and carers. The Your Pharmacy project has worked to bring more pharmacy activity on the wards, so that patients can get quicker access to the medication they need to go home.

Noise at Night and our Ssshhhh Campaign
Building on the work done on reducing noise at night through the Making Every Experience Excellent Campaign (MEEE), we tested sleep packs, which include eye masks and earphones, and a patient information leaflet and these are now being used on the wards.

The Ssshhhh campaign aims to raise awareness of noise at night and the importance of a quiet and peaceful environment for our patients. An October Schwartz round focused on "The Hospital at Night" and we saw our Trust staff and volunteers out on the wards in the evenings to survey the noise at night and talk to our patients.

Our Patient Council Reports

The Patient Council is made up of lay people with various patient or carer experiences of Derriford Hospital. Liaison with the Trust is ably provided by members of the PALS team. Members are representatives of various boards and committees both within the Trust and neighbouring trusts. Many Council members also volunteer within the hospital and their time on the wards gives immediate patient feedback to Council members on which action can be taken if required. The Council has been extremely busy over the last twelve months and has continued to build on the strong relationships already formed.

During the year we have been working on a number of key projects which include:

- Involvement with the Nursing Assessment Assurance Framework (NAAF) audits.
- Involvement with the PLACE Assessments.
- Review of all Patient Information leaflets before publication.
- Representation at the Clinical Excellence Awards, the Equality, Diversity and Inclusivity Working Group the Nutritional Steering Group, the Discharge Working Group, and at the Patient Experience Committee.
- Helping to get the Plymouth Youth Patient Council off the ground, working with the Paediatric Matron and Plymouth City Council staff.
- Help with the development of communication boxes for all our inpatient wards and outpatient departments.
- Actively involved in carers week, including taking the tea trolley out to talk to carers and staff throughout the hospital. Giving out carers packs and raising awareness. Attendance at the Plymouth and Cornwall Strategic Carers Boards.
- Involved in the Noise at Night work, including visiting wards in the evening to talk to patients and staff.
- Involvement in surveying and talking to patients in different outpatient departments about exploring alternative methods for follow up clinics.
- Supporting patients in the Emergency Department by providing tea and a chat.
- Involved in the committee for the new Emergency Department build.
- Involved in improvements made to how the Trust communicates with patients, including hybrid

mail, digital dictation, electronic communication of discharge summaries, and feedback about the communication of appointment bookings.
- Involvement in Disability and Dementia Weeks.
- Representing the Patient view on the judging panel for the Pride of Plymouth NHS Star awards.
- Contributing to the selection panels for various new staff appointments.

Work on the Council brings its own rewards – most noticeable this year being our increased involvement with members of the UHP OneBigTeam – who at all levels demonstrate their utmost commitment to doing their best to look after both the staff and each other.

Jane Hitchings
Chair

John Osborn
Vice Chair

Plymouth Healthwatch Reports

Over the last twelve months Healthwatch has maintained a strong relationship with University Hospitals Plymouth NHS Trust and has continued to work with staff around patient experience. This has been in the form of regular patient and public engagement on the Derriford site, as well as being part of the annual Patient Led Assessment of the Care Environment (PLACE) evaluation.

In addition, Healthwatch Plymouth has been involved in the discussion around offering virtual outpatient appointments for some patient groups as well as Integrated Service Provision within Plymouth, working with this Trust and Livewell Southwest as well as Primary Care Services and third sector organisations to ensure the patient voice is heard. We have also been involved on the Hotel Services Transition Board that has seen services such as portering, cleaning and food delivery transfer back to being delivered by Hospital staff.

Feedback from our regular engagement sessions is collated and presented to the hospital's Patient Experience Committee, identifying positive and negative themes of patient experience. This is used to identify future work strands to improve patient experience.

Patient-Led Assessments of the Care Environment (PLACE) is the national system for assessing the quality of the patient environment and aims to help organisations understand how well they are meeting the needs of their patients and identify where improvements can be made. Following a national review of the process by NHS England, Healthwatch volunteers, along with patient representatives from the hospital, carried out an assessment looking at the cleanliness and condition of wards and outpatient departments and how well they meet the needs for those patients with disabilities and dementia. The assessment occurred over three days in November 2019. Due to the national review, reporting criteria have changed and this has made it difficult to make a direct comparison with previous years. However, overall we have seen the progress from previous years maintained. We found the hospital to be clean, most areas well maintained, and staff really engaged in the process. Areas for further improvement were identified and presented to the hospital's PLACE working Group and we look forward to seeing the progress around these items.

Healthwatch Plymouth is looking forward to continuing working with the Trust over the forthcoming year to ensure that patient experience continues to be a significant part of the process in developing services.

Nick Pennell, Chair Plymouth Healthwatch

Locally Global – our staff take their expertise and care around the world

A number of our colleagues spend their summer holidays in Ghana, helping provide healthcare to local communities there. Jo Beer, Director of Integrated Care and Partnerships, Fred Allen, Head of Occupational Health and Wellbeing, and Jonathan Cope, GP and Associate Medical Director for Primary Care, are among those who travel to remote villages as part of a volunteer programme.

This year they took with them an ambulance donated by The South Western Ambulance Service NHS Foundation Trust. Jo and Fred picked up the keys to the vehicle that will be used to serve remote communities. The ambulance will play a vital role in transporting remote and secluded villagers to access much needed basic healthcare.

"We are completely overwhelmed by the donation. This is the best donation we could ever give back to Ghana and we are supremely grateful to Ann James and Ken Wenman for enabling us to take this vehicle back over there."

Find out more by **watching our video here**.

PROUD!

Emergency Preparedness, Resilience and Response (EPRR)

At the start of the year, the Trust was preparing for the potential impact of exiting the European Union (EU). Led by the Director of Finance, activities focused around supplies, workforce, reciprocal healthcare and research. Risks around the supply of clinical consumables and workforce were further assessed. Procurement also reviewed business continuity arrangements with over 800 suppliers, to determine the impact disruption in supplies might have on their ability to deliver services to the Trust. Whilst EU Exit preparations for a 'no deal' scenario were put on hold in June, some elements informed aspects of our emergency planning later in the year, as part of our COVID-19 preparations.

In September our annual self-assessment against the EPRR Core Standards took place, with evidence submitted being formally reviewed by NHS England and NHS Improvement, together with Devon CCG. Following review, the Devon CCG reported the Trust as 'substantially compliant' in meeting Core Standard requirements. At the same time a deep dive on preparations for severe weather was undertaken. This was followed in October by South Western Ambulance Foundation NHS Trust reviewing our arrangements to respond to a chemical, biological, radiological or nuclear (CBRN) incident. Both audits reported the organisation as 'fully compliant' in meeting the standards required, a position formally reported to the Trust Board in November.

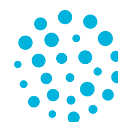
On 12th September, the Trust participated in Exercise Short Sermon, to demonstrate off site emergency arrangements in place, in the event of a reactor incident at Her Majesty's Naval Base, Devonport. Prior to the exercise, the Incident Control Centre (ICC) was moved, to enable the facility to be held in a state of readiness, in anticipation of the next emergency incident. During the exercise, staff undertook their roles both at the Tactical Co-ordination Group (Crownhill Police Station) and in the ICC, to oversee the incident response. Nuclear Medicine and Medical Physics also received a 'contaminated' casualty into Derriford Hospital, to validate their revised Radiation Emergency Response Plan.

Three weeks later the Incident Control Centre was activated again in response to the A385 bus crash near Totnes, where 14 casualties were received by Derriford Hospital from the incident. Given the diversity of injuries sustained, services were not over-whelmed but following this incident and the exercise, both the Major Incident Plan and the Emergency Department response arrangements have been reviewed and up-dated, to strengthen any future response.

From February, there was a significant focus on arrangements to receive patients infected with COVID-19 (coronavirus), with our first patients admitted in March 2020. Early preparations were based on the Pandemic Operational Response Framework and business continuity plans, then aligned with evolving national guidance, including:

- assessing what non-urgent activity could be stopped or provided elsewhere .
- releasing staff and clinical space to manage patients with COVID-19, whilst maintaining our emergency capability.
- developing new pathways for most patient groups and working with partner agencies to deliver these.

This was achieved, all whilst addressing concerns of staff and encouraging alternative ways of working, to support the wider local and national response.



Exercise Short Sermon: receiving 'casualty from incident'

It is recognised that this was a defining time for all involved in the NHS and by the end of March the organisation was working very differently from normal by:

- creating critical care beds at pace.
- re-designating wards and re-deploying staff, as plans developed and positive cases increased.
- moving services off-site and making use of the independent sector.
- managing supplies of personal protective equipment (PPE) to ensure that supplies were available for staff treating patients affected and for training.
- providing 24/7 swab testing, to inform decisions at operational level for patients and staff.
- making use of technology and resources available to deliver services differently.
- restricting visitors and providing alternative ways for families to communicate with patients.
- supporting staff across the protracted period of disruption, concerned for their own safety and welfare and those they care for.
- having command structure in place 24/7 to oversee COVID-19 response arrangements and challenges experienced.

As the organisation and the wider NHS moves forward to Phase 2 of the pandemic response, the Trust is reviewing where we can make further improvements or adopt new ways of working on a more permanent basis, influencing how we work and provide care in future.

Survival rates for patients being treated for a rare type of cancer at University Hospitals Plymouth NHS Trust are greater than anywhere else in the country, thanks to a specialist team providing early access to drugs and emerging treatments through clinical trials.

University Hospitals Plymouth NHS Trust
@UHP_NHS

Today we said ‘thank you’ to these two special ladies. Deborah Coleman and Brenda Turner started their nursing careers at the Trust in 1985, and today they retire together after 68 years of combined service.
Debbie and Brenda - thank you for 68 years of care and compassion 👏

Incidents Involving Data

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

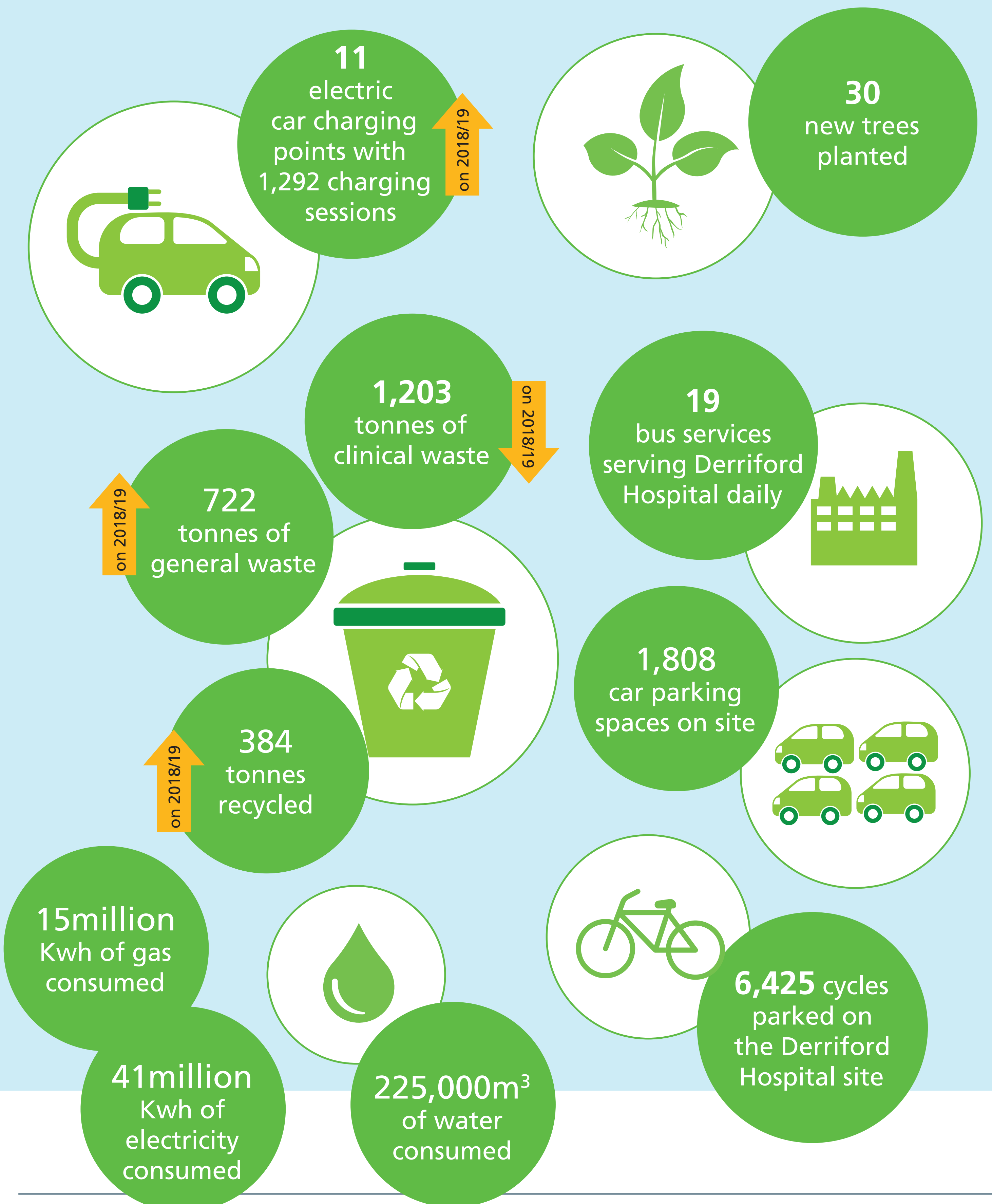
All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (DATIX). Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital. Incidents are categorised as either: low impact incidents (very low in severity), local investigation incidents (investigated by the IG team with recommendations and lessons learned) or reportable incidents (which are reported to the Information Commissioner’s Office).

In 2019/20 there were nine reportable incidents, as follows:

- A patient received a letter with personal information displayed in the window of the envelope.
- A member of staff left a work notebook containing confidential staff information in a public area.
- The address of a patient was revealed to their former partner.
- The Trust sent an email containing a general newsletter to a large distribution list revealing the email addresses of members of the public as the “bcc” function was not used.
- The Trust sent two letters to a patient’s mother instead of the adult patient.
- A patient’s condition was disclosed to a visitor without consent.
- A member of staff disclosed details about a patient’s hospital appointment in a public place.
- A member of staff has passed on information about a patient to mutual friends.
- An email was sent to a distribution list of parents of children with a certain condition containing general information however email addresses were revealed as the “bcc” function was not used.

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

Our environmental year in numbers



Health and Safety

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

We have developed a strategic plan for delivering our overall aim of reducing the incidence and risk of harm to staff, patients and visitors. This aim is underpinned by the following four objectives:

Our overall aim is to reduce the incidence and risk of harm to staff, patients and visitors by continuing to adopt the highest standards of health and safety practice at all times

Our annual plan identifies a number of more specific improvement priorities against each of these objectives.

Preventing Fraud

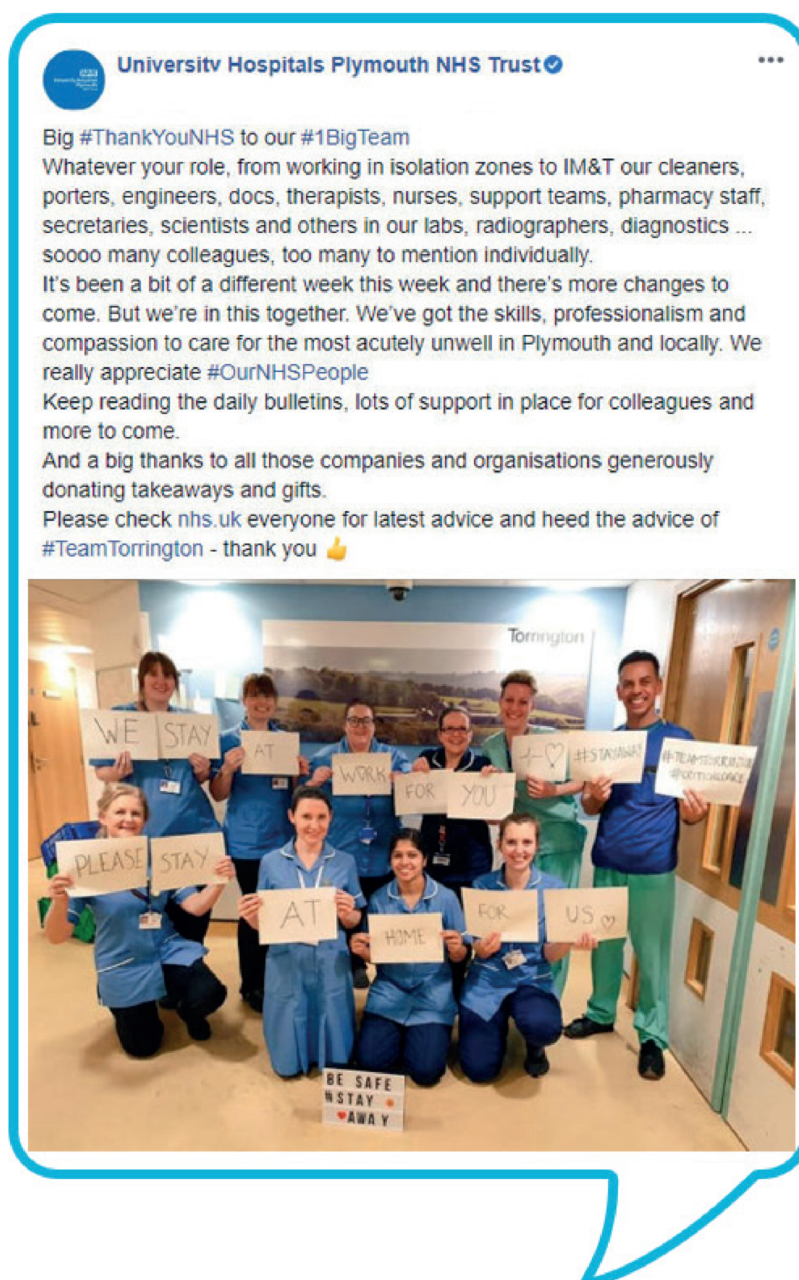
We have a clear strategy for tackling fraud, corruption and bribery and our Counter Fraud Policy sets out details of staff responsibilities and how to report suspicions of fraud or bribery.

The Trust contracts with ASW Assurance to provide a Local Counter Fraud Specialist who works with us to help ensure all counter fraud work is undertaken in line with the NHS Counter Fraud Authority standards, and that risks are mitigated and systems are resilient to fraud and corruption.

The Audit Committee receives and approves the Counter Fraud Annual risk-based Work Plan and Annual Report and also monitors the adequacy of counter fraud arrangements and reports on progress to the Board of Directors.

During 2019/20 the Trust participated in the National Fraud Initiative fraud prevention and detection data matching exercise, and the NHS Counter Fraud Authority's ongoing proactive Procurement Exercise to measure the fraud risk vulnerability indicators and contribute to the overall intelligence picture of procurement fraud in the NHS.

Investigations have resulted in disciplinary action and update on policies, whilst work has continued to implement and embed the NHS England Conflicts of Interest guidance recommendations.
Bank mandate fraud is an on-going risk to any organisation and the Trust actions fraud prevention advice received to ensure robust controls are in place.



In 2019/20, our Research Nurses standardised their uniform, changing to postal grey uniforms with RESEARCH embroidered on the cuff of their sleeves, their seniority, in line with the Trust, depicted by the colour of the uniform binding. All R&D staff were issued with blue hoodies with 'I am research….' across the back. Our dedicated and proud to be research teams can be clearly identified around the Trust so please do stop them and ask them about research.

Research, Development and Innovation

This was the first year of UHP's current five year research strategy, which aims to improve the health and wellbeing of our local population by embedding high quality, well run and relevant research as part of the Trusts core business.

This strategy is underpinned by six strategic pillars:

In line with this strategy, we are off to a flying start - we've recruited 28 patients into early phase studies in the past year, backing up the successful business case put to the Trust to develop the James Lind Research Centre to become a 24 /7 unit. This will allow us to continue to expand our commercial and early phase studies, allowing local people access to more innovative treatment options.

We are delighted to report that the newly refurbished JLRC was recommissioned back to Research and Development on 19 March 2020 and is already supporting its first study, a Trust sponsored academic COVID-19 study, Inflammatory and Biochemical markers of COVID-19 - IBOC.

Within our annual business plan 2019/20 we made a commitment to one of our key stakeholders, the

National Institue for Health Research (NIHR) Comprehensive Research Network, to increase recruitment to NIHR-adopted commercial studies by 20%. We are pleased to report we achieved this. At UHP, we were often the fastest site to set-up and recruit the first patient nationally and globally on several trials. Noted successes this year have been:

"Be On the Team" study
Over 2019/20 the UHP Research team has had direct contact with 1,000 young people in their sixth form colleges. This has allowed us to explain what Clinical Research is both formally through short assemblies and face-to-face whilst conducting study visits. This has also given us the opportunity to make links with some of the teachers and school leaders over the local area. These links will support future research collaborations going forward.

Mantle Cell Lymphoma
A publication in the Lancet was able to report that UHP Mantle Cell lymphoma patients live twice as long as anywhere else in the country, thanks to a specialist team providing early access to drugs and treatments through clinical trials. The team was led by Professor Simon Rule and although he has now moved to a new role in Canada, he still retains strong links with the University of Plymouth and UHP with his international ENRICH study sponsored by UHP. You can read more about this work here: Bit.ly/PlymouthMCL

Life coaching to address the health and welfare of the local population
Approaches which give people tools to self-manage their conditions, as part of the NHS Long Term Plan, are particularly relevant here in the south west, where there are inequalities in access to healthy lifestyles. This year saw significant funding for several UHP-sponsored Chief Investigator studies integrating a public health approach:

- Functional imagery training to reduce alcohol-related harm (Hepatology/ Psychology).
- A Tier 3 weight management service (Metabolic Medicine / Psychology).
- Completion of recruitment to the Trial of Activity to Reduce Smoking (TARS) study.
- Opening as a site for the Wesfit Cancer Surgery Trial: a targeted exercise program with a personal trainer and/or psychological support sessions with a counsellor to test whether prehabilitation before major cancer operations can improve recovery.

Building one team
One of the most exciting outcomes of 2019/20 has been invigorating a spirit of team across the Trust to deliver research together, taking us forward to 20/21 to develop an application for the next phase of research for the JLRC to become an accredited Clinical Trials Research Facility.

Our year in statistics

- We finished the year with 161 studies open to recruitment.
- 3,381 patients were recruited into trials: 266 commercial, 3,115 non-commercial/academic.
- We opened 94 new studies over the year: 33 commercial and 61 non-commercial.
- 413 research publications by UHP staff in 2019/20.

Intensive Care Rehabilitation Team named national champions

We were thrilled when Kate Tantam and the Intensive Care Rehabilitation Team were announced national winners in the 'Care and Compassion' category at the NHS Parliamentary Awards, because their work means so much to patients and families.

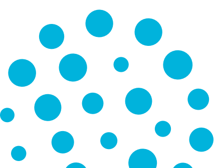
The Parliamentary Awards recognise the massive contribution made by the individuals who work in and alongside the NHS.

The ICU rehab team, led by Kate, were recognised for their dedication to improving rehabilitation and recovery for survivors of critical illness. Inspired by a patient's story, Kate undertook an 18-month audit which showed that 33% of ICU patients developed symptoms of post-traumatic stress disorder after being a patient in ICU. Kate advocated for service development to meet the need identified by her research and her energy ultimately led to the recruitment of a multi-disciplinary Critical Care Rehabilitation Team.

An inter-professional team has helped to shape, share and facilitate a cultural change which extends throughout and beyond the organisation. Since the introduction of the team, the ICU has been able to introduce a Pets as Therapy (PAT) initiative, which sees Hovis the Labradoodle acting as a member of the team, promoting and assisting in physical and psychological rehabilitation.

The Intensive Care Unit now has a garden space of its own thanks to the determination of the team, some kind volunteers, and a lot of elbow grease to clear the unused space. The garden aids rehabilitation and promotes positive mental health for staff, patients and loved ones. Having an outdoor space also allows terminally ill patients to have their pets visit them in a non-sterile environment. Rehabilitation has been critical to patients in the first phase of our response to COVID-19. **You can find out more here.**

PROUD!



PLYMOUTH HOSPITALS CHARITY

Our Charity

Looking back over the year it has been one of exciting transitions and new opportunities. We know that when people make a donation to their NHS Charity they want their money to make a difference. We can spend it on improving facilities, buying equipment, supporting staff and making experiences better for other patients in the future. We have put our donors at the heart of all we do and all our developments are measured against our donors' wishes. We often support people, family and friends when they have lost someone dear to them. The charity is grateful to each and every person for thinking of the hospital and the outreach services the Trust provides in Devon and Cornwall too.

It is important to emphasise that charitable donations are not spent on things that the NHS must but, but allow us to go over and above, adding value and improving on the essentials - making it better for everyone wherever we can.

One of our transitions has been to set up a new governance structure. Our new Charity Operational Group was set up and is fantastic with a wide representation of staff from across the Trust reviewing grant applications. This is exciting for the charity as group members act as ambassadors and will help us raise the profile of the charity across the hospital. It is always good to have new faces and with new faces come new ideas.

An exciting development came about with the Keep Me Close Fundraising Appeal. Careful thought and planning went into adjusting how the Neonatal Intensive Care Unit could support parents who have a very poorly new born baby. Using some of the income Keep Me Close had raised, the staff in NICU found suitable accommodation very close by and parents finally had somewhere to stay. The seven bedded unit opened in November and although early days, it is proving a fantastic resource for families.
Another success is that our Snowdrop Appeal, raising money for a discrete area for parents coping with baby loss, has reached its target and an amazing design for the new area has been produced. Building plans are underway and all the many brilliant and supportive fundraisers have been involved choosing colour schemes, furniture, signage and names.

Thank you so much for your incredible commitment and generosity to making a very real difference to our patients.

Furthermore, Plymouth Hospital Charity has given grants to buy all sorts of things including:

- an MRI Play Scanner to help children get over their fears about feeling trapped inside a big noisy machine
- New video panels and skylights for the Ultrasound department - giving people something to focus on when undergoing various investigations
- A new electric shuttle-bus to help people with physical difficulties get around the large site

It is due to these charitable donations and legacies that we can make things like this a reality.

The charity produces its own separate set of accounts and report - to find out more about how you can fundraise or make a donation to Plymouth Hospitals Charity visit www.plymouthhospitals.nhs.uk/charity-home.

University Hospitals Plymouth NHS Trust
@UHP_NHS

New 'bereavement bags' are being rolled out across the hospital. Innovator Ali said: "This idea was born out of my personal experience of collecting my Mum's belongings." WATCH: youtu.be/5Ys_Ja0GIW0

Our People Report #1BigTeam

We have more than 8,600 people in our diverse, committed, capable and compassionate #1BIgTeam, including more than 600 colleagues in hotel services who were formerly employed by Serco and brought back in house during this financial year.

Staff numbers by Staff Group, figures as of 31st March 2020

Scientific and Technical Staff (inc ODPs)	290.04
Healthcare Assistants and Clinical Helpers	1425.00
Administrative and Clerical Staff	1567.12
Allied Health Professionals and Therapists	374.68
Estates and Ancillary Staff	596.15
Healthcare Scientists	254.74
Medical and Dental Staff	1073.48
Nursing and Midwifery	1936.89
Total (wte)	7518.06
Total Headcount	8663
Annual Turnover	9.58%
Annual Sickness Absence	4.58%

Staff numbers by gender

Gender	Board	Senior Manager	Other	Grand Total
Female	6	99	6398	6503
Male	11	68	2081	2160
Grand Total	17	167	8479	8663

Table showing number of new staff recruited over the financial year (by staff group)

Staff Group	Total
Add Prof Scientific and Technic	28
Additional Clinical Services	326
Administrative and Clerical	287
Allied Health Professionals	64
Estates and Ancillary	686
Healthcare Scientists	20
Medical and Dental	338
Nursing and Midwifery Registered	408
Grand Total	2157

Inclusion is at the heart of everything we do
The NHS Constitution frames the expectation of all colleagues who have a duty "not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation". We also know that having a diverse workforce improves the experience of our patients and the working environment.

Every colleague at UHP has an important part to play in ensuring our hospital has an inclusive working environment that provides services to meet the needs of our local and peninsula wide community. Our inclusion agenda recognises that everyone matters as well as understanding that there are times when people, particularly those from protected groups, may face unfairness and discrimination. We have a moral responsibility to work in a way that creates fairness as well as a legal and public sector duty which we take very seriously. We always aim to create policies and practices that eliminate workplace discrimination and health inequalities, as well as strengthening our relationships within the community and with our colleagues who may identify with any of the protected groups.

A key part of our inclusion agenda is to better understand how our patients and colleagues experience our hospital. To do this, we ask for feedback in a number of ways including the friends and family questionnaire for our patients and the national staff survey for our colleagues.

Alongside this we have a Patient Council and this year we plan to embed our Staff Networks into the workplace. We will create five networks: BAME/Race, Women, LGBT+, Religion and Disability. Each network will have an Executive Champion to recognise the commitment of our Trust Board to our inclusion agenda and their understanding that colleagues within protected groups experience the workplace differently from the majority of the workforce. Our networks will enable us to step into the shoes of colleagues within protected groups by giving them a voice, and by listening to them to understand without judgement. This, we are sure, will build on our collective intelligence to facilitate better decision making that works towards our aim of ensuring we maintain an inclusive hospital environment for all.

Inclusion is about bringing people together by focusing on who we are, not what we are, recognising and valuing uniqueness, at the same time as creating a sense of belonging and connection. Leadership style is important in everything we do and what matters to us is that those in a leadership capacity lead their teams in a compassionate, inclusive and collaborative way that enables people to flourish and be the best they can be.

Over the last year we have maintained our focus on inclusion by enhancing our mandatory training, continuing to develop our leaders through a comprehensive education package, achieving Disability Confident status in recruitment, introducing the Health Passport for colleagues, being involved in local and national inclusion events such as Equality, Diversity an Human Rights Week, and the Plymouth Respect Festival, as well talking openly about the challenges we all face. We submit annual reports for Workforce Race Equality Standards, Workforce Disability Equality Standard, Gender Pay Gap Analysis

and follow NICE guidance. Alongside this we monitor our Ethnicity Pay Gap, the diversity of our workforce at all levels and actively encourage colleagues from protected groups to develop and progress in their careers as well as ensuring our recruitment and selection processes are robust, equitable and fair. We also use the Equality Delivery System which is a tool designed for NHS organisations to work in partnership with our colleagues and our community to review and improve what we do to enhance equity and fairness.

Establishing and maintaining existing relationships with our community and our colleagues will continue to be an important part of what we do to in the coming year. This helps us to understand where we need to focus our efforts to ensure that everyone counts.

* Protected groups as defined by the Equality Act 2010 - age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

Listening to our #1BigTeam

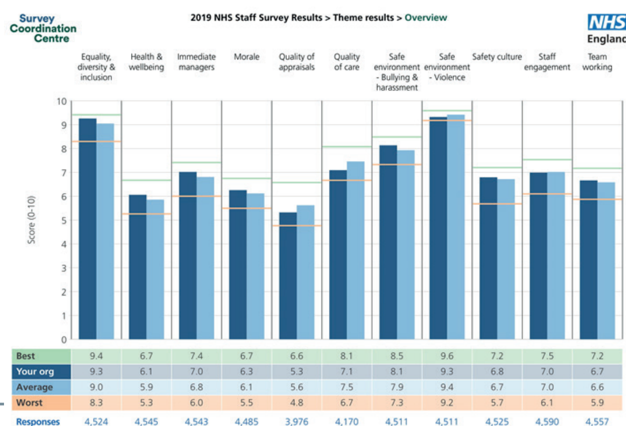
We are constantly listening to our colleagues, through surveys, Big Conversations, feedback from touchpoints such as induction and exit interviews, learning from when things go right, as they so often do, as well as from when things go wrong.

So what are our people telling us? What does it feel like to work at UHP? One of the ways we listen which is comparable to other similar organisations is through the national Staff Survey. The national data is presented in themes (groups of questions). When comparing our results to last year:

- Two have statistically significantly improved at UHP between 2018/ 2019 (Equality, Diversity and Inclusion and the Quality of Appraisals).
- Nine have stayed the same.
- None have statistically significantly declined.

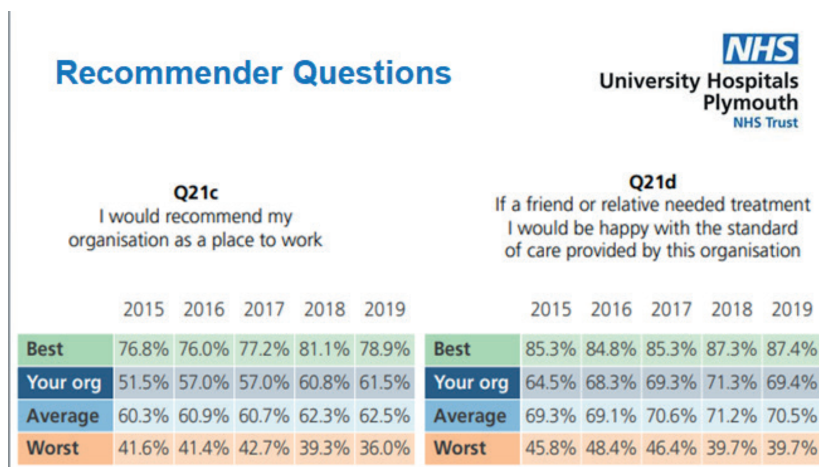
We continue to make steady progress in the reported experience of staff. When comparing ourselves to the average acute trust in 2019 (shown below):

- Seven were better than average.
- One remains the same as average (Staff Engagement).
- Three are lower than average (Quality of Appraisals, Safe Environment - violence - and Quality of Care).



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	9.3	6.1	7.0	6.3	5.3	7.1	8.1	9.3	6.8	7.0	6.7
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	4,524	4,545	4,543	4,485	3,976	4,170	4,511	4,511	4,525	4,590	4,557

The below graph shows how we compare in terms of staff recommending UHP as a place to work and be treated.



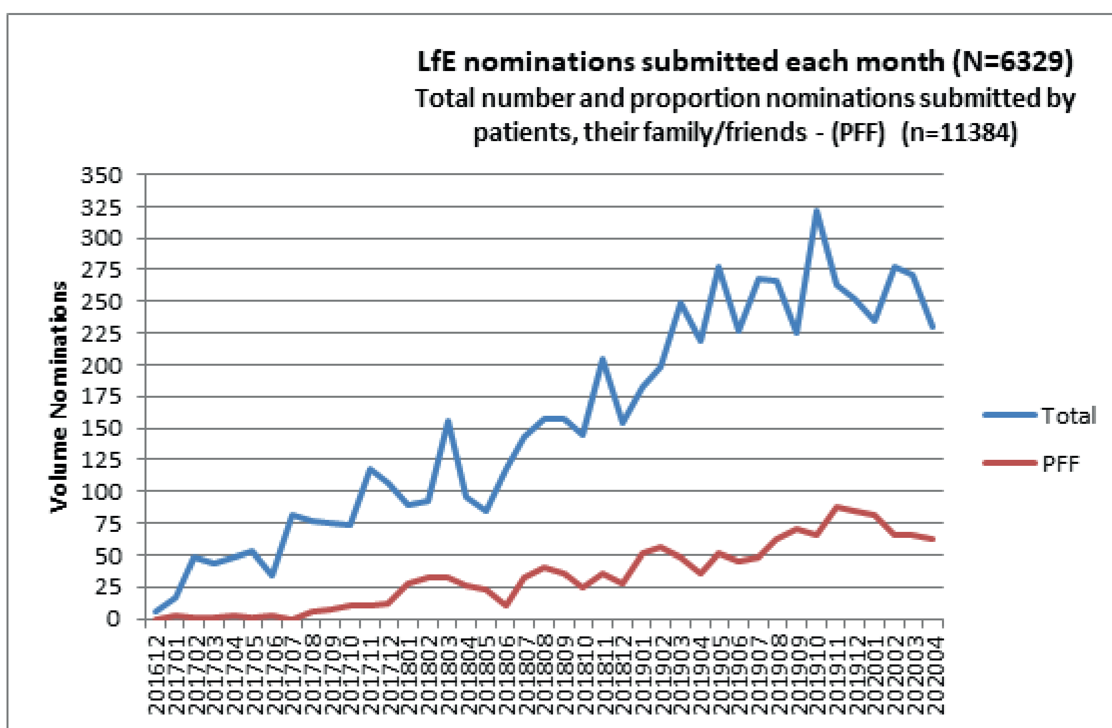
Recommender Questions

NHS University Hospitals Plymouth NHS Trust

Q21c I would recommend my organisation as a place to work	2015	2016	2017	2018	2019
Best	76.8%	76.0%	77.2%	81.1%	78.9%
Your org	51.5%	57.0%	57.0%	60.8%	61.5%
Average	60.3%	60.9%	60.7%	62.3%	62.5%
Worst	41.6%	41.4%	42.7%	39.3%	36.0%

Q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	64.5%	68.3%	69.3%	71.3%	69.4%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

We have a Say Thank You and Learn from Excellence scheme which offers staff, patients and their families an easy way to say thanks and help us capture and learn from episodes of excellence. By completing a quick and easy online form, staff and patients or their families can generate a card which contains their words of thanks. This is sent to the individual member of staff or team named and we know that staff really appreciate it when their Thank You card arrives in the post. This scheme has grown since its inception in 2012, as the below graph indicates, with a particular focus from our Communications Team this year on promoting the scheme to patients and families.



A new study has shown that people in the advanced stage of multiple sclerosis (MS) experience significant improvements in movement and balance thanks to a specialised standing frame. Sponsored by University Hospitals Plymouth NHS Trust and published in Lancet Neurology, the study in people with progressive MS also showed that the intervention appeared cost-effective, leading researchers to conclude that it could be routinely implemented within MS care throughout the UK.

The study, called Standing Up in Multiple Sclerosis (SUMS), was funded by the National Institute for Health Research (NIHR) Research for Patient Benefit Programme and led by the University of Plymouth.

John Kendrick from Sparkwell near Plymouth, Devon was assigned the standing frame intervention and, after years of not being able to move a great distance, was able to walk his daughter down the aisle on her wedding day.

He said: "There is absolutely no doubt in my mind that had it not been for the standing frame, I would not have been able to walk my daughter into church to marry her husband. It was a challenge, using a crutch to help me and obviously holding on to her too, but I'm so proud I did it.

"With secondary progressive MS, my mobility has decreased and I'm starting to lose feeling in my right hand. But the standing frame, which I'm continuing to use, has helped to keep me mobile."

Read more here.

PROUD!

OUR ACCOUNTABILITY REPORT

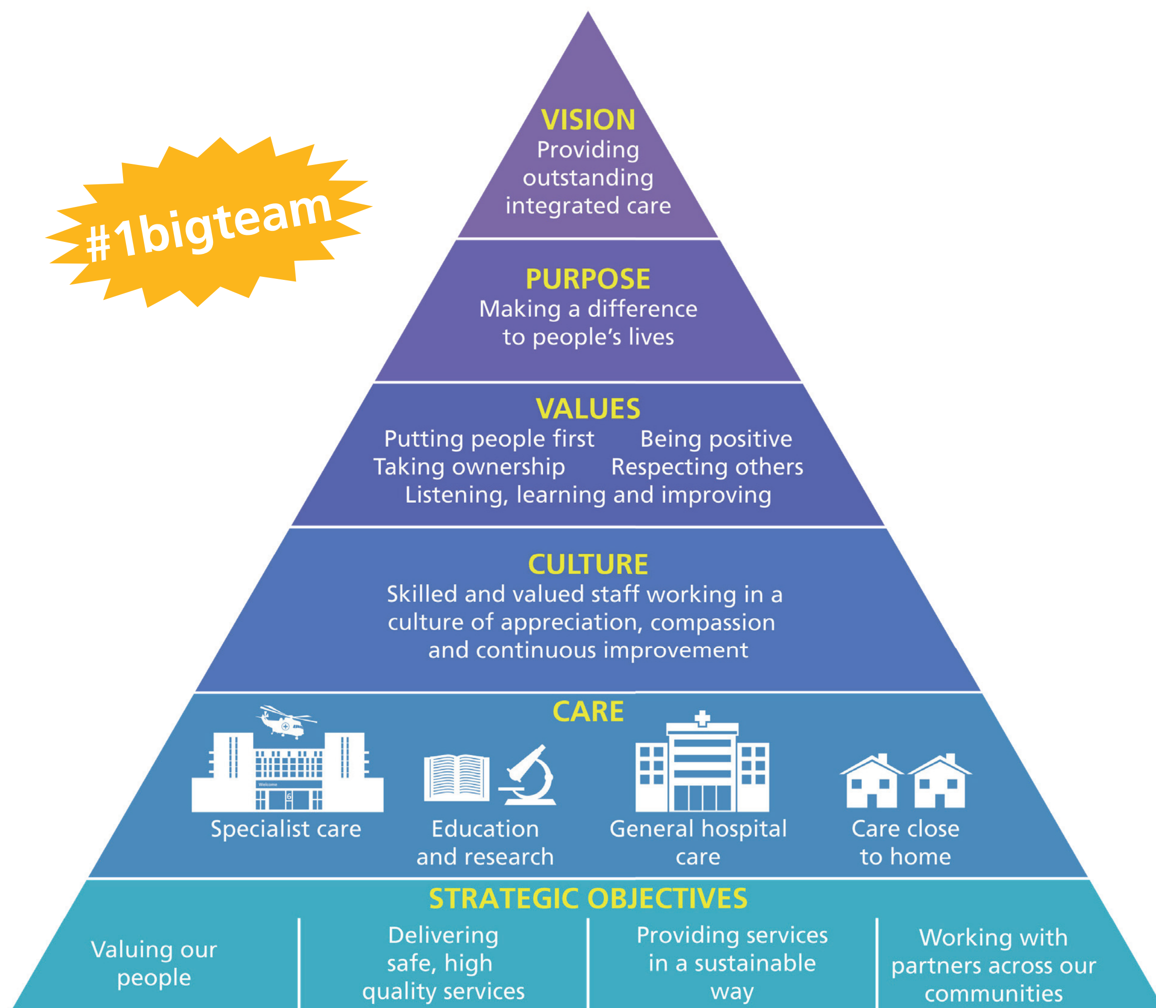
Our Board of Directors

The Board of Directors, led by the Chairman, sets the Trust's strategy, its vision, values and culture. The Board is accountable for the delivery of high quality, safe services to patients and is collectively accountable for the organisation, its decisions and performance. The Board comprises voting and non-voting members.

The Trust's Standing Orders set out the matters reserved to the Board and our Standing Financial Instructions and Scheme of Reservation and Delegation define our financial decision making framework.

The Chief Executive is supported by a team of Executive Directors, who together are responsible for the overall day to day management of our operational services, our finances and delivering the Board's strategy.

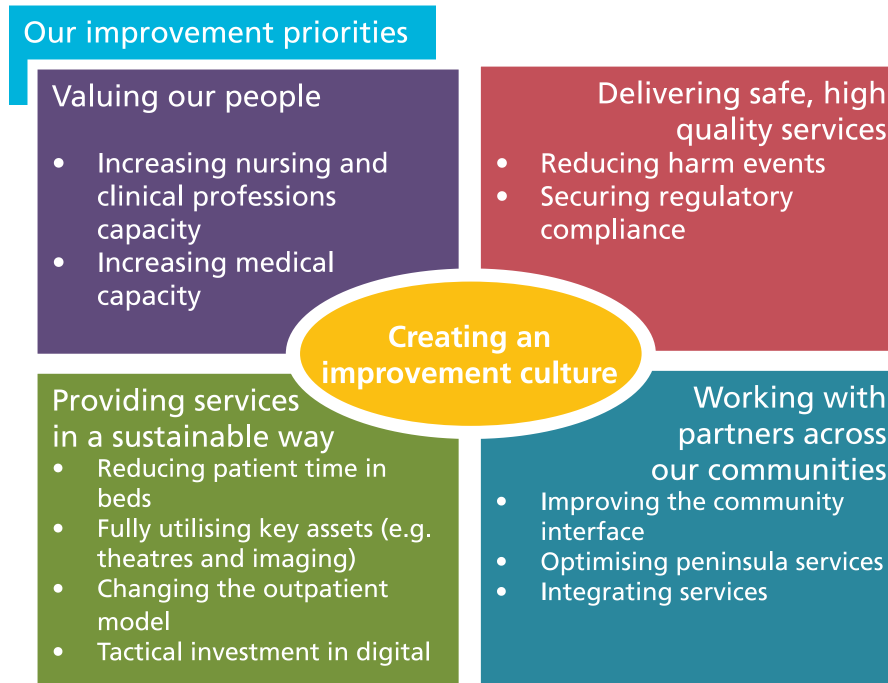
Our 2019/20 Operational Plan is summarized in the diagram below.



University Hospitals Plymouth NHS Trust
@UHP_NHS

The Trust has this week welcomed more than 600 members of Hotel Services staff (housekeepers, cleaners, patient catering, porters, supervisors, linen room and postal staff) who were previously employed by Serco.
Welcome to #1BigTeam

The Plan detailed our improvement priorities for 2019/20 which, together, facilitated the Board's aim to ensure that skilled and valued staff worked together in a culture of appreciation, compassion and continuous improvement.



Our Plan was underpinned using NHS Improvement's LEAN programme. We call this our People First programme. The three-year 'lean programme' will build on the success of NHS Improvement's partnership with the Virginia Mason Institute, which saw leaders and clinicians across selected trusts receive tools and hands-on support, including coaching, mentoring and education in LEAN techniques.

Arrangements for overseeing delivery of our 2019/20 Operating Plan included the weekly monitoring of metrics by the Executive Team, covering the key themes of NHS Constitutional standards, financial and operational efficiencies, harm reduction workstreams, staffing workstreams, and People First priorities to support staff to identify, lead on, and effect improvements to the services they deliver. All staff, including support staff, have been included in this initiative.

The risks to our overarching aims are set out in the Board Assurance Framework. In reviewing these risks, the Board is supported by its Committees, which review in more depth the risks and assurances associated with different aspects of the Board's responsibilities. The Board's Committees are explained in more detail on the following pages.

Members of the Board of Directors in 2019/20

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

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the Act) introduced a 'fit and proper person' test for Directors of NHS organisations. The Trust Board approved a local 'fit and proper person' test in 2015 to enable the Trust to demonstrate that it has the appropriate systems and processes in place to ensure that all new appointees to, and holders of, Director posts, are, and continue to be, fit and proper persons. This process has been updated to incorporate subsequent Care Quality Commission guidance and in November 2019 the Board noted that an annual review and self-assessment demonstrated compliance with the Act, including the revisions introduced in 2017, and that Board appointees had met the 'fit and proper person' test. The Care Quality Commission recommended that the Trust adopted a formal Fit and Proper Persons Policy and this was approved by the Board in November 2019.

Non-Executive Directors

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

V – voting Director
NV – non-voting Director

Richard Crompton, Chairman (V)
Richard was initially appointed in August 2012 and was re-appointed in 2016 and 2018. A former Chief Constable of Lincolnshire Police, Richard also served with the Metropolitan Police and the former Devon & Cornwall Constabulary. Partnership working has been a constant theme throughout Richard's career and he continues to be closely involved with organisations aimed at improving services, particularly those for the most vulnerable.

Declarations of interests:

- Independent Chairman of the Safeguarding Panel for Dimensions UK, a national provider of a range of services for the learning disabled and autistic.
- Independent Chairman, Wiltshire Safeguarding Adults Board.

Bill Boa (Associate, NV)
Bill joined the Board in March 2020 for a two year term. Bill is dual qualified with the Institute of Chartered Accountants in England and Wales and the Chartered Institute of Public Finance and Accountancy. Bill has worked as Chief Finance Officer/Director of Finance in the acute, mental health, community services and Primary Care Trust sectors and also worked in the former South West Strategic Health Authority. For the last eight years Bill has been self-employed; his company provides financial

and consultancy services to the NHS and private sector. During that time he has been interim Chief Finance Officer at North Bristol NHS Trust, Great Ormond Street Hospital for Children NHS Foundation Trust, Cambridge University Hospital NHS Trust, St George's University Hospital NHS Trust and Barts Health NHS Trust.

Declarations of Interest:

- Founder and Director, Boa & Associates Consultancy Ltd, a limited company providing financial and organisational consultancy services to the NHS. Spouse is also a Director of the company. Current clients include:
  - Barts Health NHS Trust – acting as Financial Improvement Director of the Trust.
  - Rushcliffe Clinical Commissioning Group (CCG) – providing 'expert witness' NHS financial support to the CCG.
- Supply Chain Co-ordination Ltd – providing expert finance and organisational advice to this organisation, the co-ordinating body for NHS supply chain services in England.
- Trustee and Treasurer of Arts & Health South West, a registered and incorporated charity: a learning, advocacy, networking and development organisation promoting the value of arts and creativity for the benefit of health and wellbeing.
- Founding Trustee, National Centre for Creative Health, expected to be established as a charitable incorporated organisation.
- Chair of Audit and Risk Committee, Health Data Research UK, an independent non-profit organisation supported by Government and charitable funding that brings together Universities, NHS organisations, industry partners, patient groups and research institutes across the UK to unite the UK's health data assets to make health data research and innovation happen at scale and to enable discoveries that improve people's lives.

Giles Charnaud (V)
Giles was appointed to our Board in September 2016 for four years, having previously been Chief Executive of Rowcroft House Foundation Limited (Rowcroft Hospice). He resigned from the Board in September 2019; he declared no interests over the period covered by this report.

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

Declarations of interests:

- President of the Academy of Medical Educators.
- Member of the Council of the Faculty of Medical Leadership and Management.
- Member of the Medical Practitioner Tribunal Service Committee.
- Professor of Postgraduate Medical Education University of Manchester.
- Visiting Professor Lancaster University.
- Director of Postgraduate Clinical Training University of Nicosia.
- Associate, General Medical Council.

University Hospitals Plymouth NHS Trust
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We remain Outstanding for Caring which reflects the care and compassion of our staff in delivering the best care possible to our patients. #abetterpicture

- Suitable Person for the Medical Practitioner Tribunal Service.

Professor Elizabeth Kay, MBE (V)
Liz was appointed Associate Non-Executive Director in September 2016 and a Non-Executive Director in February 2019. Formerly the Foundation Dean of the Peninsula Dental School, Liz is a committed clinician and teacher and a Public Health Academic Consultant working with Public Health England, focusing on the delivery of appropriate care to those who find clinical care particularly challenging. Liz sits on the Editorial Boards of three journals, including the British Dental Journal and peer reviews papers for a large number of other academic publications. In addition, she authors textbooks in collaboration with colleagues from around the world. Liz was awarded her MBE in 2017 for services to dental education.

Declarations of interests:
- Director and Trustee of Oral Health Foundation Charity (President Elect 2017).
- Chair of management board of research funding committee of the British Dental Association
- Advisory Board BUPA Oasis Healthcare.
- Chair of NICE Guideline Committee on Epilepsies.
- British Dental Association Health and Sciences Committee member.
- Trustee and Vice Chair, British Medical and Dental Student Trust.
- Director and Trustee of the College of General Dental Practice.

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

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

Mike Leece, OBE (V)
Mike was appointed to the Board in June 2015 and was re-appointed for a further two years in 2017. Mike's term of office concluded in May 2019; he declared no interests over the period covered by this report.

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

University Hospitals Plymouth NHS Trust
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Derriford Hospital has turned orange to mark #WorldPatientSafetyDay @WHO
We're also:
- Encouraging all departments and wards to make a safety pledge
- Running the Very Important Peropheral cannulas challenge
- All Matrons will be conducting huddles on pressure ulcers and falls

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

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

Declarations of interest:
- A self-employed executive coach and OD specialist, not currently working with the NHS. Helen mentors a member of staff in a charitable organisation closely associated with University Hospitals NHS Trust.
- An associate consultant with the Invisible Grail, which focuses predominantly on higher education sector work, and Skylite, an affiliate of Lee Hecht Harrison Penna, which works across all sectors, including the NHS nationally.

Estelle Thistleton (V)
Estelle was appointed in September 2016 for a four year term. She resigned from the Board in November 2019.

Declarations of interests:
- Director Maine Partnership Ltd, a consultancy in leadership development that did business with the NHS.

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

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

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

Ann James, Chief Executive (V)
Ann took up her appointment as Chief Executive in September 2012. As former cluster Chief Executive

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

Declarations of interests:

- Chair, South West Leadership Academy.
- Chair, Southwest Talent Board.
- Member, One Plymouth.
- Chair, National Institute Health Research Peninsula Partnership Group.
- Member, Plymouth Growth Board.
- Vice Chair, Board of Governors, Devonport High School for Girls

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

Declarations of interests:

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

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

Sarah Brampton, Director of Finance (V)
Sarah was appointed as Director of Finance in April 2019. Sarah previously worked for the Trust as Director of Financial Services and Deputy Director of Finance, before taking up the post of Director of Finance at Devon Partnership NHS Trust in March 2013. She was later appointed Deputy Chief Executive there in 2016. Sarah has more than 20 years' healthcare experience and has worked in all sectors of the NHS, including acute, mental health and commissioning.

Declarations of interest:

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

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

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

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

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

Declarations of interests until July 2019:
- Director, Hughes Diagnostics.
- Designated Member with Plymouth Radiology Consultants LLP.

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

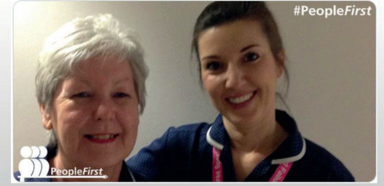
Declarations of interests:
- Member of Plymouth Employment and Skills Board as a representative of the Health sector.

Neil Kemsley (V)
Neil joined the Trust as Director of Finance in November 2015 and resigned in March 2019. In the period covered by this report Neil declared the following interest:

University Hospitals Plymouth NHS Trust
@UHP_NHS

A nurse-led improvement project in Derriford Hospital's Emergency Department is changing the way patients with cardiac conditions experience urgent care. #PeopleFirst

bit.ly/HeartFailurePilot



- Brother-in-law is Partner at PWC (but has no involvement in UK public sector).

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

Declarations of interests:
- Trustee of Plymouth Access to Housing.
- Non-Executive Director, Plymouth Science Park Ltd.
- Member of GS1 UK Healthcare Advisory Board.

Directors' attendance of public board meetings in 2019/2020

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

Non-Executive Directors	Meetings attended
Richard Crompton, Chairman	7 of 7
Bill Boa	1 of 1
Giles Charnaud	2 of 3
Jacky Hayden	7 of 7
Liz Kay	5 of 7
Hisham Khalil	5 of 7
Mike Leece	2 of 2
Graham Raikes	7 of 7
Helen Teague	5 of 6
Estelle Thistleton	5 of 7
Henry Warren	7 of 7

Executive Directors	Meetings attended
Ann James	7 of 7
Kevin Baber	7 of 7
Jo Beer	6 of 7
Sarah Brampton	7 of 7
Lenny Byrne	5 of 7
Lee Budge	5 of 7
Phil Hughes	6 of 7
Steven Keith	6 of 7
Nick Thomas	5 of 7

University Hospitals Plymouth NHS Trust
@UHP_NHS

At UHP we've been celebrating International Nurses Day with an Appreciation Station stocked with cakes and fruit, "pin the hat on the nurse", a pamper station cake sales, a marathon challenge and much more all over the hospital.
Happy International Nurses Day!

Board evaluation and effectiveness

The Board held regular development sessions during 2019/2020 with the aims to:

- Ensure that it had a good understanding of the environment in which it operates.
- Maximise the Board's influence through formal and informal engagement to build understanding and relationships with other key stakeholders.
- Enhance the Board's knowledge through a series of 'master-classes' on subjects relevant to its role and responsibilities.
- Maintain the Board's visibility by adopting a personable and interactive approach to leadership through effective engagement with staff and patients.
- Develop the Board's skills by using external facilitation to objectively review and observe performance and optimise effectiveness as a team.

Among the topics covered in Board Development during 2019/20 were:

- Securing the improvement trajectories in the 2019/20 Plan, including the role of the Board and its Committees in seeking assurance of delivery.
- Governance arrangements.
- Talent management and leadership development.
- Developments in Devon STP, including the Long Term System Plan and System Governance proposals.
- The Care Quality Commission Well-Led Framework.
- The People First approach to quality improvement.
- Developing an Integrated Care Partnership for Plymouth.
- Supporting teams in cultural development.
- The role of the Board in countering fraud.
- Developing a specification to support externally facilitated Board development.
- Responding to the Care Quality Commission inspection report.
- Longer term financial outlook.

Standing Committees of the Board

Our Board has seven sub-committees, six of which are chaired by Non-Executive Directors. They are:

- Audit
- Remuneration
- Finance & Investment
- Safety & Quality
- People & Culture (formerly Human Resources & Organisational Development)
- Research
- Charitable Funds

Audit Committee

The Audit Committee ensures that an effective system of internal controls is in place and maintained. Independently of the Trust Board, it reviews and scrutinizes the Trust's objectives and the associated risks and controls set out in the Board Assurance Framework. A Committee comprised only of Non-Executive Directors, it met on four occasions during the year and is chaired by Graham Raikes. Along with the chair, the core members are the chairs of other Committees of the Board. All Non-Executive Directors, with the exception of the Chairman and the NED representing the University of Plymouth, receive papers and may attend if they wish. The Directors of Finance and Corporate Business regularly attend

and all other members of the Executive team routinely receive papers and attend when the agenda demands.

Non-Executive Directors' attendance at Audit Committee meetings during 2019/20 was:

Non-Executive Directors	Meetings attended
Graham Raikes	4 of 4
Giles Charnaud	0 of 2
Jacky Hayden	3 of 4
Liz Kay	0 of 4
Mike Leece	0 of 1
Helen Teague	2 of 3
Estelle Thistleton	0 of 3
Henry Warren	4 of 4

Remuneration Committee

This Committee oversees the performance and remuneration of the Executive team. It is comprised only of Non-Executive Directors and all our Non-Executive Directors are members of it. It is chaired by Graham Raikes. It met on three occasions during 2019/20: in July 2019 to review the Chairman's appraisal of the Chief Executive and the Chief Executive's appraisals of her Executive team; in October 2019 to review its Terms of Reference and to consider a matter for referral to NHS Improvement; and in February 2020 to consider guidance from NHS Improvement on Very Senior Manager Pay for 2019/20.

Members' attendance at Remuneration Committee meetings during 2019/20 was:

Non-Executive Directors	Meetings attended
Graham Raikes	3 of 3
Giles Charnaud	1 of 1
Richard Crompton	3 of 3
Jacky Hayden	2 of 3
Liz Kay	2 of 3
Helen Teague	2 of 3
Estelle Thistleton	1 of 2
Henry Warren	3 of 3

Finance and Investment Committee

This Committee oversees the Trust's financial risks, the development and delivery of the financial elements of the Trust's strategic and operational plans, monitoring performance against NHS Constitution standards and overseeing capital plans for the maintenance and development of the hospital. Henry Warren is the Committee's Chairman. Other Non-Executive members in the period were Giles Charnaud, Mike Leece and Graham Raikes. This Committee meets monthly. Board members' attendance during 2019/20 was:

Core NED/Executive Member	Meetings attended
Henry Warren, Chairman	11 of 11
Giles Charnaud	5 of 5

Mike Leece	2 of 2
Graham Raikes	8 of 11
Chief or Deputy Chief Executive	7 of 11
Director of Finance	11 of 11
Chief Operating Officer	8 of 11

Safety & Quality Committee
This Committee is responsible for overseeing delivery of the Trust's quality plans and providing assurance to the Board on the key safety and quality risks. It met six times in 2019/20 and is chaired by Jacky Hayden. Board members' attendance during 2019/20 was:

Core NED/Executive Member	Meetings attended
Jacky Hayden, Chair	6 of 6
Giles Charnaud	3 of 3
Chief Operating Officer	4 of 6
Chief Nurse	5 of 6
Medical Director	5 of 6

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

People & Culture Committee
This Committee oversees delivery of the Trust's people objectives, addresses our key people risks, delivery of our People Strategy and has oversight of HR policies. It met on six occasions during the year and is currently chaired by Helen Teague. Board members' attendance during 2019/20 was:

Core NED/Executive Member	Meetings attended
Helen Teague	2 of 3
Liz Kay	2 of 4
Mike Leece, former Chair	1 of 1
Estelle Thistleton, former Chair	4 of 4
Director of People	6 of 6
Chief Nurse or nominee	5 of 6
Medical Director's nominee	0 of 6

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

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

In 2019/20 the corporate trustee introduced revisions to the charity's governance arrangements in order to separate the operational and strategic elements of its charitable governance. The Charitable Funds Management Committee has been disbanded and a new Charity Operational Group and Charity

Strategic Group have been introduced. The Charity Strategic Group is chaired jointly by Executive Directors Lee Budge and Kevin Baber and it has met throughout 2019/20. Membership is drawn from across the Trust and includes the independent, external Chair of the Charity Operational Group. More details on the work of Plymouth Hospital's Charity can be found in the Charity's annual report and financial statements.

A couple from Plymouth have launched a charity which will support bereaved parents who have suffered neonatal loss or stillbirth.

Aimee and Ryan Conroy felt compelled to do something to help future bereaved parents after their little girl, Luna Valentina Conroy, was sadly born sleeping in November 2017.

"We wanted to embrace a new journey," said Aimee and Ryan. "Something we could channel all our love and energy into on behalf of our Luna."

The charity, Luna's Fund, aims to offer an array of services for families to use, in order to create new memories.

Examples of the services offered by Luna's Fund will include:

- Redecoration of the baby's nursery for parents who choose that this room is too painful for them to endure daily; to restore the room to its original/alternative use.
- A relaxing getaway to help both the mind recovering from trauma and the body recovering from labour, allowing parents to have some time out to process what has happened.
- Food hamper deliveries to help reduce the lack of appetite whilst promoting nutritional goodness; to offer comfort through small luxuries and to allow the family to avoid facing the reality of grocery shopping and social environments in the early stages.

How to contact Luna's Fund: www.lunasfund.com

PROUD!

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

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 provide only reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in University Hospitals Plymouth NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

The Terms of Reference for each committee are reviewed and approved by the Trust Board on a regular basis. Each committee is chaired by a Non-Executive Director. Committee attendance for each Non-Executive and Executive Director is summarised in the Trust's Annual Report.

Clinical leadership remains a central part of our governance architecture as it helps us remain focused on our primary goal of delivering high quality care. With this in mind, we have organised the Trust into a series of business units known as 'Service Lines'. Each Service Line is aligned to one of four 'Care Groups' each of which is headed by a Clinical Director and a Care Group Manager who are members of the Trust Management Executive. Leadership is given to the risk management process in the following ways:

- Care Groups are provided a monthly report setting out their performance on key aspects of risk management practice.
- The Executive Team meets on a monthly basis with each Care Group to review all aspects of their performance including risk management arrangements.
- The Trust Management Executive (TME) receives periodic reports to review the Corporate Risk Register and the overall effectiveness of risk management arrangements.

The risk and control framework

Risk management arrangements
The Trust has a 'Risk Management Framework' which has been approved by the Trust Board. The Framework sets out the key responsibilities for the management of risk and seeks to ensure that the risks to the achievement of the Trust's objectives are understood, reported and appropriately mitigated. The Board Assurance Framework (BAF) is the key strategic tool for the management of risk and assurance. The Framework enables the Board to demonstrate how it has identified and met its assurance needs in relation to the delivery of the Trust's objectives. It includes:

- A description of identified risks and potential consequences together with the source of the risk.
- The Board risk owner and the relevant 'Assurance Group'.
- Arrangements or controls in place to oversee and mitigate risk.
- Current evidence to substantiate whether or not the risk is being effectively managed and/or mitigated.
- Identified gaps in processes and/or outcomes required to mitigate the risk and an 'assurance rating'.
- Further action commissioned by the Assurance Group.

Furthermore:

- Actions required to mitigate risks or improve the level of assurance are identified and incorporated within the forward work programme of the relevant committee.
- The Board and its committees review the framework on a monthly basis to ensure that key risks are identified and seek assurance that appropriate mitigating actions are being taken.
- The Audit Committee reviews aspects of the assurance framework on a regular basis to satisfy itself that appropriate systems of control are being maintained.
- Our corporate reporting template requires all reports to include consideration of a broad range of risks in by completing an impact assessment covering quality, finance, equality & diversity, environment and sustainability.

Key risks to the achievement of our objectives have been regularly reviewed and updated throughout the year by the Board and its committees. The key areas of focus have included:

AIM 1: Delivering safe, high quality services

- Follow-up Backlogs
- Quality Governance
- CQC Compliance
- Medical Equipment
- Infection Control
- Clinical Administration
- CQUINS

AIM 2: Valuing our people

- Safe Staffing
- Culture and Staff Experience
- Core Requirements

- Clinical Education

AIM 3: Providing services in a sustainable way

- Financial Performance
- Operational Performance
- Use of Resources
- Financial Sustainability
- Capital Infrastructure

AIM 4: Working with partners

- System Transformation
- Digital Technology

AIM 5: Maintaining strong governance

- Health and Safety
- Fire Safety
- Emergency Planning
- Cyber Security

Finally, the Trust actively encourages risks and incidents to be reported through our DATIX system. This is evidenced and reviewed through our Integrated Performance Report presented to the Board.

Quality governance arrangements

The Trust has comprehensive quality governance arrangements in place. This includes regular reports to the Board and its committees showing the Trust's performance across a wide-range of safety and quality metrics. The Trust was inspected by the CQC in August-September 2019, with the report published in December 2019. We have again been rated as 'Requires Improvement' overall for our services. Our rating for each of the domains assessed by the CQC is shown below:

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

The Trust no longer has any 'Inadequate' ratings and did not receive any Section 29A Warning Notices as a result of this inspection. One of the previous recipients of a Warning Notice, Diagnostic Imaging, improved from 'Inadequate' to 'Requires Improvement' in the Responsive and Well Led domains. Our Maternity service is now rated 'Good' overall and 'Outstanding' for Caring. It is also the first Maternity service in the peninsula to be rated 'Good' for the Safe domain.

The 'Requires Improvement' rating is based upon 33 critical actions identified as Must Dos which are the focus for the organisation and the action plan. As part of the wider plan relating to ongoing CQC compliance we have also created a plan to address the Should Do actions as advised by CQC which will

be implemented in tandem with the Must Dos.

The Trust's action plan was submitted to CQC in February 2020. The key themes to address within our actions relate to:

- Strengthening our governance framework.
- Compliance with mandatory training.
- Staffing levels.
- Record keeping.

In line with its revised Terms of Reference, the Quality Assurance Committee will receive a monthly update on progress of delivery of the action plan with onward reporting to Safety and Quality Committee and Trust Board.

The Trust continues to be fully registered with the CQC across all of its locations without conditions and continues to monitor compliance across all of the fundamental standards.

We are on a journey of continuous improvement and we continue to monitor, review and constantly improve the quality of care across the services that we provide.

NHS Provider licence

NHS trusts are subject to the equivalent of certain provider licence conditions under NHS Improvement's Single Oversight Framework. The Trust Board has reviewed its compliance with these conditions and continues to monitor its corporate governance arrangements.

The Care Quality Commission (CQC) report published in December 2019 includes information, particularly as part of the 'well-led' assessment, which is relevant to the Trust's governance arrangements. Such issues are incorporated within the action plan referred to previously.

Developing workforce safeguards

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

The People and Culture Committee has been overseeing compliance with national 'Developing Workforce Safeguards' requirements on behalf of the Trust Board throughout 2019/20. The Trust Board received a report on this in November 2019 which highlighted that whilst there is robust assurance around the methodology used to calculate safe numbers of frontline nurses, in other staff groups, there is a lack of national guidance beyond some royal college publications and further work is required in these areas to strengthen the level of assurance.

An action plan has been developed to improve compliance and this continues to be identified as a key risk with the Board Assurance Framework and, as such, will be reviewed by the Trust Board throughout 2020/21.

Managing conflicts of interest

The Trust has conducted a comprehensive review of the 'Managing Conflicts of Interest in the NHS' guidance and has updated its Standards of Business Conduct Policy to reflect this. The Trust has not yet published on its website an up-to-date register of interests for decision-making staff as this is pending the procurement and implementation of a declarations module for our Electronic Staff Record (ESR) system. Notwithstanding this, it is important to note that declarations of interest are recorded for all Trust Board meetings.

Managing data quality and security

The Trust has continued to adopt a pro-active approach to data quality in 2019/20 by maintaining its risk-based approach to assessing the key performance data presented to the Trust Board and subjecting this to independent internal audit scrutiny to test and report on its accuracy, reliability and validity. This includes a rolling programme of audit reviews of the systems and data which underpin reporting against national performance standards such as waiting times.

The Trust recognises the importance of effective leadership in addressing the Cyber Security threat and has established a number of arrangements for ensuring that senior leaders drive this agenda. The Trust has conducted a number of reviews in order to test the adequacy of its Cyber Security arrangements. The Trust Board reviewed the Cyber Security Annual Report in January 2020 which gave assurance that the threats associated with cyber security were being appropriately managed.

NHS Pension Scheme

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

Equality, diversity and human rights legislation

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

Environmental responsibilities

The Trust has undertaken risk assessments and has a draft 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.

Use of resources

The Trust has established arrangements for reviewing and improving economy, efficiency and effectiveness in the use of our resources. We are actively engaged in the national Getting It Right First Time (GIRFT) and Model Hospital work programmes and continue to use benchmarking to identify variation in performance and/or practice. These arrangements were independently assessed as 'Requires Improvement' by NHS Improvement in 2019.

Information governance

All incidents with an Information Governance element are recorded on the Trust Incident Reporting System (DATIX). Incidents are scored by the Information Governance team in conjunction with the Caldicott Guardian and the Senior Information Risk Owner using guidance provided by NHS Digital. Incidents are categorised as either: low impact incidents (very low in severity), local investigation incidents (investigated by the IG team with recommendations and lessons learned) or reportable incidents (which are reported to the Information Commissioner's Office). In 2019/20 there were nine reportable incidents, as follows:

- A patient received a letter with personal information displayed in the window of the envelope.
- A member of staff left a work notebook containing confidential staff information in a public area.
- The address of a patient was revealed to their former partner.
- The Trust sent an email containing a general newsletter to a large distribution list revealing the email addresses of members of the public as the "bcc" function was not used.
- The Trust sent two letters to a patient's mother instead of the adult patient.
- A patient's condition was disclosed to a visitor without consent.
- A member of staff disclosed details about a patient's hospital appointment in a public place.
- A member of staff has passed on information about a patient to mutual friends.
- An email was sent to a distribution list of parents of children with a certain condition containing general information however email addresses were revealed as the "bcc" function was not used.

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

Quality Account

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. This is reviewed by the Trust Board and the Safety & Quality Committee to ensure that it represents a balanced view and that there are appropriate controls in place to ensure the accuracy of data contained within it. The Quality Account is usually subject to an annual review by our external auditors, however, this requirement has been withdrawn in 2019/20 as part of a series of measures to allow NHS organisations to focus on managing the response to the COVID-19 pandemic.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of 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 the information provided in this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and committees of the Board. Executive Directors who have responsibility for the development and maintenance of the system of

internal control also provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant issues

We have much to be proud of in the quality of care that we give to our patients but continue to face severe challenges in a number of key areas. The most significant internal control issues facing the Trust in 2019/20 may be summarised as follows:

- **COVID-19 implications:** Towards the end of the 2019/20 financial year, the Trust, along with the wider NHS, began developing plans for responding to the spread of Coronavirus (COVID-19). This required an unprecedented response from clinical and managerial teams and temporary changes to our governance arrangements. All of these changes are fully documented and in accordance with national guidance.
- **Operational pressures:** The Trust continues to face significant pressure from a sustained increase in the number of emergency attendances and high levels of acuity. The hospital has been under operational distress for a considerable time which has had a major impact on our ability to achieve a number of key national performance standards and/or the improvement trajectories agreed with NHS Improvement.
- **Quality:** We have retained our overall rating of 'Requires Improvement' from the CQC and headline ratings for each domain remain unchanged from the previous inspection. Whilst we have not received any Warning Notices, further work is required to address some issues on a sustainable basis. We have adopted a comprehensive approach to doing this which includes regular reports to the Trust Board.
- **Financial position:** The Trust originally set a break-even budget for 2019/20 but this was revised in October 2019 and the Trust is reporting an in-year deficit (before impairments) of £32 million due to a reduction in income and the loss of Sustainability & Transformation Funding.

Fundamental system transformation is needed if we are to address these challenges and meet the increasing demands on health and social care within the finite resources available. For our part, we will continue to work with other stakeholders within the wider health & social care community to do what is right for the people we serve by better integrating the services they need.

Conclusion

A number of significant internal control issues have been identified in this Annual Governance Statement. My review confirms that whilst many key components of an effective system of internal control are in place as at 31 March 2020, there is still scope for strengthening the Trust's arrangements to provide a sound basis for securing delivery of our objectives. This will continue to be a key area of focus for the Board in 2020/21.

Signed (on behalf of the Trust Board)Ann James
Chief Executive 23 June 2020

REMUNERATION REPORT

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

Salaries and allowances (subject to audit)

2019/20	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£000	£	£	£000	£000
Richard Crompton, Chairman	35-40		2,400			40-45
Michael Leece, Non-Executive Director (see note 1)	5-10					5-10
Henry Warren, Associate Non-Executive Director	5-10					5-10
Giles Charnaud, Non-Executive Director (see note 2)	0-5		900			0-5
Helen Teague, Non Executive Director (see note 3)	5-10					5-10
Estelle Thistleton, Non-Executive Director (see note 4)	5-10		900			5-10
Jacky Hayden, Non-Executive Director	5-10					5-10
Liz Kay, Non-Executive Director	5-10					5-10
Bill Boa, Associate Non Executive Director (see note 15)	**0-5**					**0-5**
Hisham Khalil, Non-Executive Director	0-5	170-175				180-185
Graham Raikes, Non-Executive Director	5-10		1,000			5-10
Ann James, Chief Executive	185-190		600	500		185-190
Kevin Baber, Chief Operating Officer	140-145		100	500		140-145
Neil Kemsley, Director of Finance (see note 5)	25-30		3,300	1,800		30-35
Sarah Brampton, Director of Finance (see note 6)	135-140		600	0	45-47.5	185-190
Steven Keith, Director of People	125-130		100		15-17.5	140-145
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	120-125		200			120-125
Phil Hughes, Medical Director	115-120	75-80	500	500		195-200
Lee Budge, Director of Corporate Business (part time)	80-85		100	400	7.5-10	90-95
Lenny Byrne, Chief Nurse and Director of Clinical Professions	130-135				30-32.5	160-165
Jo Beer, Director in Integrated Care (see note 7)	**105-110**					**105-110**

2018/19	Salary for duties as a director or senior manager (bands of £5,000)	Salary for duties other than as a director or senior manager (bands of £5,000)	Expense payments (taxable) total to nearest £100	Salary sacrifice arrangements total to nearest £100	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£000	£	£	£000	£000
Richard Crompton, Chairman	35-40		2,900			40-45
Michael Leece, Non-Executive Director	5-10					5-10
Elizabeth Raikes, Non-Executive Director (note 8)	0-5		100			0-5
Henry Warren, Associate Non-Executive Director	5-10					5-10
Giles Charnaud, Non-Executive Director	5-10					5-10
Estelle Thistleton, Non-Executive Director	5-10		4,100			10-15
Jacky Hayden, Non-Executive Director	5-10					5-10
Liz Kay, Associate Non-Executive Director (see note 9)	5-10					5-10
Hisham Khalil, Non-Executive Director (see note 10)	0-5	130-135				135-140
Graham Raikes, Non-Executive Director (see note 11)	0-5		100			0-5
Ann James, Chief Executive	185-190		100	500		185-190
Kevin Baber, Chief Operating Officer	140-145			500		140-145
Greg Dix, Director of Nursing (see note 12)	120-125		100			120-125
Neil Kemsley, Director of Finance	135-140		4,200	5,500	15-17.5	160-165
Steven Keith, Director of People	125-130		100		22.5-25	145-150
Nick Thomas, Deputy Chief Executive and Director of Planning & Site Services	110-115		100		7.5-10	115-120
Phil Hughes, Medical Director	110-115	75-80	300	500		190-195
Lee Budge, Director of Corporate Business	85-90			400	20-22.5	105-110
Lenny Byrne, Chief Nurse and Director of Clinical Professions (see note 13)	0-5					0-5

Notes

1 Term of office completed 31 May 2019
2 Term of office completed 30 September 2019
3 Appointed 1 June 2019
4 Term of office completed 30 November 2019
5 Left the Trust 16 June 2019
6 Appointed 15 April 2019
7 Appointed Director of Integrated Care 1 May 2019
8 Term of office completed 24 September 2018
9 Invoiced by the University of Plymouth until 31 January 2019; on Trust payroll from 1 February 2019
10 Existing Trust employee appointed as non-executive director from 31 July 2018. This note covers only the period from that date.
11 Appointed 25 September 2018
12 Left the Trust 31 March 2019
13 Appointed 25 March 2019
14 Salary for duties as director includes only that proportion of remuneration relating to non clinical duties as a director or senior manager of the Trust. All remuneration for clinical work undertaken during the period is disclosed as other remuneration.
15 Appointed 23 March 2020
16 Expense payments are expenses allowances that are subject to UK income tax

Pension Benefits (subject to audit)

Name and title	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2010 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Real Increase in Cash Equivalent Transfer Value £000
Ann James, Chief Executive (see note 1)							
Phil Hughes, Medical Director (see note 1)							
Kevin Baber, Chief Operating Officer (see note 1)							
Nick Thomas, Director of Planning & Site Services	0	0	50-55	155-160	1,240	1,193	8
Lee Budge, Director of Governance (see note 2)	0-2.5	0	10-15	0	193	173	5
Steven Keith, Director of People	0-2.5	0	35-40	80-85	729	678	16
Sarah Brampton, Director of Finance	2.5-5	0-2.5	40-45	90-95	733	661	34
Jo Beer (see note 1)							
Lenny Byrne, Chief Nurse and Director of Clinical Professions	0-2.5	0-2.5	25-30	65-70	478	427	22

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

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

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

University Hospitals Plymouth NHS Trust
@UHP_NHS

A nurse-led improvement project in Derriford Hospital's Emergency Department is changing the way patients with cardiac conditions experience urgent care. #PeopleFirst

bit.ly/HeartFailurePilot

Fair Pay (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce.

The salaries and allowances table above shows that the highest paid director was the medical director, whose total remuneration fell into the £195,000 - £200,000 band (2018-19 £190,000 - £195,000). The mid-point of this band was 8.2 times (2018-19 6.9) the median remuneration of the workforce, which was £24,214 (2018-19 £28,050.) The range of remuneration was from £7,626 to £283,989 (2018-19 £7,235 to £281,020.) The movement in this measurement was caused by the bringing back in house of the Trust's hotel services arrangements during the year.

In 2019-20 eighteen employees (2018-19 fifteen) received total remuneration in excess of the highest paid director's, with total remuneration ranging from £198,263 - £283,989 (2018-19 range £194,600 - £281,020.)

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

Off payroll engagements (not subject to audit)

There were no off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months.

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

	Number
Number of new engagements, or those that reached six months duration between 1 April 2019 and 31 March 2020	1
Of which	
Number assessed as caught by IR35	1
Number assessed as not caught by IR35	0
Of which	
Number engaged directly (via PSC contracted to the Trust)	1
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

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

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

Exit packages (subject to audit)

	Number of compulsory redundancies 2019/20	Total number of exit packages 2019/20	Total number of exit packages 2018/19
Exit package cost band (including any special payment element) <£10,000	1	1	-
Total number of exit packages by type	1	1	-
Total cost (£)	£3,000	£3,000	

Analysis of staff costs (subject to audit)

	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	271,526	1,611	273,137	247,672
Social security costs	27,278	-	27,278	24,784
Apprenticeship levy	1,333	-	1,333	1,208
Employer's contributions to NHS pensions	46,243	-	46,243	29,074
Pension cost - other	95	-	95	-
Temporary staff	-	20,133	20,133	18,447
Total gross staff costs	**346,475**	**21,744**	**368,219**	**321,185**
Recoveries in respect of seconded staff	-	-	-	(1,716)
Total staff costs	**346,475**	**21,744**	**368,219**	**319,469**
Of which				
Costs capitalised as part of assets	2,180	90	2,270	2,353

Average staff numbers (subject to audit)

			2019/20	2018/19
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	1,030	7	1,037	1,097
Ambulance staff	-	-	-	3
Administration and estates	1,724	73	1,797	1,468
Healthcare assistants and other support staff	1,214	187	1,401	1,111
Nursing, midwifery and health visiting staff	1,837	153	1,990	1,970
Nursing, midwifery and health visiting learners	-	-	-	1
Scientific, therapeutic and technical staff	1,170	21	1,191	1,220
Other	7	-	7	8
Total average numbers	**6,982**	**441**	**7,423**	**6,878**
Of which:				
Number of employees (WTE) engaged on capital projects	51	4	55	72

Consultancy (not subject to audit)

Expenditure on consultancy in 2019/20 was £607,000 (2018/19 £489,000.)

Signed:

Ann James
Chief Executive

The Trade Union (Facility Time Publication Requirements) Regulations 2017
University Hospitals Plymouth NHS Trust Response for Period 1 April 2019 to 31 March 2020

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

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

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
47	**42.16**

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

Percentage of time	Number of employees
0	12
1-50%	33
51-99%	1
100%	1

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

	Figures
Provide the total cost of facility time	£171,699
Provide the total pay bill (as defined by the Trade Union (Facility Time Publication Requirements) Regulations 2017)	£326,574,840
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.05%

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

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**7.45%**

OUR FINANCIAL STATEMENT AND NOTES

Our Financial Statement and Notes

Strategic Report 1 April 2019 to 31 March 2020

Finances
The Trust set itself a challenging financial plan for the year. The plan was to break even, which was compliant with the control total set by NHS England (NHSE). To achieve this the Trust needed to deliver a Financial Improvement Programme (FIP) of £25.5m and ensure that other risks highlighted in its operational plan were managed. Within the plan the Trust was required to achieve an underlying deficit position of £22.4m to enable it to receive a further £22.4m of national funding in the form of £6.5m of Marginal Rate Emergency Threshold (MRET) funding, which was granted following the acceptance of the control total, and £9.1m Provider Sustainability Funding (PSF) and £6.9m Financial Recovery Fund (FRF), both of which were contingent on achievement of the financial plan.

In October 2019 it became apparent that the Trust would not meet the challenging financial plan set and it submitted a revised forecast outturn for the year to NHSE of a deficit of £32.4m. This reflected a variance from its underlying financial plan of £22m and then a loss of PSF and FRF funding of £10.5m as a result. The Trust reported a final position in line with its forecast of £32.9m, with an adverse movement of only £0.6m as a result of an increase in the assessment of untaken staff leave at the end of March due to the preparations required for the COVID-19 outbreak. The Trust position reflects a deterioration of £5.8m from the previous year's deficit of £27.1m.

The 2019-20 position including technical adjustments was a deficit of £62.8m. These adjustments include an impairment of £24m following a revaluation of the Trust's main hospital site which reflected an updated assessment of the site's notional sizing, an adjustment for an impairment for the unforeseen obsolescence due to the changing technological advances in clinical systems of the Trust's e-Notes capital project of £6.4m, and an adjustment to the final PSF allocated to the Trust from the previous year of £0.5m.

2019-20 Income and Expenditure Performance	Plan £M	Actual £M	Variance £M
Underlying Income and Expenditure Performance	(22.4)	(44.4)	(22.0)
Increase in Annual Leave due to COVID-19 preparations	0.0	(0.6)	(0.6)
Marginal Rate Emergency Threshold income (MRET)	6.5	6.5	0.0
Provider Sustainability Fund (PSF)	9.1	3.4	(5.7)
Financial Recovery Fund (FRF)	6.9	2.2	(4.7)
Trust Income and Expenditure Performance	0.0	**(32.9)**	**(32.9)**
Revaluation Impairment	0.0	(24.0)	(24.0)
e-Notes Impairment	0.0	(6.4)	(6.4)
PSF allocation for previous year received in 2019-20	0.0	0.5	0.5
Final Trust Income and Expenditure Performance	**0.0**	**(62.8)**	**(62.8)**

The adverse financial position of £22m was driven by the following factors:

1. An under-delivery on savings plans of £4.5m. The Trust achieved a financial improvement plan of £21.0m (3.4%) against a target of £25.5m (4.3%).
2. A variance on service delivery budgets of £8.6m. This includes £3.7m contract underperformance primarily due to lower than planned elective activity driven by staffing vacancies in some critical areas and the consultant pension tax issue, and operational pressures within the hospital that led to high number of theatre cancellations. Although non-elective activity was below plan, acuity of patients increased, which kept emergency bed occupancy at extremely high levels throughout the year and this impacted on the Trust's ability to deliver planned care. This also influenced an overspend on expenditure budgets of £4.9m, which included increased medical bank and locum costs covering wards.
3. An adverse variance of £8.8m on other budgets, which includes a £3.2m depreciation increase from a technical accounting change regarding asset lives and a further depreciation overspend of £1m for the impact of revaluations carried out at the end of 2018-19. The remaining variance includes various other pressures including the £0.5m write off of the Theatre Information Management System costs and a reduction in injury cost recovery income of £1m.

Although it is disappointing not to achieve our original financial target, through a combination of improved efficiency, innovations, income generation and strict financial controls, we delivered £21m of internal financial improvement plans. The Trust also, until the impact of the COVID-19 outbreak in March, broadly maintained its operational performance despite ever-increasing demand and acuity.

Overview of income and expenditure position

2019-20 Financial Plan

The Trust was set a financial control total by NHSE of a breakeven position. This reflected a significant improvement from the previous year's deficit position of £27.1m. Although the financial plan reflected a significant increase in income for an increase in tariff (which incorporated elements of the Provider Sustainability Fund within it, the new allocation of MRET of £6.5m and the new Financial Recovery Fund of £6.9m) the Trust still had a FIP target of £25.5m. This was to offset the impact of the loss of non-recurrent income from 2018-19, and to offset the impact of cost pressures where inflation funding did not cover expected increases in costs. The FIP programme was also required to cover the loss of tariff income for the new central procurement top slice, the efficiency factor included in the national tariff and a reduction in income for the Clinical Negligence Scheme for Trusts (CNST). The Trust also identified a number of internal cost pressures. including additional IT investment requirements, operating leases for essential equipment replacement and the increased cost of bringing the Trust's hotel services contract back in house.

The Trust's financial plan also included cost and income increases of £18.7m to account for the increase in clinical services required to be delivered and reflecting increased demand and requirements to ensure planned performance trajectories were met. 2019-20 also saw an increase in the NHS employer's pension contribution from 14% to 20%. This increase was funded and transacted centrally by NHSE on behalf of the Trust.

The summarised movement of the Trust's planned income and expenditure to improve the position by £27.1m is shown below:

Planned Income Movements	£M
Loss of Non Recurrent Income	
Loss of PSF received in 2018-19	(6.1)
Loss of other non-recurrent contract income	(9.2)
Income Increases for 2019-20	
Contract tariff for increased clinical activity volumes	18.7
Full year impact of Orthopaedic Partnership and other service transfers	5.9
Increase in national tariff income for inflation	13.3
Increase in national tariff incorporating PSF and MFF increases	10.2
Other changes in Tariff including efficiency factor, procurement topslice and CNST reductions	(5.5)
Central income to cover increase in NHS Pension Employers Contribution	14.0
Financial Improvement Plan	6.2
Marginal Rate Emergency Threshold income (MRET)	6.5
Provider Sustainability Fund (PSF)	9.1
Financial Recovery Fund (FRF)	6.9
	70

Planned Income Movements	£M
Investments in capacity to deliver the growth in contracted clinical activity service levels	18.7
Full year impact of Orthopaedic Partnership and other service transfers	5.9
Increase in NHS Pension Employers Contribution	14.1
Non-pay inflation increases	14.0
Contract tariff for increased clinical activity volumes	3.9
Cost pressures including equipment leases, hotel services and IT investments	5.6
Financial Improvement Plan	(19.3)
	42.9

The Trust's £25.5m FIP was made up of targeted additional income of £6.2m and cost savings of £19.3m. Income increases were targeted through a range of measures including increased clinical activity and a further increase in commissioner income for structural funding issues. Cost savings were to be delivered through a number of workstreams including theatre and outpatient productivity programmes, agency reductions, procurement, savings against activity growth costs, alternative workforce models, estates, support services and drugs costs.

At the time the plan was set, the Trust was aware of some risks to its financial performance. This included an outstanding conclusion of the contracting process with Devon CCG, clarification of further guidance regarding a change in national guidance on the assessment of the useful life of its buildings, the final impact of legacy contracting arrangements with commissioners from 2018-19 and a number of further cost pressures for which further mitigation measures were being sought.

2019-20 Financial Results

In October 2019 it became apparent that the Trust would not meet the challenging financial plan set and submitted a revised forecast outturn for the year to NHSE of a deficit of £32.4m. This reflected a variance from its underlying financial plan of £22m and then a loss of PSF and FRF funding as a result of £10.5m. The Trust reported a final position in line with its forecast of £32.9m, with an adverse movement of only £0.6m as a result of an increase in the assessment of untaken staff leave at the end of March due to the COVID-19 outbreak and the preparations required to deal with the pandemic.

The Trust has an overall cumulative deficit (taking each year with the next) of £137.3m. This means that as expected the Trust has broken its statutory duty to break-even. As required in this case, the Trust's auditors notified the Secretary of State with a Section 30 Notice to this effect.

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

Statement of Comprehensive Income	2019-20 £000s	2018-19 £000s	Diff £000s
Revenue from patient care activities	503,911	452,530	51,381
Other operating revenue	67,581	57,771	9,810
Total Income	**571,492**	**510,301**	**61,191**
Gross employee benefits	(361,500)	(313,612)	(47,888)
Other operating costs	(221,043)	(205,605)	(15,438)
Depreciation and Amortisation	(16,521)	(12,778)	(3,743)
Total Expenditure	**(599,064)**	**(531,995)**	**(67,069)**
Operating surplus/(deficit)	**(27,572)**	**(21,694)**	**(5,878)**
Investment revenue	150	112	38
Other gains and (losses)	12	9	3
Finance costs	(2,682)	(2,313)	(369)
Public dividend capital dividends payable	(1,592)	(3,195)	1,603
Impairments and reversals	(31,172)	4,234	(35,406)
Retained surplus/(deficit) for the year	**(62,856)**	**(22,847)**	**(40,009)**

Retained surplus/(deficit) for the year	**(62,856)**	**(22,847)**	**(40,009)**
Impairments/(Impairments Reversals)	31,172	(4,234)	35,406
Adjustments in respect of donated asset reserve elimination	(154)	(85)	(69)
Retain impact of DEL I&E (impairments) / reversals	(631)	-	(631)
Remove impact of prior year PSF post accounts reallocation	(480)	-	(480)
Adjusted retained (deficit)	**(32,949)**	**(27,166)**	**(5,783)**

Income

The majority of revenue from patient care activities comes from NEW Devon and Kernow Clinical Commissioning Groups (commissioning services for the local population) and NHSE who commission specialist, dental and screening services. In 2019-20 the Trust treated 70,244 elective patients, 58,427 non elective patients and delivered over 570,000 outpatient appointments. The Emergency Department had 103,964 attendances with another 41,187 at the Trust's Minor Injury Units.

Within planned care, elective activity was only 373 spells below plan, but the case mix of the activity delivered was below plan by £4.7m. This is reflective of some services that have had delays in implementing additional capacity plans driven by staffing vacancies in some critical areas and the consultant pension tax issue, but also reflects the fact that elective capacity has been restricted during

periods in the year as operational pressures have limited bed capacity. This performance also reflects a significant reduction of activity at the end of March due to the cancellation of routine surgery to enable the preparations for the COVID-19 pandemic to take place. Although below plan, total elective activity actually increased by nearly 7,000 spells (10%) compared to the previous year. Although 1,200 cases were due to the full year impact of the Plymouth Orthopaedic Partnership with Care UK, there was a significant increase in Endoscopy of over 3,000 spells. Cardiac Surgery and Cardiology also increased their activity through their partnerships with the independent sector. At the end of the year outpatients was below plan by 4,560 attendances. There were various over and under performances in specialties, but again there was an overall increase from the previous year of 23,000 (4%). The Trust saw an increase in non-face-to-face contacts of 20% due to new programmes implemented during the year, and then as a result of the COVID-19 pandemic. The performance against the Trust's key operational performance standards was broadly similar to the previous year until the impact of the COVID-19 pandemic in March.

Within urgent care, Emergency Department activity slightly reduced from the previous year although some changes were made to the way activity that came though the Trust's Acute Admissions Unit (AAU) was recorded. Generally non-elective activity was also reduced from the previous year. Although non-elective activity was below plan, acuity of patients increased, and there was a significant growth in patients aged over 75. This kept emergency bed occupancy at extremely high levels throughout the year which impacted on the Trust's ability to deliver planned care.

Revenue from patient care activities increased by £51.4m in 2019/20 (11%). As mentioned above, income was expected to increase significantly because of the increases in the tariff for PSF that was now reflected in tariff, inflation increases, contract growth and funding for the increase in employers pension contributions.

Other operating revenue increased by £9.8m (16%). This was due to the new MRET and FRF income which was £6.4m greater than the PSF received the previous year. The final income achieved is actually below the increase expected, because the Trust did not receive £10m of PSF and FRF income due to its financial performance.
This category also includes £30.0m of income derived from education, training and research (R&D) activities, including the training of junior doctors and nursing staff. The balance represents income generated from clinical and general services provided by the Trust to other organisations and from charges for the use of Trust services and facilities. This income has increased as R&D has grown by £0.7m. Other areas have also increased, with inflation and additional education income awarded to the Trust for specific programmes including nurse apprenticeships. Education income has also increased due to a refinement to the way the Trust accounts for GP trainees that it hosts for the locality, and recharges to other organisations.

Expenditure

With over 6,400 permanently employed whole time equivalent (WTE) staff, pay costs, including salaries, national insurance and pension contributions, comprise the majority of the Trust's operating expenses and account for over 60% of the Trust's total expenditure. Staff costs increased by £47.9m from 2018-19. The primary reason for the increase is, as expected, staff increments and inflation increased by £14.1m in line with nationally agreed pay scales and there was also a £14m increase for the uplift in NHS Employers Pension contributions. There was also a significant increase of £6m for the transfer of the Trust's hotel

services staff from an outsourcing contract arrangement to be part of the Trust. The remaining increase also includes £1.2m for GP Trainees in the locality for which the Trust hosts their employment.

The average number of staff employed during the year increased by 510 WTE, 300 of which were support for clinical staff incorporating the part year effect of the hotel services transfer (c600 increase for half the year). The remaining cost and staff of 210 WTE and £12.6m reflects more staff to treat the additional numbers of patients. This included increased ward staffing due to successful international recruitment drives carried out in the second half of the year that has seen nursing numbers rise by over 100. Temporary staffing has remained similar to last year overall, although expenditure on agency staff has further reduced in 2019-20 from £5.6m to £4.2m as the Trust increased its use of local bank staff and continued to reduce the hourly rates paid.

Non-pay costs incurred in 2019-20 totalled £221.0m, an increase of £15.4m. The most significant area of cost increases was for the purchase of healthcare services from non NHS bodies, up by £10.9m. This included £5.9m for increased costs relating to a full year of the Care UK partnership which started in November 2018. The partnership, involving Trust staff and independent sector staff working together, has helped to ensure the Trust was able to maintain elective Orthopaedic services during the winter period and for other work to be carried out within the hospital. The Trust also entered into two similar arrangements during 2019-20. It has entered a partnership arrangement with the independent provider Spire to undertake cardiac surgery to ensure waiting lists were reduced, which has increased costs by £1.8m. The Trust also opened the Peninsula Heart Clinic on the hospital site in partnership with Regents Park to increase delivery of elective cardiology services, increasing costs by £1.1m. There was also a further increase in costs related to outsourcing arrangements for diagnostic services, with increased expenditure on imaging reporting and additional scanning capacity along with increased endoscopy capacity totalling £1.3m. This cost has helped the Trust to increase compliance against the diagnostic target to ensure that a greater proportion of diagnostic tests are carried out within 6 weeks of referral.

Costs also increased for inflationary pressures that were expected to be £3.9m. This pressure was most notable in utilities where inflation has been significantly above RPI. Premises costs also increased due to increased IT investments, which included a new lease agreement to replace out of date PCs. A further £3.1m of the increase is in high cost drugs reflecting increased use of Homecare Drugs. Clinical supplies and services increased by £3.3m due to the impact of inflation and the increase in clinical activity. Costs reduced within general supplies and services reflecting the transfer of the hotel services contract to an in-house service with £5.5m of costs transferring to pay. There was also a reduction in the CNST premium of £1.1m because NHS Resolution were able to give Trusts a rebate due to lower than expected costs in recent years.

The Trust had an increase in depreciation of £3.7m which includes £3.2m depreciation increase from a technical accounting change regarding asset lives and further depreciation pressure for the impact of revaluations carried out at the end of 2018-19. The movement in the Trust's financing costs reflect increased interest payments from cash loans that supported the deficit position and a significant reduction in PDC dividend charges as a result of the reduction in the value of the Trust's buildings due to the impairment.

Savings Plans

The Trust achieved a financial improvement plan of £21.0m (3.4%) against a target of £25.5m (4.3%).

Scheme	£M
Organisational Productivity	**4.5**
Contractual Income Opportunities	1.8
Medical Workforce	1.0
Theatre Productivity	0.4
Outpatient Utilisation	0.1
Length of Stay	1.1
Support Services Programmes	**1.5**
Imaging Transformation	0.2
Pathology	0.4
Other Support Service Line Programmes	0.9
Cost reduction Programmes	**11.9**
Agency Savings	1.5
Overseas visitors and Private Patient	0.1
Pharmacy drug savings	2.1
Procurement savings	2.1
Bed Watch cost reductions	0.4
Other Frontline Service Line Programmes	5.6
Corporate Programmes	**3.1**
Estates	1.3
Corporate Services Review	0.7
Technical Financial Savings - reduced PDC Interest	1.1
Total	**21.0**

Cash and Working Capital

The Trust's cash plan for the year reflected the utilisation of the £2.9m brought forward balance on capital expenditure to end the year with a reduced balance of £1m. The actual balance stands at £6.4m, an increase of £3.5m from plan which reflects later than planned capital spend in March for which cash payments have yet be processed. Inventory increased during the year by £0.9m in part as a result of reduced activity levels in March due to COVID-19 preparations, meaning less stock was used than expected.

The Trust originally planned to have limited cash support other than that required to support it in lieu of PSF and FRF payments. However, due to the variance from plan and the deficit position, the Trust was awarded £34.3m of revenue cash support loans. The funding has allowed the Trust to continue with good performance against the Better Payment Practice Code with 96% of invoices paid within the required time. The Trust has paid the required 3.5% dividend on public assets employed.

Capital Investments

The Trust spent £26.7m of capital which was funded from internally generated funds including depreciation of £16.1m, finance leases of £1.9m and public dividend capital (PDC) of £7.1m.

The Trust was awarded £3.5m of PDC funding for the construction of two 3T MRIs. This project is underway with completion expected in August and the remaining funding to be drawn down next year. The Trust also received funding from the NHS Energy Efficiency Fund of £0.5m to complete the installation of LED lighting in non-clinical areas. A further £1.0m capital PDC was awarded to the Trust for urgent care to help overall patient flow with the Discharge Lounge operational since 14th December. During October the Trust was awarded two further allocations of £0.2m and £0.1m for winter diagnostic equipment and in December a further £1.1m to replace MRI East which was purchased in March. Finally an allocation of £0.5m was received to support the completion of works on the Lind Unit for additional Planning Investigation Unit beds. The Trust has been awarded a further £0.6m capital for COVID-19 preparation which included essential equipment for critical care and additional laptops to support home working.

The Trust has been successful in applying for additional Capital Resource Limit (CRL) using finance lease funding for the theatre air handling improvements and for the electrical substation.

The Trust's internally funded programme included continued spend to build up the business cases for the Hybrid Theatres project and Transformation of Urgent and Emergency Care project for which the Trust has been provisionally allocated national STP funding. Other projects included essential estates backlog maintenance and IMT projects including the initial implementation of electronic prescribing.

Capital Spend	£M
Interventional and Hybrid Theatres Project	2.1
Transformation of urgent and emergency care	1.1
Estates maintenance	4.1
IM&T projects	3.6
Rolling equipment replacement	1.3
Other projects	7.4
Electrical infrastructure	2.0
Energy Efficiency	0.6
3rd MRI	0.9
Discharge lounge	1.1
Planned Investigation Unit expansion	0.5
Further diagnostic funding	0.3
MRI replacement funding	1.1
COVID-19	0.6
Total	**26.7**

Future Plans

Due to the COVID-19 outbreak the Trust, along with the rest of the NHS, did not complete its annual planning process. The Trust has been informed of interim financial arrangements put in place by the NHSE for the period to 31st October 2020 to ensure that Trust has the means required to respond to the pandemic. This involves ensuring the Trust has sufficient funds to achieve a breakeven position, cover the financial impact of COVID-19 on its services and to fund any reasonable expenditure required to respond to it. The Trust will also receive the additional capital funds that are required.

Prior to the outbreak the Trust had been working with its partners across Devon as part of the Devon Sustainability and Transformation Partnership (STP) to deliver the NHS long term plan for the county. The STP submitted a plan in January 2020 which included the delivery of a four year financial recovery plan. The plan provided the strategic pathway to ensure that all partners work together to restore operational and financial sustainability. Key elements include actions to reduce elective and outpatient referrals and actions to reduce and manage emergency admissions effectively, including reducing the number of patients awaiting transfer to alternative care settings. In line with this plan the Trust submitted a draft financial plan of a £37.7m deficit (before any further national funding) in early March.

As part of this work the Trust set up a Corporate Recovery Unit to ensure that an operational and financial recovery plan was fully developed and delivered. The Trust has a number of workstreams within its FIP including reducing the length of stay of its emergency patients and ensuring that productivity programmes in elective care and theatres are delivered. The plan also focuses on developing alternative

outpatient pathways, procurement savings and tackling high temporary staffing costs. This work has, and will, continue during the COVID-19 pandemic to ensure that the Trust emerges with a sustainable financial position; it will also ensure that any best practice that has been prompted by the pandemic, for example increased non-face to face outpatients and reduced hospital occupancy, is further developed as part of its plan. The Trust will be using these efficiency programmes, together with the financial framework to be confirmed by NHSE for the remainder of the year and beyond, to ensure that it is in a strong position to achieve financial sustainability and recover and improve operational performance levels in the future.

Despite the adverse trading in 2019-20 and the current interim financial arrangements, the Trust remains a going concern and this status is supported by both NHSE and the External Auditors. The Trust will continue to provide the services currently commissioned and will continue to receive the financial support required to ensure cash flow is maintained. In early April 2020 the Trust received confirmation of a new cash regime being introduced by NHSE and DHSC for 2020-21. This confirms that historic debt will be transferred to PDC in September 2020 and that future financial support from April 2020 (if required) will be made available and given as PDC funding.

University Hospitals Plymouth NHS Trust

Annual Accounts for the year ended 31 March 2020

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed Chief Executive

Date 23 June 2020

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Chief Executive
23 June 2020

Finance Director
23 June 2020

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

Report on the Audit of the Financial Statements

Qualified opinion

We have audited the financial statements of University Hospitals Plymouth NHS Trust (the 'Trust') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

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

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

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic we did not observe the counting of physical inventories at the end of the year. We were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities held at 31 March 2020, which have a carrying amount in the Statement of Financial Position of £13.132m, by performing other audit procedures. There may be an impact on the valuation of drug costs and consumables costs for the same reason.

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

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant

uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

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

Material uncertainty related to going concern

We draw attention to note 1.2 in the financial statements, which states that, although the Trust's view is that the current Covid 19 financial arrangements are likely to be extended to October 2020, the specific NHS financial regime beyond this is unknown. Given the limited cash reserves of the Trust and underlying deficit position the Trust is likely to require some form of cash support under this framework. These events or conditions, along with the other matters as set forth in note 1.2 indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Emphasis of Matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.22 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As disclosed in Note 1.22 to the financial statements, some uncertainty associated to the valuation of the Trust's land and buildings does exist, and a relatively small variation could have a material impact on the accounts.

Our opinion is not modified in respect of this matter.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that

there is a material misstatement of the other information, we are required to report that fact.
As described in the basis for qualified opinion section of our report, we were unable to obtain sufficient appropriate audit evidence regarding the inventory quantities, which have a carrying amount in the Statement of Financial Position of £13.132m at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

Other information we are required to report on by exception under the Code of Audit Practice
Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the National Health Service Act 2006; and
- except for the possible effects of the matter described in the basis for qualified opinion section of our report, based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.
- Matters on which we are required to report by exception
- Under the Code of Audit Practice, we are required to report to you if:
- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.
- We have nothing to report in respect of the above matters except on 18 March 2020 we referred a matter to the Secretary of State under sections 30 (a) and 30 (b) of the Local Audit and Accountability Act 2014 in relation to the Trust's expected breach of its statutory break-even duty for the three-year period ending 31 March 2020 and that the Trust had no plans to achieve cumulative financial balance over the period to 2021/22 which would lead to an ongoing breach of the Trust's

breakeven duty for the three year-periods ending 31 March 2021 and 31 March 2022.

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

The Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matter described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects University Hospitals Plymouth NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion
Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- In five of the last six years the Trust has not achieved its statutory break-even duty and its cumulative deficit as at 31 March 2020 was approximately £137m.

- When the Trust set its original budget for 2019/20, it expected to achieve a break-even position.
- The break-even budget for 2019/20 included the achievement of a savings target of £25.6m. The delivery of the break-even position was also reliant on allocations of £9.1m from the Provider Sustainability Fund (PSF) and £6.9m from the Financial Recovery Fund (FRF), although both of these were contingent on the Trust achieving its financial plan.
- In October 2019 it became apparent that the Trust would not meet the original financial plan it had set and it submitted a revised forecast outturn for the year to NHS England, which showed a deficit of £32.4m. The Trust reported a deficit for the year of £32.9m.
- The key reasons for the variance against the original budget were the loss of £10.5m from the PSF and FRF support, under-delivery of £4.5m against the savings plans, service delivery challenges including income reduction of £3.7m and increased medical bank and locum costs of £4.9m and increased depreciation of £4.2m, largely as a result of asset life changes.
- The original budget for 2019/20 was not realistic and efforts to tackle this issue during the year were insufficient to address the Trust's underlying financial pressures.

These matters identify weaknesses in the Trust's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures and the delivery of financial savings plans. They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we

undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of University Hospitals Plymouth NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

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

Bristol
24 June 2020

Statement of Comprehensive Income

	Note	2019/20	2018/19
		£000	£000
Operating income from patient care activities	3	503,911	452,530
Other operating income	4	67,581	57,771
Operating expenses	7, 9	(630,236)	(527,761)
Operating (deficit) from continuing operations		**(58,744)**	**(17,460)**
Finance income	12	150	112
Finance expenses	13	(2,682)	(2,313)
PDC dividends payable		(1,592)	(3,195)
Net finance costs		**(4,124)**	**(5,396)**
Other gains	14	12	9
(Deficit) for the year		**(62,856)**	**(22,847)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(3,093)	-
Revaluations	16	99	3,334
Total comprehensive (expense) for the period		**(65,850)**	**(19,513)**

The following table is a note to the accounts:

Adjusted financial performance (control total basis):		
(Deficit) for the period	(62,856)	(22,847)
Remove net impairments not scoring to the Departmental expenditure limit	30,541	(4,234)
Remove I&E impact of capital grants and donations	(154)	(85)
Remove 2018/19 post audit PSF reallocation (2019/20 only)	(480)	
Adjusted financial performance (deficit)	**(32,949)**	**(27,166)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	15	3,276	788
Property, plant and equipment	16	199,725	225,613
Receivables	20	3,337	2,878
Total non-current assets		**206,338**	**229,279**
Current assets			
Inventories	19	13,132	12,220
Receivables	20	26,680	27,475
Cash and cash equivalents	21	6,393	2,960
Total current assets		**46,205**	**42,655**
Current liabilities			
Trade and other payables	22	(49,192)	(46,011)
Borrowings	24	(142,649)	(30,156)
Provisions	26	(231)	(283)
Other liabilities	23	(2,684)	(2,502)
Total current liabilities		**(194,756)**	**(78,952)**
Total assets less current liabilities		**57,787**	**192,982**
Non-current liabilities			
Borrowings	24	(2,649)	(79,032)
Provisions	26	(1,020)	(1,100)
Total non-current liabilities		**(3,669)**	**(80,132)**
Total assets employed		**54,118**	**112,850**
Financed by			
Public dividend capital		207,666	200,548
Revaluation reserve		7,597	10,870
Other reserves		652	652
Income and expenditure reserve		(161,797)	(99,220)
Total taxpayers' equity		**54,118**	**112,850**

The notes on pages 6 to 46 form part of these accounts.

Name Ann James

Position Chief Executive

Date 23 June 2020

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

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

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**197,825**	**7,663**	**652**	**(76,500)**	**129,640**
(Deficit) for the year	-	-	-	(22,847)	**(22,847)**
Other transfers between reserves	-	(127)	-	127	**-**
Revaluations	-	3,334	-	-	**3,334**
Public dividend capital received	2,723	-	-	-	**2,723**
Taxpayers' and others' equity at 31 March 2019	**200,548**	**10,870**	**652**	**(99,220)**	**112,850**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Other reserves

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating Deficit		(58,744)	(17,460)
Non-cash income and expense:			
Depreciation and amortisation	7.1	16,521	12,778
Net impairments	8	31,172	(4,234)
Income recognised in respect of capital donations	4	(587)	(476)
Decrease in receivables and other assets		452	3,561
Increase in inventories		(912)	(594)
Increase in payables and other liabilities		1,589	3,543
Decrease in provisions		(125)	(79)
Net cash flows used in operating activities		**(10,634)**	**(2,961)**
Cash flows from investing activities			
Interest received		150	112
Purchase of intangible assets		(4,429)	(115)
Purchase of PPE and investment property		(18,440)	(20,017)
Sales of PPE and investment property		21	31
Net cash flows used in investing activities		**(22,698)**	**(19,989)**
Cash flows from financing activities			
Public dividend capital received		7,118	2,723
Movement on loans from DHSC		34,306	23,481
Movement on other loans		(170)	409
Capital element of finance lease rental payments		(31)	(30)
Interest on loans		(2,550)	(2,206)
Other interest		-	(14)
Interest paid on finance lease liabilities		(25)	(27)
PDC dividend paid		(1,883)	(2,646)
Net cash flows from financing activities		**36,765**	**21,690**
Increase / (decrease) in cash and cash equivalents		**3,433**	**(1,260)**
Cash and cash equivalents at 1 April		**2,960**	**4,220**
Cash and cash equivalents at 31 March	21	**6,393**	**2,960**

Notes to the Accounts (see also note at foot of Statement of Comprehensive Income on page 1)

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.2 Going concern
These accounts have been prepared on a going concern basis.

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative than, the dissolution of the Trust without the
transfer of its services to another entity.

As directed by the 2019/20 Department of Health Group Accounting Manual, the directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The directors also consider that the financial framework put in place by NHS England including the availability of the Financial Recovery Fund, the availability of PDC cash support and the repayment of historical debt, as well as the interim COVID-19 financial arrangements put in place until July 2020, are also evidence that the Trust will have adequate resources to continue in operational existence in the immediate future. It is, however, acknowledged that, although the current Covid financial arrangements are likely to be extended to October 2020, due to Covid the specific NHS financial regime beyond this is unknown. Given the limited cash reserves of the Trust and underlying deficit position the Trust is likely to require some form of cash support under this framework. Therefore, although we are

confident that this funding will be forthcoming it does represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern.

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time. The Trust also has contracts with other bodies for non healthcare services and recognises income received in relation to performance obligations satisfied in year.

Revenue from research, education and training contracts

Where research, education and training 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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.4 Other forms of income

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

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme

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

payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

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

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

Subsequent expenditure

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

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly

attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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

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.

Assets under construction are valued at cost, representing the cost to date of building projects or other assets not yet brought into use.

Depreciation

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

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

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

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

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 all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

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

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

[[[Useful lives of property, plant and equipment
Min life Max life
Years Years
Buildings, excluding dwellings 5 61
Plant & machinery 2 35
Transport equipment 7 7
Information technology 3 16
Furniture & fittings 5 20]]]

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

Note 1.8 Intangible assets
Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

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

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

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

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

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

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful

lives are shown in
the table below:

	Min. life Years	Max. life Years
Software licences	3	11
Licences & trademarks	3	11

Note 1.9 Inventories
Inventories are valued at current cost. This is considered to be a reasonable approximation to net realisable value due to the high turnover of stocks.

Note 1.10 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument.

The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Classification and measurement

Financial assets are measured at amortised cost.

Financial liabilities are measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

For financial assets that have become credit impaired since initial recognition, 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 credit losses relating to other NHS bodies are not recognised, in accordance with NHS regulations.

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

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

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

Note 1.12 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 an item of property plant and equipment.

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

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

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

The Trust as a lessor

Operating leases

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

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount

rate of minus 0.5%
in real terms.

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

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

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

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

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or moreuncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise Or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans

Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.16 Value added tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Foreign exchange
The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

Note 1.18 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.19 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been adopted early in 2019/20.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted
IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% 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 2021 for existing finance leases.

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

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020.

Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable.

However, the Trust does expect this standard to have a material impact on non-current assets, liabilities

and depreciation.

Note 1.21 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:
Land and buildings are valued on a Modern Equivalent Asset basis. Judgement has been applied in determining that an alternative site in Estover on the oustskirts of Plymouth is appropriate for the land valuation and in assessing the smaller footprint than the actual Derriford building which a modern equivalent might have: the District Valuer has used a notional size of 85% following a review of functional obsolescence and occupation percentages.

Note 1.22 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Land and buildings were inspected and revalued by the District Valuer in the last weeks of the financial year, when the Covid 19 outbreak was in its very early stages.

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

Although the District Valuer states in his report that in his opinion there is no material uncertainty attaching to his valuation of the Trust's land and buildings, some uncertainty clearly does exist, and a relatively small variation could have a material impact on the accounts. For every 5% change, the valuation could differ by £6,820,000, with a consequent effect on the PDC dividend payable in 2020/21 of £119,000; this would affect the values shown in note 16 in particular.

Note 2 Operating Segments
The Trust has no material operating segments other than healthcare and reporting to the Board is consistent with this.

	2019/2020 £000s	2018/2019 £000s
Income	**571.492**	**510,301**
Operating deficit	**(58,744)**	**(17,460)**
Net assets	**54,118**	**112,850**

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities (by nature)

	2019/20	2018/19
	£000	£000
Acute services		
Elective income	97,792	84,129
Non elective income	147,939	135,896
First outpatient income	28,747	40,538
Follow up outpatient income	37,306	21,072
A & E income	19,491	18,107
High cost drugs income from commissioners (excluding pass-through costs)	49,762	47,500
Other NHS clinical income	99,517	92,957
All services		
Private patient income	2,725	3,123
Agenda for Change pay award central funding*		4,135
Additional pension contribution central funding**	14,041	-
Other clinical income	6,591	5,073
Total income from activities	**503,911**	**452,530**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

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

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
Income from patient care activities received from:	£000	£000
NHS England	196,291	166,067
Clinical commissioning groups	298,585	272,103
Department of Health and Social Care	-	4,135
Other NHS providers	1,252	985
NHS other	317	177
Local authorities	3,240	3,420
Non-NHS: private patients	2,725	3,123
Non-NHS: overseas patients (chargeable to patient)	377	539
Injury cost recovery scheme	933	1,641
Non NHS: other	191	340
Total income from activities	**503,911**	**452,530**
Of which:		
Related to continuing operations	503,911	452,530

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

	2019/20	2018/19
	£000	£000
Income recognised this year	377	539
Cash payments received in-year	206	574
Amounts added to provision for impairment of receivables	197	104
Amounts written off in-year	-	33

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,542	-	**5,542**	4,844	-	**4,844**
Education and training	27,276	768	**28,044**	23,752	627	**24,379**
Non-patient care services to other bodies	8,731		**8,731**	8,024		**8,024**
Provider sustainability fund (PSF)	3,666		**3,666**	6,091		**6,091**
Financial recovery fund (FRF)	2,406		**2,406**			
Marginal rate emergency tariff funding (MRET)	6,470		**6,470**			
Income in respect of employee benefits accounted on a gross basis	1,941		**1,941**	3,043		**3,043**
Receipt of capital grants and donations		587	**587**		476	**476**
Charitable and other contributions to expenditure		1,264	**1,264**		1,210	**1,210**
Rental revenue from operating leases		771	**771**		970	**970**
Other income	8,159	-	**8,159**	8,734	-	**8,734**
Total other operating income	**64,191**	**3,390**	**67,581**	**54,488**	**3,283**	**57,771**
Of which:						
Related to continuing operations			**67,581**			**57,771**

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Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,502	1,958

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

Note 6 Fees and charges

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

	2019/20	2018/19
	£000	£000
Income	2,357	2,483
Full cost	(2,193)	(2,146)
Surplus	**164**	**337**

The only charging scheme with income exceeding £1m was car parking. Much of the cost relates to the lease of the multi-storey car park, which is included in "rentals under operating leases" in note 7.1 below.

Note 7.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	540	1,147
Purchase of healthcare from non-NHS and non-DHSC bodies	26,328	15,450
Staff and executive directors costs	361,500	313,612
Remuneration of non-executive directors	103	92
Supplies and services - clinical (excluding drugs costs)	60,015	56,718
Supplies and services - general	12,187	17,515
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	65,146	61,969
Inventories written down	484	52
Consultancy costs	607	489
Establishment	4,053	3,311
Premises	17,165	15,385
Transport (including patient travel)	705	583
Depreciation on property, plant and equipment	16,129	12,463
Amortisation on intangible assets	392	315
Net impairments	31,172	(4,234)
Movement in credit loss allowance: contract receivables / contract assets	(79)	(95)
Movement in credit loss allowance: all other receivables and investments	-	7
Change in provisions discount rate	63	(16)
Audit fees payable to the external auditor		
audit services- statutory audit	76	67
other auditor remuneration (external auditor only)	-	10
Internal audit costs	181	172
Clinical negligence	14,697	15,812
Legal fees	560	486
Insurance	511	501
Research and development	5,086	4,940
Education and training	3,567	2,421
Rentals under operating leases	4,472	3,690
Early retirements	(52)	65
Redundancy	3	-
Car parking & security	1,690	2,341
Hospitality	52	54
Losses, ex gratia & special payments	277	157
Grossing up consortium arrangements	269	253
Other services, eg external payroll	470	461
Other	1,867	1,568
Total	**630,236**	**527,761**
Of which:		
Related to continuing operations	630,236	527,761

Note 7.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	10

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	631	-
Unforeseen obsolescence	6,448	-
Changes in market price	24,093	(4,234)
Total net impairments charged to operating surplus / deficit	**31,172**	**(4,234)**
Impairments charged to the revaluation reserve	3,093	-
Total net impairments	**34,265**	**(4,234)**

Further details of impairments are given at notes 15 and 18 to the accounts.

Changes in market price include an impairment of £23,930,000 relating to the revaluation of the main Derriford building.

Note 7.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	-	10

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	631	-
Unforeseen obsolescence	6,448	-
Changes in market price	24,093	(4,234)
Total net impairments charged to operating surplus / deficit	**31,172**	**(4,234)**
Impairments charged to the revaluation reserve	3,093	-
Total net impairments	**34,265**	**(4,234)**

Further details of impairments are given at notes 15 and 18 to the accounts.

Changes in market price include an impairment of £23,930,000 relating to the revaluation of the main Derriford building.

Note 9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	273,137	247,672
Social security costs	27,278	24,784
Apprenticeship levy	1,333	1,208
Employer's contributions to NHS pensions*	46,243	29,074
Pension cost - other	95	-
Temporary staff (including agency)	20,133	18,447
Total gross staff costs	**368,219**	**321,185**
Recoveries in respect of seconded staff	-	(1,716)
Total staff costs	**368,219**	**319,469**
Of which		
Costs capitalised as part of assets	2,270	2,353

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

Note 9.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £252k (£120k in 2018/19).

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

Note 10 Pension costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.
NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that

may arise from this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

Pension costs - other scheme

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

Note 11 Operating leases

Note 11.1 University Hospitals Plymouth NHS Trust as a lessor

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

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

	2019/20	2018/19
	£000	£000
Operating lease revenue		
Minimum lease receipts	771	970
Total	**771**	**970**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	676	525
- later than one year and not later than five years;	3,519	1,335
- later than five years.	2,790	1,532
Total	**6,985**	**3,392**

Note 11.2 University Hospitals Plymouth NHS Trust as a lessee

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

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

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	4,472	3,690
Total	**4,472**	**3,690**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,034	3,429
- later than one year and not later than five years;	18,228	8,078
- later than five years.	37,856	27,511
Total	**61,118**	**39,018**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	150	112
Total finance income	**150**	**112**

Note 13.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,664	2,269
Finance leases	25	27
Interest on late payment of commercial debt	-	14
Total interest expense	**2,689**	**2,310**
Unwinding of discount on provisions	(7)	3
Total finance costs	**2,682**	**2,313**

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

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	14

Note 14 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	21	9
Losses on disposal of assets	(9)	-
Total other gains / (losses)	**12**	**9**

Note 15.1 Intangible assets - 2019/20

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

The impairment relates to software forming part of the Enotes IT project written off as a consequence of unforeseen obsolescence - see also note 18.

Note 15.2 Intangible assets - 2018/19

	Software licences £000	Licences & trademarks £000	Total £000
Valuation / gross cost at 1 April 2018	**-**	**2,621**	**2,621**
Additions	-	115	**115**
Valuation / gross cost at 31 March 2019	**-**	**2,736**	**2,736**
Amortisation at 1 April 2018	**-**	**1,633**	**1,633**
Provided during the year	-	315	**315**
Amortisation at 31 March 2019	**-**	**1,948**	**1,948**
Net book value at 31 March 2019	**-**	**788**	**788**
Net book value at 1 April 2018	**-**	**988**	**988**

Note 16.1 Property, plant and equipment - 2019/20

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

Note 16.2 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**4,802**	**142,682**	**23,360**	**116,524**	**228**	**27,706**	**5,012**	**320,314**
Additions	-	149	18,898	222	-	15	90	**19,374**
Impairments	-	(99)	-	-	-	-	-	**(99)**
Reversals of impairments	-	4,333	-	-	-	-	-	**4,333**
Revaluations	-	315	-	-	-	-	-	**315**
Reclassifications	-	5,805	(12,689)	4,695	12	1,956	221	**-**
Disposals / derecognition	-	-	-	(1,208)	-	-	-	**(1,208)**
Valuation/gross cost at 31 March 2019	**4,802**	**153,185**	**29,569**	**120,233**	**240**	**29,677**	**5,323**	**343,029**
Accumulated depreciation at 1 April 2018	**-**	**-**	**-**	**84,300**	**161**	**21,609**	**3,088**	**109,158**
Provided during the year	-	3,019	-	6,932	13	2,162	337	**12,463**
Revaluations	-	(3,019)	-	-	-	-	-	**(3,019)**
Disposals / derecognition	-	-	-	(1,186)	-	-	-	**(1,186)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**90,046**	**174**	**23,771**	**3,425**	**117,416**
Net book value at 31 March 2019	**4,802**	**153,185**	**29,569**	**30,187**	**66**	**5,906**	**1,898**	**225,613**
Net book value at 1 April 2018	**4,802**	**142,682**	**23,360**	**32,224**	**67**	**6,097**	**1,924**	**211,156**

Note 16.3 Property, plant and equipment financing - 2019/20

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

Note 16.4 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	4,802	151,041	29,569	28,714	66	5,750	1,727	**221,669**
Finance leased	-	-	-	498	-	-	-	**498**
Owned - donated	-	2,144	-	975	-	156	171	**3,446**
NBV total at 31 March 2019	**4,802**	**153,185**	**29,569**	**30,187**	**66**	**5,906**	**1,898**	**225,613**

Note 17 Donations of property, plant and equipment

Donated assets totalling £587k (2018/19 £476k) were received during the year from a number of different local and national charities and other organisations.

Note 18 Revaluations of property, plant and equipment

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

This year's valuation was the full quinquennial valuation, with a detailed physical inspection of all properties. See note 1.22 on page 17 for an explanation of the uncertainty caused by the COVID-19 pandemic.

The fall in valuation of land and buildings has been taken to the revaluation reserve, where a balance existed in that reserve, or otherwise to expenditure as an impairment. The significant impairment in this year's accounts reflects an alteration to the notional sizing of the main hospital building reflecting recent estates assessments.

In addition to these building impairments, a total of £5,539k of assets under construction were impaired during the year. £4,908k related to the element of the Enotes IT project rendered worthless by unforeseen obsolescence due to the changing landscape of clinical information systems, and £631k to fruitless payments for IT projects that were not implemented
See also notes 8, 15 and 30.

Note 19 Inventories

	31 March 2020	31 March 2019
	£000	£000
Drugs	3,269	2,735
Consumables	9,702	9,310
Energy	161	175
Total inventories	**13,132**	**12,220**

Inventories recognised in expenses for the year were £111,510k (2018/19: £102,114k). Write-down of inventories recognised as expenses for the year were £484k (2018/19: £64k).

The Trust's inventory balance of £13,132,000 is material to the Trust's accounts. The Trust is satisfied that its inventory balance is presented fairly and confident that it is not materially misstated: stocktakes were carried out at the balance sheet date as normal, with only a very few areas (some 4% of total stock value) unable to count as a result of the COVID-19 pandemic. However, the restrictions on movement in the United Kingdom in March 2020 meant that the Trust's auditor was unable to attend the relevant year-end inventory counts and the auditor has been unable to gain sufficient audit evidence from alternative procedures. This limits the scope of the auditor's work, and under auditing standards the auditor is required to issue a qualified opinion in this respect. We are aware that a number of trusts in the country are affected by the same issue in 2019/20 and we understand NHS Improvement will disclose the extent to which this has impacted the sector in its consolidated provider accounts when published later in 2020

Note 20.1 Receivables

	31 March 2020	31 March 2019
	£000	£000
Current		
Contract receivables	20,431	22,888
Allowance for impaired contract receivables / assets	(903)	(1,106)
Allowance for other impaired receivables	(5)	(5)
Prepayments (non-PFI)	5,448	3,726
PDC dividend receivable	116	-
VAT receivable	1,089	1,754
Other receivables	504	218
Total current receivables	**26,680**	**27,475**
Non-current		
Contract assets	4,215	3,685
Allowance for other impaired receivables	(918)	(807)
Other receivables	40	-
Total non-current receivables	**3,337**	**2,878**
Of which receivable from NHS and DHSC group bodies:		
Current	10,824	13,812
Non-current	40	-

Note 20.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - restated	**1,913**	**5**	**-**	**2,059**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			2,059	(2,059)
New allowances arising	-	-	-	7
Changes in existing allowances	(79)	-	-	-
Reversals of allowances	-	-	(95)	-
Utilisation of allowances (write offs)	(13)	-	(51)	(2)
Allowances as at 31 Mar 2020	**1,821**	**5**	**1,913**	**5**

Note 21 Cash and cash equivalents movements

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

	2019/20	2018/19
	£000	£000
At 1 April	**2,960**	**4,220**
Net change in year	3,433	(1,260)
At 31 March	**6,393**	**2,960**
Broken down into:		
Cash at commercial banks and in hand	28	31
Cash with the Government Banking Service	6,365	2,929
Total cash and cash equivalents as in SoFP	**6,393**	**2,960**
Total cash and cash equivalents as in SoCF	**6,393**	**2,960**

Note 22 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	15,266	20,632
Capital payables	7,963	6,014
Accruals	11,194	5,624
Receipts in advance and payments on account	260	-
Social security costs	4,055	3,612
VAT payables	150	150
Other taxes payable	3,336	3,313
PDC dividend payable	-	175
Other payables	6,968	6,491
Total current trade and other payables	**49,192**	**46,011**

Of which payables from NHS and DHSC group bodies:		
Current	2,380	2,214

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	2,684	2,502
Total other current liabilities	**2,684**	**2,502**

Note 24.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	142,324	29,954
Other loans	169	170
Obligations under finance leases	156	32
Obligations under PFI, LIFT or other service concession contracts	-	-
Total current borrowings	**142,649**	**30,156**
Non-current		
Loans from DHSC	-	77,950
Other loans	429	598
Obligations under finance leases	2,220	484
Obligations under PFI, LIFT or other service concession contracts	-	-
Total non-current borrowings	**2,649**	**79,032**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £142,324k are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern issue for the Trust.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2019/20

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

Note 24.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**84,197**	**359**	**546**	**85,102**
Cash movements:				
Financing cash flows - payments and receipts of principal	23,481	409	(30)	**23,860**
Financing cash flows - payments of interest	(2,206)	-	(27)	**(2,233)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	163	-	-	**163**
Application of effective interest rate	2,269	-	27	**2,296**
Carrying value at 31 March 2019	**107,904**	**768**	**516**	**109,188**

Note 25 Finance leases

Obligations under finance leases where the Trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**3,065**	**692**
of which liabilities are due:		
- not later than one year;	258	57
- later than one year and not later than five years;	1,036	225
- later than five years.	1,771	410
Finance charges allocated to future periods	(689)	(176)
Net lease liabilities	**2,376**	**516**
of which payable:		
- not later than one year;	156	32
- later than one year and not later than five years;	581	142
- later than five years.	1,639	342

One new finance lease was entered into during the year.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**741**	**642**	**-**	**1,383**
Change in the discount rate	**30**	**33**	**-**	**63**
Arising during the year	**61**	**119**	**40**	**220**
Utilised during the year	(85)	(124)	-	**(209)**
Reversed unused	**(72)**	**(127)**	**-**	**(199)**
Unwinding of discount	**(4)**	**(3)**	**-**	**(7)**
At 31 March 2020	**671**	**540**	**40**	**1,251**
Expected timing of cash flows:				
- not later than one year;	84	147	**-**	**231**
- later than one year and not later than five years;	337	105	**-**	**442**
- later than five years.	250	288	**40**	**578**
Total	**671**	**540**	**40**	**1,251**

Legal claims relate to personal injury cases.

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

	Pensions: early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2018	**793**	**666**	**1,459**
Change in the discount rate	(8)	(8)	**(16)**
Arising during the year	44	168	**212**
Utilised during the year	(90)	(169)	**(259)**
Reversed unused	-	(16)	**(16)**
Unwinding of discount	2	1	**3**
At 31 March 2019	**741**	**642**	**1,383**
Expected timing of cash flows:			
- not later than one year;	90	193	**283**
- later than one year and not later than five years;	354	134	**488**
- later than five years.	297	315	**612**
Total	**741**	**642**	**1,383**

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £206,940k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of University Hospitals Plymouth NHS Trust (31 March 2019: £150,755k).

Note 27 Contingent assets and liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(45)	(91)
Gross value of contingent liabilities	**(45)**	**(91)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(45)**	**(91)**
Net value of contingent assets	**-**	**-**

Flowers and others v East of England Ambulance Trust [2019] EWCA Civ 947

In June 2019 the Court of Appeal ruled that under section 13.9 of the Agenda for Change contract, employees are entitled to have non guaranteed and voluntary overtime taken into account when calculating holiday pay. The Trust concerned has applied for permission to appeal to the Supreme Court against the ruling and the outcome is as yet unknown. No accrual or provision has been included in these accounts for any possible liability arising should the appeal be disallowed and no contingent liability has been disclosed as it is not yet possible to form a view as to any likely or possible impact.

Note 28 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	10,628	5,347
Intangible assets	290	-
Total	**10,918**	**5,347**

Note 29 Financial instruments

Note 29.1 Financial risk management

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

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

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

Interest rate risk
The Trust borrows from government, subject to affordability as confirmed by NHS Improvement. Interest is charged at the National Loans Fund rate, fixed for the life of the loan. The cash regime is changing from 2020/21 with all loans to be replaced by Public Dividend Capital

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because most of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note 20. The total gross value of non NHS/ public sector receivables at 31.3.20 was £14,443,000 (18/19 £12,090,000)
Liquidity risk

The Trust's operating costs are incurred under contracts with primary care organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

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

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	24,382	**24,382**
Cash and cash equivalents	2,960	**2,960**
Total at 31 March 2019	**27,342**	**27,342**

Note 29.3 Carrying values of financial liabilities

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

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	107,904	**107,904**
Obligations under finance leases	516	**516**
Other borrowings	768	**768**
Trade and other payables excluding non financial liabilities	38,270	**38,270**
Total at 31 March 2019	**147,458**	**147,458**

Note 29.4 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	£000
In one year or less	177,073	68,254
In more than one year but not more than two years	307	49,537
In more than two years but not more than five years	703	29,326
In more than five years	1,638	341
Total	**179,721**	**147,458**

Note 29.5 Fair values of financial assets and liabilities

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

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	12	11	17	3
Fruitless payments	3	7,079	-	-
Bad debts and claims abandoned	34	13	179	51
Stores losses and damage to property	230	136	83	64
Total losses	**279**	**7,239**	**279**	**118**
Special payments				
Compensation under court order or legally binding arbitration award	1	160	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	128	107	187	156
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**129**	**267**	**187**	**156**
Total losses and special payments	**408**	**7,506**	**466**	**274**
Compensation payments received		-		-

Fruitless payments relate to the impairment of IT projects, most notably the e-notes system which has been subject to unforeseen obsolescence. See also notes 8, 15, 16 and 18.

Note 31 Related parties

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

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :
NHS Devon CCG
NHS Kernow CCG
NHS England
Health Education England
NHS Resolution
NHS Business Services Authority
NHS Pension Scheme

Note 32 Events after the reporting date
On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issues of Public Dividend Capital (PDC) to allow the repayment. Given that this relates to liabilities that existed at 31 March 2020, DHSC has updated its Government Accounting Manual to advise that this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £142,324k as at 31 March 2020 in these financial statements have been classified as current, as they will be repayable within 12 months.

In the weeks between the balance sheet date and the signing of the accounts, the COVID-19 pandemic has had a significant effect on the Trust. From a financial point of view, interim funding arrangements have been put in place by NHS England and NHS Improvement until the end of July 2020 to address income and cashflow issues. Although NHS England have given some assurances about funding levels beyond this, the contractual uncertainty has been reflected in a disclosure highlighting the material uncertainties around the going concern of the Trust (see note 1.2). An appropriate disclosure has also been made that reflects a material uncertainty around the valuation of the Trust's estate due to the potential economic environment caused by the pandemic (see notes 1.22 and 18.)

Note 33 Better Payment Practice code

Non-NHS Payables	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Total non-NHS trade invoices paid in the year	87,686	246,659	90,637	226,671
Total non-NHS trade invoices paid within target	84,558	236,300	86,182	215,067
Percentage of non-NHS trade invoices paid within target	96.4%	95.8%	95.1%	94.9%
NHS Payables				
Total NHS trade invoices paid in the year	3,100	12,624	2,762	10,681
Total NHS trade invoices paid within target	2,915	11,769	2,564	9,868
Percentage of NHS trade invoices paid within target	94.0%	93.2%	92.8%	92.4%

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

Note 34 External financing limit

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

	2019/20 £000	2018/19 £000
Cash flow financing	37,790	27,843
Finance leases taken out in year	-	
External financing requirement	**37,790**	**27,843**
External financing limit (EFL)	39,309	28,439
Under spend against EFL	**1,519**	**596**

Note 35 Capital Resource Limit

	2019/20 £000	2018/19 £000
Gross capital expenditure	27,296	19,489
Less: Disposals	(9)	(22)
Less: Donated and granted capital additions	(587)	(476)
Charge against Capital Resource Limit	**26,700**	**18,991**
Capital Resource Limit	26,731	19,506
Under spend against CRL	**31**	**515**

Note 36 Breakeven duty financial performance

	2019/20 £000
Adjusted financial performance deficit - control total basis	(32,949)
Remove impairments scoring to Departmental Expenditure Limit	631
Add back income for impact of 2018/19 post-accounts PSF reallocation	480
Breakeven duty financial performance deficit	**(31,838)**

Note 37 Breakeven duty rolling assessment

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

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(4,989)	(35,996)	(39,900)	3,407	(27,166)	(31,838)
Breakeven duty cumulative position	(5,839)	(41,835)	(81,735)	(78,328)	(105,494)	(137,332)
Operating income	430,817	432,771	450,348	507,781	510,301	571,492
Cumulative breakeven position as a percentage of operating income	(1.4%)	(9.7%)	(18.1%)	(15.4%)	(20.7%)	(24.0%)

Paragraph 2(1) of Schedule 5 of the National Health Service Act 2006 states that *"Each NHS trust shall ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account"*. NHS trusts normally plan to meet this duty by achieving a balanced position on their income and expenditure account each and every year. The interpretation of the statutory financial duty for NHS trusts to break even was clarified in 1997/99 which recognised that although NHS trusts are expected to achieve a balanced position on their income and expenditure account each and every year, there may be reasons for the NHS trusts to report deficits in one year which may be offset by surpluses achieved in another year(s). This is particularly relevant to situations where NHS trusts must recognise costs in advance of cash outlay, for example for clinical negligence or pension costs, and when managing the recovery of an NHS trust with serious financial difficulties. A run of three years may be used to test the break-even duty, but in exceptional cases the Department of Health may agree to a five year time-scale.

The Trust has reported a deficit position for six out of the last seven years and the cumulative deficit now stands at £137.3m.
It plans to breakeven under the COVID-19 financial regime in early 2020/21 and then meet the NHS England control total and break even with support from the Financial Recovery Fund for the remainder of the year 2020/21.