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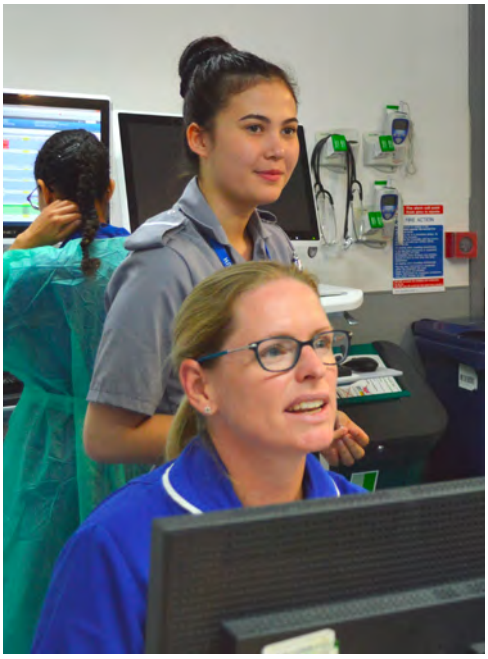

2020/21

Annual Report and Accounts

Milton Keynes University Hospital NHS Foundation Trust
Annual Report and Accounts
2020/21

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

This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors of Milton Keynes University NHS Foundation Trust on 10 June 2021.

Professor Joseph Harrison
Chief Executive
10 June 2021

The Annual report can be made available in other languages and formats on request

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Chair's Introduction

I am delighted to introduce the Annual Report for the Trust for year of 2020/21, which has been one of the most challenging periods faced by the hospital since it opened in 1984.

The pandemic has affected everyone, not just at Milton Keynes University Hospital and MK in general, but across the world. It has been an unprecedented time in our lives, not least for NHS staff and volunteers who have risen to the challenge of dealing with extraordinary situations and circumstances not normally expected of our staff, patients, their loved ones and carers.

At MKUH supporting our staff has always been a priority and this has never been more true than in the past year. While we have introduced various practical initiatives and facilities to improve the health and wellbeing of our staff, like opening and expanding a Staff Hub to provide peaceful place for staff to take a break, we as a Trust have recognised the psychological impact the pandemic has had and tried to offer staff time and space to take stock of their extraordinary efforts in the most difficult of circumstances.

Right from the start of the pandemic in the UK in March 2020, the Trust started hosting live virtual Q&A events up to three times a week to enable staff to hear updates from the senior leadership team, ask any questions and raise any issues. We followed this with our annual staff engagement event, Event in the Tent, in September 2020 focusing on three themes: rest; resilience and recovery. While these virtual forums only form part of the support offered to staff, they were great examples of how openness and availability really helped our leaders to listen to colleagues and provide the support they needed during this difficult period.

I want to personally thank all our staff for their incredible contribution, in the most trying of times. They have been amazing.

On behalf of the Board and as Chairman of the Council of Governors, I would also like to thank all of the Trust's governors who contributed to ensuring that the hospital has received feedback on how well it has been meeting the needs of the local community.

As a Foundation Trust, MKUH has a Council of Governors which plays a vital role in representing the interests of the hospital's members. We have both staff and publicly elected governors who represent constituencies in Milton Keynes and the surrounding area, and governors who are appointed to represent the interests of certain stakeholders. Their key role in the oversight of services here at the hospital is one for which I am most grateful.

It also gives me great pleasure to acknowledge the tireless support of our Non-Executive Directors, who continue to provide constructive challenge and support to our Executive team.

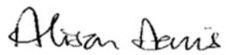
We have welcomed Terry Whittle to the Board as our new Director of Finance, replacing Mike Keech whom we thank for his outstanding contribution during his time here. And on that note, I would like to extend my gratitude to our Chief Executive, Professor Joseph Harrison, and the rest of the Executive Board for their efforts during 2020/21 which of course has been an incredibly challenging period for all. They have led our Trust

through two waves of the pandemic and provided reassurance and direction in what have been extremely turbulent times.

Despite the significant challenges presented by the pandemic, we at MKUH have continued to press on with plans to develop our estate, and in February 2021 we began work on our new £14.88 million Pathway Unit. This will help to ensure some patients requiring urgent treatment will be able to receive it, while avoiding having to attend the Emergency Department (ED) and an unnecessary admission to a hospital ward. The Trust plans to complete the unit, which will be situated close to our ED.

Work also got underway on the construction of our new multi-storey car park behind the Urgent Care Centre, which will provide approximately 500 car spaces. And in October 2020 the Trust was granted funding to build a Women and Children's Hospital, which will bring together paediatric, gynaecology and obstetrics services under one roof.

These exciting developments help us to look to the future with plenty of hope and optimism as we continue to improve our hospital and the services we provide to patients and the communities of Milton Keynes. I very much hope the outlook is looking bright and positive for Milton Keynes University Hospital NHS Foundation Trust and the communities it serves.



Alison Davis
Chair

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Performance Report

1.1 Overview of Performance

The performance overview provides a summary of the Trust's performance for 2020/21. It includes a statement from the Chief Executive providing his perspective on how the Trust has performed during the year; provides a brief synopsis of the Trust's purpose and activities and on its history and statutory (legal) background. This section also outlines the key risks and issues to the delivery of the Trust's objectives faced by the organisation in 2020/21.

1.1.1 Chief Executive's Statement on Performance

The impact of the COVID-19 pandemic has been felt very keenly at Milton Keynes University Hospital. It has required us to completely change both our activity and, in some cases, the footprint of the hospital to ensure we were in the best position possible to treat the thousands of local people, both ill with the virus and with other conditions, who needed our care. Of course, this fundamental shift in our ways of working needs to be taken into account when assessing the year's performance.

We know that the communities of Milton Keynes have all had to shoulder the burden of these challenging times and I would like to thank them for their continued support and patience while we work hard to deal with the effects of the pandemic.

One of those effects was the impact on our ability to carry out elective (planned) procedures and some outpatient clinics at the height of the pandemic. The significant level of resourcing required to respond to COVID-19, along with the effects that shielding and isolating had on staffing, meant that staff were redeployed and our capacity to carry out our normal activity was greatly reduced while we continued to prioritise our sickest patients.

We did manage to retain a large proportion of outpatient activity throughout by deploying alternative technologies and delivering a number of virtual clinics either by video or telephone to our patients. However, like all other Trusts, we stopped all but very urgent elective work at certain periods during the year, and there is a significant backlog of elective work which, since March 2021, the Trust has been working to reduce while continuing to deal with incoming demand, by bringing back our normal levels of activity.

Our collaboration with local independent providers, alternative treatment options and some new pathways, has allowed us to deliver most of our cancer activity, although our cancer performance, compared to non-COVID-19 times, dropped in terms of the numbers of patients overall being treated within 62 days.

Our four-hour emergency access target performance was also similar, as the Trust failed to meet its target but performed comparatively well with the numbers of patients assessed, admitted or discharged within four hours placing us in the top 25% of performing hospitals in the country.

While we should be encouraged that these measures mean we are one of the better performing hospitals in the country, we have not lost sight of the patients behind these statistics and are working hard to improve in all of these areas.

As well as looking after people suffering with COVID-19, I am proud to say we have played a pivotal role in vaccinating local people against the virus. In December 2020, we opened one of the first vaccination centres in the east of England and administered over 35,000 doses to local health and care staff, and people in the first four priority groups. This marked an extraordinary effort from staff, who successfully ran the centre at a time when around 60% of our bedspace was taken up by patients with COVID-19.

We have also continued to improve the way we support our staff. In March 2020, we introduced our new Staff Hub which gave colleagues an extra place to take a break. This was followed by our successful 12 Weeks of Wellbeing initiative in January 2021 to both promote existing support and introduce new initiatives which look to improve the physical and emotional wellbeing of staff. This included the introduction of hugely popular half-price healthy meals in the restaurant, the formation of a host of virtual social clubs to keep staff connected in lockdown and posting over 5,000 care packages to staff which contained a support booklet, the award of an extra day's annual leave and an all-important barista coffee voucher.

These initiatives were in addition to the standard benefits which we have introduced over the past couple of years, including free parking and free tea and coffee for all staff, which have helped to reduce our staff turnover rate from 9.6% in April 2020 to 7.1% in March 2021. Our Stability index has increased from 84.4% in April 2020 to almost 89% in April 2021, whilst the NHS Staff Survey 2020 results show that staff engagement scores have improved in terms of the colleagues recommending the Trust as a place to work and as a place to receive treatment. In terms of the survey, we have also seen improvements in our scores associated with how the Trust has supported staff health and wellbeing and how the views of colleagues are received by the organisation.

Despite the challenges presented by the pandemic, #TeamMKUH have never lost sight of our commitment to providing safe and effective care while improving the experience of our patients. With that in mind, we have continued to develop our estate to ensure we have world-class facilities to look after the growing population. This includes the start of a construction of our new pathway unit next to ED and the development of plans to build a new women's and children's hospital, surgical block and imaging centre in the next five years.

As well as facilities to increase our capacity to deliver excellent care, we have continued to look at ways our services can work smarter. The continued development of the MyCare app, further additions to our electronic eCARE and a partnership with Apple Health have all been innovations this year that aim to give improved secure access to patient records for both our clinicians and the patients themselves. This is an important step forward, allowing people more autonomy to view their records and have informed discussions with our clinicians about their care.

Looking forward, MKUH received a significant boost in our efforts to reduce the patient waiting lists in May 2021 with the announcement that we were appointed as one of NHS England's elective accelerator sites. This means we are receiving funding and additional support to implement innovative ways to increase the number of elective operations we can deliver by 25%. I am pleased to say this work is already underway and we are already making good progress in reducing wait times for operations.

Finally, I welcome Alison Davis, our new Trust Chair, who took up the position following the retirement of Simon Lloyd, to whom I give huge thanks for his contribution to MKUH over the years. I am sure we can look forward to the future with confidence as the Trust Board and our Governors work closely with Alison in the coming years.

Professor Joseph Harrison
Chief Executive

10 June 2021

1.1.2 Purpose and Activities of the Trust

Milton Keynes Hospital NHS Foundation Trust was founded on 1 October 2007 under the National Health Service Act 2006. The hospital has around 553 beds, including day acute and neonatal beds and employs around 3821 staff, providing a full range of acute hospital services and an increasing number of specialist services to the growing population of Milton Keynes and surrounding areas. All in-patient services and most outpatient services are provided on the main hospital site.

The Trust is organised into four clinical divisions (medicine, surgery, women and children and core clinical) and a number of corporate directorates. The executive directors, and clinical service unit (CSU) leadership teams, are responsible for the day-to-day management and running of the hospital's services, with ultimate management accountability resting with the Chief Executive.

1.1.3. Trust Objectives

The Trust Board has agreed a process for agreeing and refreshing its objectives each year, ensuring that these remain linked to its vision, values and strategy.

The Trust's vision is set out as:

"Our vision for Milton Keynes University Hospital NHS Foundation Trust is to be an outstanding acute hospital and part of a health and care system working well together"

The Trust's values are:

These are linked to our strategy. This has five key priorities which will help us to be an outstanding acute hospital and part of a health and care system working well together

Underpinning our strategy are our objectives – which describe what we will deliver in the coming year. For the past five years, we have kept the same ten strategic objectives, the most critical being improving patient safety, experience and clinical effectiveness.

MKUH is part of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS), which was formerly known as a Sustainability and Transformation Partnership (STP). The BLMK ICS is one of 44 ICS 'footprints' set up across England under the Five Year Forward View as a new approach to plan and deliver services by place rather than around individual organisations. In June 2017, BLMK was named as one of eight health and social care systems across the country that is to become Accountable Care System (ACS). The continuing development of ACS (now referred to as Integrated Care System) will see local health and care organisations working more closely together to provide joined up and better coordinated care.

1.1.4 History and Statutory Background of the Trust

Milton Keynes Hospital was officially opened in 1984 and is located at Standing Way, Eaglestone, Milton Keynes, MK6 5LD. The acute services provision at that time included operating theatres, an ED, maternity services, general and speciality wards, full diagnostic x-ray facilities, and a major pathology department.

Other projects that were completed soon after this major development included a postgraduate education centre and an extended physiotherapy department, including a hydrotherapy pool.

Construction of phase two started in 1988 and focused on the expansion of facilities to support the continued population growth of Milton Keynes (estimated increase from 1984 to 1994 - 40%).

The development comprised six additional 28-bed wards, a further suite of operating theatres, extra accommodation for the pathology department and additional accommodation for staff.

Phase two opened in 1992. Milton Keynes General NHS Trust formally came into being on 1 April 1992. Since then, significant changes have included the expansion of postgraduate education facilities, the provision of a new MRI scanning unit and the expansion and relocation of the cardiology unit and coronary care ward. In recent years the site has grown further with the addition of a 28-bed orthopaedic ward, a GP paediatric assessment unit, fracture clinic and refurbishment of the ED.

Expansion continued with the opening of a £1.5m Macmillan Haematology and Oncology Unit within the main hospital. In January 2005 the biggest single development on the site for ten years, a £12m treatment centre dedicated to day cases and extended day case surgery, was opened with 60 bed spaces and a further four operating theatres. The centre has proved very popular with patients.

During 2006/07 the sexual health centre was refurbished and a new £2.5m angiography unit opened. Construction work on a new multi-storey car park was completed in July 2007 and cardiology services continue to develop. Extra capacity has been added to clinics such as orthopaedics, ophthalmology and a rolling refurbishment of wards and corridors is on-going.

Since becoming an NHS Foundation Trust on 1 October 2007, sustained expansion has continued. During 2008/09 Ward 14, previously run by the

local primary care Trust, was fully refurbished and reopened by the hospital. In April 2009 the hospital opened a new significantly expanded £4.6m state-of-the-art endoscopy unit and a new 22 bed ward.

In response to the number of patients requiring step down facilities rather than acute care, the Trust invested in the conversion of a ward into a therapist-led facility for patients on the road to recovery. The Phoenix Unit, as it was named, opened in 5 November 2012, and has 20 beds.

A new 20-bed surgical ward, Ward 24, opened in February 2017. Ward 24 helps the hospital manage an ever-increasing demand for services throughout the year and is used by elective surgery patients. It is the first building to be opened under the hospital's site development programme. It was followed by the new £5.4m main entrance that opened in May 2017 and the £8.5m Academic Centre opened by HRH the Duke of Kent in February 2018.

The Trust entered into a partnership with the University of Buckingham to establish the first independent Medical School in the country. The first medical students commenced preclinical training at the University in January 2015, and in April 2015 the Trust changed its name to Milton Keynes University Hospital NHS Foundation Trust to reflect this status. The first cohort of University of Buckingham medical students began full-time clinical training with the Trust in March 2017. Seventy students will complete their MB ChB course at the hospital over the next six months, with thirty-eight students training on site at any one time.

In late 2018, the Trust opened Ward 12, a new eight bed ward to accommodate the increasing need for inpatient beds. The Acorn Suite opened next to the ED in 2018, increasing clinical assessment space. A dedicated paediatric ED, with separate outside entrance during core hours was also opened. This has been welcomed by parents and carers of our younger patients.

In March 2020, we opened our brand new £15m Cancer Centre, which brings all Cancer Services on the Trust site under one roof in a state of the art, airy dedicated space. This Centre was supported financially with a £10m donation from MK Council, £2m from Macmillan and the rest generated by our hospital charity's cancer centre appeal. It features a 24-bedded ward with single rooms and shared bays, an extensive area for outpatient treatment, a wellbeing area, along with offices and an aseptic suite for the preparation of cancer treatment drugs.

In February 2021, work on a new £14.88 million Pathway Unit, which will relieve pressure on the ED, by providing urgent treatment to some patient so they do not have to ED and or being unnecessarily being admitted to hospital. The plan is to complete the construction of the Unit, which will be situated close to our ED, by August 2022.

In October 2020 the Trust was granted funding to build a Women and Children's Hospital, which when it opens in 2024, will bring together Paediatric and Obstetrics Services under one roof.

In 2020/21, the Trust recruited over 4,553 patients to participate in research projects, with more data still to be included. It is the Trust's aim that research becomes an embedded feature of the patient journey and that where possible, they will always be offered the opportunity to participate in clinical trials.

Having submitted expressions of interest for several commercial studies, MKUH has been involved in research across a range of different clinical specialities with most speciality areas now research active. This demonstrates the Trust's growing recognition by industry and its success in forging relationships with commercial partners intending to perform quality research.

1.1.5 Key Risks and Issues

The Board Assurance Framework reflects the principal risks against the achievement of the

Trust's strategic objectives, including clinical and non-clinical risk. These risks are managed through the risk management processes in place in the Trust, with oversight and scrutiny through executive and non-executive chaired boards and committees. The risks which were identified on the Board Assurance Framework at the end of the 2020/21 financial year, along with further details on risk management, are contained within the Annual Governance Statement from page **XX**.

1.1.6 Going Concern Disclosure

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

1.2 Performance Analysis

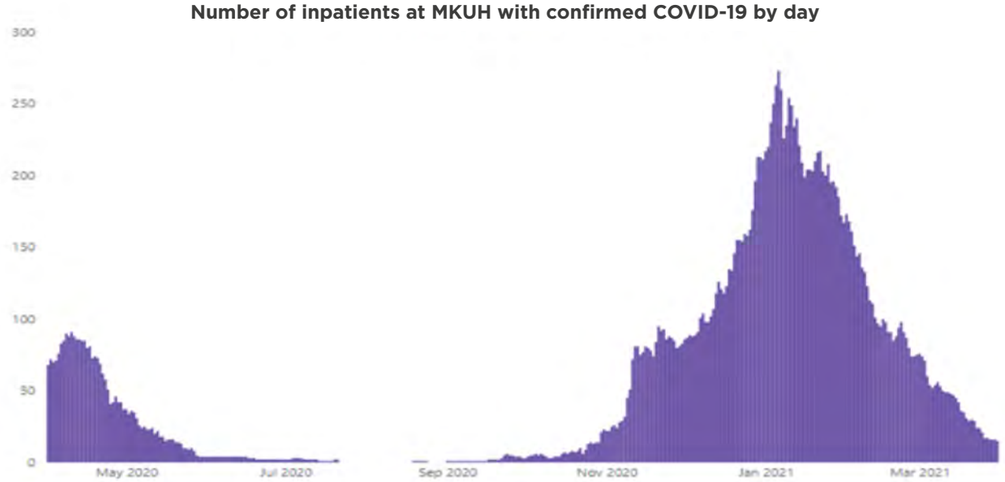
This section of the report provides a summary of the Trust's key performance indicators and outlines how it monitors performance against these measures. It also provides a detailed analysis and explanation of the development and performance of the Trust during the year using a wide range of data, including key financial information.

This section also provides a summary of environmental matters and some background on social, community and human rights issues, important events and overseas operations.

1.2.1 Impact of the COVID-19 Pandemic on Trust Operations

The COVID-19 pandemic had a major impact across 2020/21 in relation to the provision of planned and elective care. The graph below shows the burden of COVID-19 in the hospital across the year, with over half of the Trust's available beds being occupied by patients with COVID in January and February 2021. Even at times when the burden of COVID was lower, the provision of planned care has been challenging given the need to separate patient pathways, test patients prior to planned procedures, reduce bed densities, ensure access to high dependency beds and anaesthetic support as required, and ensure appropriate spacing and air handling in relation to invasive procedures (aerosol generating procedures, including lung function tests and diagnostic tests in ENT). Across the year, we have worked hard to ensure that cancer pathways have continued to operate insofar as is possible with clinical triage and prioritisation of urgent cases. Routine planned care (including operations) have been impacted. During both of the COVID peaks, only high priority operations were undertaken. Across autumn 2020, we undertook some more routine cases when possible – both at MKUH and also working with partners (under a national contract) at Ramsay Blakelands and BMI Saxon Clinic. Many services have used innovative means to provide planned care, including telephone and video-conference clinics. The volume of planned care, including surgery, dramatically increased in March 2021 and this acceleration continues into 2021/22 in order to prevent further extension in waiting times.

Number of inpatients at MKUH with confirmed COVID-19 by day



1.2.2 Management of Healthcare-Associated or Nosocomial COVID-19 Infections

In common with most other NHS organisations, we have had a number of COVID outbreaks within the hospital over the course of the pandemic. These have been managed according to a standardised process with the involvement of Public Health England and infection prevention and control experts from the NHS Region (independent of MKUH).

An outbreak of an infectious disease is defined as two new cases linked in time and place. In relation to COVID-19, this can involve patients and/or staff. A key challenge is that by the time a first (index) case is identified, exposure and infection of others may well have occurred already.

NHS England have introduced defined timeframes in terms of the length of time between admission to a healthcare environment and a first positive COVID test. If this time period is relatively short, the patient likely acquired COVID in the community (and was asymptomatic and incubating the virus at the point of admission). If this time is longer, the likelihood is that the patient acquired COVID in hospital – whether from the environment, other patients or staff members.

The specific timeframes are as follows: community acquired (positive within 48 hours of admission); indeterminate healthcare associated (positive screen 3-7 days after admission with no prior hospital admission in the previous 14 days); probable healthcare associated (positive specimen 8-14 days after admission, or a specimen date 3-14 days after admission in previous 14 days); and, definite healthcare associated (positive specimen date 15 days or more following admission).

We are committed to being open, honest and transparent and to providing as much information, support and care as we can to families who have lost a loved one to Covid-19, particularly where that infection may have been acquired in hospital. Information (with personal information removed) on nosocomial infection is available on our website.

1.2.3 Activity

Activity in the Trust was significantly impacted by the COVID-19 pandemic in 2020/21, and the variation in activity during the year, compared to 2019/20, was as follows:

313,363 outpatient attendances, 18.3% less than 2019/20

16,255 elective spells, 35.1% less than 2019/20

22,208 non-elective admissions, 23.4% less than 2019/20

73,397 ED attendances, 18.6% less than 2019/20

3,537 babies were delivered, 1.0% fewer than 2019/20

"Many services have used innovative means to provide planned care, including telephone and video-conference clinics."

1.2.4 Key Performance Measures

The Trust measures performance in key service and quality areas against key national indicators, which each have nationally defined standards. In addition, the Trust has also developed a series of local service quality indicators in conjunction with Milton Keynes CCG, as well as a number of internal indicators of quality and performance that are not required to be reported nationally.

Where possible, relevant and applicable, performance indicators are consistently reported at aggregate Trust level, as well as at Divisional and CSU level to provide a more granular view. This approach provides an insight into performance and is used to highlight risks and/or uncertainty in specific areas or services. Performance reports and key performance indicators are used as a basis for influencing the agenda at monthly Trust and Divisional Management Board accountability meetings, alongside financial, workforce and other key elements of information about the Trust. This 'balanced scorecard' approach allows correlations to be made across a wide range of information about different areas in the Trust to drive and inform a culture of continuous improvement.

The COVID-19 pandemic has clearly had a major impact on planned elective care across the entire NHS during 2020/21. As a result, the national standard for consultant-led Referral to Treatment (RTT) waiting times of 92% has not been viable for the Trust to achieve. However, during the second half of the year, there has been a determined effort to manage patient waiting times through the clinical validation and vigilant management of incomplete elective pathways, considering their priority and urgency. This has resulted in an expected increase in long waiters both nationally and locally, but by the end of March 2021, 57.8% of incomplete pathways had waited less than 18 weeks. This represents a steady and closely managed recovery from a low of 42% that was reported by the Trust in July 2020.

Diagnostic waiting times were inevitably impacted by COVID-19, with performance touching a low of 53.6% of patients waiting less than six weeks for a diagnostic test at the end of April 2020. Recovery in relation to diagnostic waiting times was achieved through the vigilant management and planning of services, improving to 80.1% by the end of June 2020. This level of performance was successfully sustained throughout the rest of the year, with 83.2% of patients waiting less than six weeks for a diagnostic test at the end of March 2021.

The table below summarises performance against key national indicators for 2020/21:

Indicator	Threshold/Target	Trust Performance	
National Requirements			
Clostridium Difficile Infections (hospital associated)	Ceiling: 15	14	Achieved
MRSA Bacteraemia (hospital associated)	Zero Tolerance	1	Not Achieved
All cancers, 31 day wait for second or subsequent treatment	96%	94.5%	Not Achieved
All cancers: 62-day wait for first treatment	85%	78.9%	Not Achieved
All cancers: 2-week wait from referral to first appointment	93%	84.1%	Not Achieved
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways OR the mean average waiting time for patients in weeks.	92%	57.8% (March 2021)	Not Achieved
Maximum wait of 4 hours in the ED from arrival to admission, transfer or discharge	95%	93.1%*	Not Achieved
Acute Foundation Trust – Minimum Standards			
Friends and Family Test (Patient Recommend Rate)	None	Not Available	No Threshold
Complaints responded to within the required timeframe	90%	91.0%	Achieved

**This figure represents the combined performance of the Trust's Type 1 and Type 3 units.*

1.2.5 Detailed Quality Performance Analysis

1.2.5.1 Referral to Treat (RTT)

The COVID-19 pandemic had a major impact on planned care across the entire NHS during 2020/21. As a result, the national standard for consultant-led Referral to Treatment (RTT) waiting times of 92% has not been viable to achieve locally or nationally.

Month 2020/21	NHSI Trajectory	Trust Performance
April	66.0%	64.1%
May	59.0%	56.9%
June	61.0%	46.7%
July	63.0%	42.0%
August	65.0%	49.0%
September	67.0%	53.0%
October	69.0%	55.8%
November	71.0%	58.0%
December	73.0%	56.1%
January	75.0%	53.2%
February	77.0%	54.7%
March	79.0%	57.8%

1.2.5.2 Accident and Emergency 4-hour target

The Trust did not achieve the target of treating 95% of patients attending the ED within 4 hours. However, its overall performance of 93.1% (all types) for the year placed it among the top performing trusts with a Type 1 department nationally.

Month 2020/21	NHSI Trajectory	Trust Performance
April	90.0%	95.6%
May	90.0%	99.1%
June	90.0%	98.8%
July	90.0%	97.6%
August	90.0%	97.6%
September	90.0%	96.0%
October	90.0%	94.3%
November	90.0%	92.2%
December	90.0%	84.4%
January	90.0%	83.4%
February	90.0%	86.7%
March	90.0%	90.3%

1.2.6 Development of the Business during the Year

The Trust continued to engage fully in the development of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System (ICS). This is a system in which the respective NHS organisations (both commissioners and providers) in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. This collaborative approach to providing care is already leading to better outcomes for local people, including reductions in the length of time that patients need to wait before they can be discharged from the hospital back into community settings.

In addition to the collaboration with ICS partners, the partnership between the Trust and the University of Buckingham Medical School continues with positive results. The first cohort of students trained in the University's Academic Centre on the Trust site and within the hospital's wards and clinical areas graduated in September 2019, with several graduates taking on employment with us. A range of Trust clinicians continue to actively participate in all aspects of training.

The Trust continued the roll out of its Electronic Patient Record (EPR) system, known as eCare, which was first introduced in May 2018. Further roll out eCARE was delayed due to the pressures caused by the COVID -19 pandemic. During the pandemic additional functionality was added into eCARE to support clinical teams with the management of patients with Coronavirus. This included a COVID-19 workflow supporting the identification and treatment plans, reporting of numbers of positive cases in the hospital and reporting of Oxygen usage. eCARE was also used during the Covid vaccination programme, supporting decision making around suitability of the vaccine for patients and completion of the patient record at a local level. Expansion into Anaesthetics, Intensive Care, Paediatrics

and Theatres is due to relaunch in May 2021 with completion expected in the Autumn. The aim of eCare is to better utilise technology to increase patient safety and clinical effectiveness with significant benefits already in evidence. We are constantly looking at growing these benefits when further functionalities of the system are realised. It is expected that this system, together with other new technological innovations that the Trust is investing in, will revolutionise the way that care is provided across the hospital.

In 2019/20 the Trust took delivery of a state-of-the-art surgical robot. Clinicians undertook comprehensive training using the robot before going live in theatres. The robot has been used to assist in performing a number of procedures, particularly in the areas of colorectal and gynaecological surgery and to date results have been impressive, with both clinical staff and patients giving positive feedback.

1.2.7 Impending Developments and Future Development Trends

Since April 2020, work has commenced on the construction of a new imaging building to enable the Trust to provide increased capacity for MRI (magnetic resonance imaging) and CT (computed tomography) scans. A new PET CT Scanner (positron emission tomography–computed tomography) is already operational on site. The Trust has also completed the extensive upgrade and refurbishment of some wards, patient and public facilities, and departments such as Pharmacy and Radiology.

Work has progressed on the development of our new Assessment Unit which will include a 26-bed ward to manage the flow of emergency medical admissions into the Trust. The Unit will take referrals from the ED, General Practice and from Outpatient clinics. Patients attending the Unit will receive full nursing and medical assessments of their physical and healthcare needs. Treatment options will be discussed and initiated within this area with a plan that either allows them to return home or be admitted to an appropriate medical ward. The Unit will be managed by a clinical and nursing team consisting of medical consultants, a ward sister and senior staff and supported by a whole range of healthcare professionals.

The Assessment Unit will provide:

- rapid assessment, diagnosis and initial treatment of emergency medical patients;
- rapid access for GPs
- rapid access nurse led clinics
- rapid access to diagnostic services;
- follow up consultant clinics ensure that patients are admitted to the appropriate beds wherever possible;
- enable an informed decision as to whether the patient requires admission or can be discharged home or to residential care with a plan of treatment.

The Unit will be part of a Trust-wide initiative, working closely with the ED to create an Acute Care Pathway which has been designed to simplify the patient journey, improve the services we offer and enhance the patient experience.

In December 2019, the Trust was informed that it was going to be the recipient of 'seed funding' from the Department of Health and Social Care's HIP2 (Health Infrastructure Plan) as part of a planned £200m hospital redevelopment programme in Milton Keynes. As part of the HIP Programme, the Trust issued a Strategic Outline Case (SOC) in November 2020, which identifies the challenge and response to significant population growth in Milton Keynes over the next 30 years. The SOC stated that the response required a new Women's and Children's Hospital to provide state of the art facilities to replace current facilities on the MKUH site, additional Surgical Wards and Theatres in the Surgical Ward Block with Intermediate Care and additional Imaging provision. The DHSC's New Hospital Programme Team are currently reviewing progress on the 40 national schemes to ensure that there is a commercially viable and timely Programme over the next decade, and we expect a response early in 2021-22 on MKUH's submission.

1.2.8 Review of Financial Performance

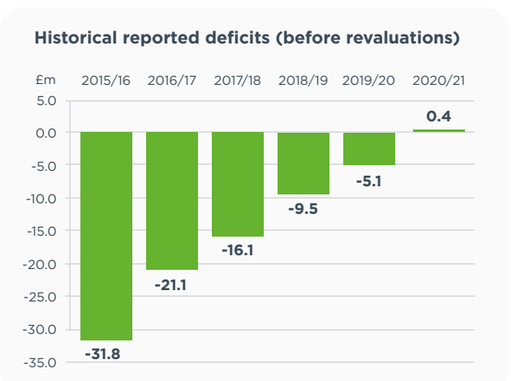
The many references throughout this annual report to the profound impact arising from the pandemic on hospital services, triggered significant change to the NHS finance regime during 2020/21. The normal operating model framing business practices across the NHS in England, was suspended at the beginning of the financial year as the true extent of the pandemic on the NHS began to unfold. In its place an emergency pandemic finance regime was introduced across the NHS in England.

The core tenet of the pandemic finance regime was a centralised funding model, designed to reimburse NHS organisations for costs incurred in responding to the pandemic, and reinforce cashflows for swift payment of goods and services. For the first half of the year this model was operated nationally by NHSE/I with regional support, switching during the second half of the year to coordination by local Integrated Care Systems.

As the NHS entered the new finance year of 2021/22, the emergency finance regime has been superseded by a transitional funding settlement for Integrated Care Systems up to the end of September 2021.

The Trust financial performance for 2020/21 was a surplus of £0.4m (excluding other comprehensive income) against a planned deficit of £3.6m. The results are reflective of the national funding regime intention in supporting breakeven performance for NHS organisations. The exceptional impact of the pandemic on altering the cost base and revenue streams of the Trust, undermines fair comparison between the financial performance of 2020/21 with historical results.

For completeness, in actual terms, 2020/21 performance represents a £5.5m improvement on the reported deficit of £5.1m in 2019/20, and a £32.2m improvement compared to 2015/16 when the Trust reported its largest deficit (£31.8m):



The pandemic financial regime introduced by the government comprised of block funding, including a core funding component supplemented by top-up funds for direct pandemic related costs (e.g., incremental costs for segregating covid suspected and non-covid patient pathways). The Trust received £26.5m of top-up income, including £1.2m related to COVID reimbursement.

The Trust's income increased in 2020/21, with operating income from patient services (excluding pandemic top-up funds) increasing by £18.6m (7.9%) to £253.5m for the year ending 31 March 2021. Operating expenditure was £297.0m for the same period, representing a 12.1m (4.2%) increase compared to 2019/20.

During 2020/21, the Trust continued to invest in the hospital's infrastructure through its capital programme. It spent £40.8m on capital schemes receiving £23.8m in Public Dividend Capital from Department of Health and Social Care for a number of initiatives including replenishment of diagnostic equipment, commencement of construction of a new Pathway Unit, as well as funding for enabling works for the Health Infrastructure Plan scheme (HIP2) for the proposed development of a new Women's and Children's Hospital, Surgery Block; Intermediate Care Centre and Imaging Centre.

Statement of Comprehensive Income

Operating income from patient care activities increased by £18.6m (7.9%) to £253.5m compared to the previous year. This was not related to increases in patient care activity, elements of which saw significant disruption to provision (e.g., planned care services), instead this was for reimbursement of costs incurred under the pandemic finance regime. The Trust block contract income increased by £55.9m (34%), however this was offset by a reduction in other NHS clinical income £39.7m (92.4%) which was due to changes in the funding regime during the pandemic. Another reduction as a consequence of the pandemic was a reduction in private patient income of £0.2m (44%). There were other increases in the following areas:.

- Other Non-NHS clinical income £2.1m (67.6%); and
- Pension funding £0.6m (8.4%), central funding towards the additional costs of increases to the employer pension contribution rate (14.38% to 20.68%).

Non-clinical income was broadly comparable to 2019/20 at £47.8m, increasing by £0.7m (1%), however there were decreased in the following areas:

- Grant income of £2.4m which was a result of no large-scale appeals in 2020/21, the previous year saw the cancer centre appeal; and
- COVID related income including other income £1.7m; car parking £0.8m; and non-patient care services to other bodies £0.6m.

The above reductions were offset by increases in other pandemic related income streams including reimbursement and top-up funding of £1.6m and £3.9m for consumables (donated by DHSC) and donated equipment of £0.7m.

Operating expenses increased by £12.1m (4.2%) on the previous year to £297.0m, of which the main increases were:

- £14.9m (8.3%) related to an increase in staffing costs. This included additional costs of £5.9m for annual leave because of staff inability to use the annual leave entitlement (due to service pressures and staffing shortages) and £0.5m for additional pension costs due to the increase in the employer pension contribution rate (match funded);
- Trust infrastructure costs accounted for £3.9m (27%) including IT software support,
- equipment, costs, and utility costs;
- Clinical consumables funded by DHSC in response to COVID £3.5m (100%);
- Depreciation and amortisation increased by £0.7m(7.5%);
- Clinical negligence premium increased by £1.5m (21.8%);
- Operating leases £0.7m (166.1%); and
- Training costs £0.5m (10.2%).

These were offset by reductions in healthcare from non-NHS providers of £3.5m (53.4%), clinical consumables excluding drugs £2.4m (13.5%) and asset impairments of £7.4m (99.9%).

Statement of Cash Flows and Net Debt

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHSE/I announced reforms to the NHS cash regime for the 2020/21 financial year.

During 2020/21, as part of a debt equity swap, existing DHSC interim revenue and capital loans (as of 31 March 2020) were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The Trust had outstanding interim loans totalling £130.8m which were converted to PDC during the 2020/21 financial year. The Trust also received £23.8m in PDC in-year to support several large-scale capital schemes and COVID related equipment purchases as detailed in the capital expenditure section.

The Trust ended the year with cash and cash equivalents of £48.8m, which was £32.5m higher than the previous year. This was due to cash flow advances to support the NHS through the pandemic and the timing of capital purchases.

Total Assets Employed

£m	2020/21	2019/20
Non-Current Assets	192.6	160.2
Current Assets	72.3	45.3
Current Liabilities	(76.5)	(174.0)
Non-Current Liabilities	(7.4)	(7.4)
Total Net Assets Employed	**181.0**	**24.1**

Total assets employed increased by £156.9m to £181.0m. This was due to the outstanding interim loans of £130m being converted to PDC, increased cash of £32.5m offset by increase in payables.

Capital Expenditure

The Trust invested £40.8m in capital schemes during 2020/21 which was funded through a combination of internally generated resources and public dividend capital. It made significant investments in information technology £10.1m which included the continuation of the Trust's eCare programme, a hosted Voice to Text software system for medical grade dictation, IT hardware and system support to ensure that staff could work remotely during the pandemic, a new Pathology IT system and upgrades to the Trust network. The Trust strives towards its commitment to be amongst the most technologically advanced NHS hospitals in England.

Alongside these technology investments the Trust funded the purchase of medical equipment including MRI £2.7m, Endoscopy £2.6m, CT £1.3m and Mammography £0.3m. In addition, the Trust spent £2.0m from targeted national pandemic funding on several projects that enabled the Trust to implement safe, covid-compliant working, as well as specific equipment requirements during the year.

Delivering programmes within the pandemic working restrictions, investments of £17.5m were made in the physical estate, including:

- HIP2 infrastructure, £8.9m;
- Pathway Unit, £1.7m;
- Critical infrastructure work, £1.6m;
- Urgent and emergency repairs, £1.6m;
- Backlog maintenance and upgrades for £2.2m (this included the first phase of installation of solar panels on the hospital roof); and
- Replacement of ageing clinical equipment and statutory estates works accounted for £5.7m.

The Trust is planning on significant investment in the capital programme for 2021/22, continuing the development of the Pathway Unit, whilst awaiting a funding outcome on HIP2 for the proposed development of a new Women's and Children's Hospital, Surgery Block, Intermediate Care Centre and Imaging Centre.

1.2.9 Counter Fraud

The Trust has an established counter-fraud policy to minimise the risk of fraud or corruption, together with a whistleblowing policy to be followed in the event of any suspected wrongdoing being reported. This policy also highlights the relevant provisions of the Bribery Act 2010, and the offences for which individual members of staff and the Trust corporately could be liable under this Act. The policy and related materials are available on the intranet and counter-fraud information is prominently displayed across the Trust's premises. The Trust's Local Counter Fraud Specialist (LCFS) reports to the Director of Finance and performs a programme of work designed to provide assurance to the Board in regard to fraud, bribery and corruption.

The LCFS attends Audit Committee meetings to present the programme and the results of counter-fraud work. The LCFS also gives regular fraud awareness sessions for Trust staff and investigates concerns reported by staff. Where these are substantiated, the Trust takes appropriate criminal, civil or disciplinary measures.

1.2.10 Statutory and Other Declarations

Compliance with HM Treasury Cost Allocation and Charging Guidance

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Cabinet Office public sector information guidance.

Accounting Policies and Other Retirement Benefits

The accounting policies for pensions and other retirement benefits are set out in the accounting policies section of the Financial Statements and the arrangements for senior employees' remuneration can be found in the Remuneration Report.

Political and Charitable Donations

The Trust continues to benefit from charitable donations generated and managed by its charity, Milton Keynes Hospital Charity, and is grateful for the efforts of fundraisers, members of the public, local companies and grant-giving organisations for their continued support. The Trust also continues to benefit from charitable donations made from independent charity The Friends of MK Hospital and Community, which celebrated its 40th anniversary in 2019 and continue to raise funds through profits from its hospital shop and other events in the community.

Board of Directors and Accounts' Preparation

The Annual Report and Accounts have been prepared under a direction issued by NHS Improvement. In support of the Chief Executive, as accounting officer of the Trust, the Board of Directors has responsibilities in the preparation of the accounts.

NHS improvement, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006 directs that the accounts give a fair and true view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial period.

To this end, the Board of Directors are required to:

- Apply on a consistent basis accounting policies laid down by NHS
- Improvement with approval of the Treasury
- Make judgements and estimates that are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- Keep 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 Act
- Safeguard the assets of the Trust and hence take reasonable steps for the prevention and detection of fraud and other irregularities

Critical Accounting Judgements

There are a range of judgements and estimates that have been made in the preparation of the annual accounts. These include the valuation of the Trust's estate. These judgements have been reviewed and are considered appropriate and in accordance with the appropriate accounting standards and further analysis can be found in the accounting policies section of the Financial Statements.

Audit Disclosure

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information.

Statement on Report as Fair, Balanced and Understandable

The Board of Directors are responsible for preparing and agreeing the financial statements contained in the annual report and accounts. The Board confirms that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Enhanced Quality Governance Reporting

Arrangements for governing service quality are outlined in the Annual Governance Statement, which is presented as part of this Annual Report.

The Trust continues to measure performance on a monthly basis and is taking additional actions where required, to ensure that it meets all of its mandated performance targets. Performance review meetings are held with the regional NHS Improvement Team every two months and updates are promptly provided in response to all queries raised about the Trust's performance.

There were no material inconsistencies between the Trust's assessment of key risks and either subsequent NHS Improvement ratings or Care Quality Commissions assessments. The Trust Annual Governance Statement details how the Trust has reviewed and assessed the effectiveness of the Trust's systems of internal control.

Outlook for 2021/22

The COVID-19 pandemic has had a significant impact on how the hospital provides its services which is expected to continue during 2021/22. The Trust will continue to work hard to deliver those routine operations that were cancelled during winter 2020/21 as a result of the second wave of the pandemic and reduce the waiting list for these operations. It is also important to the Trust to continue to ensure the health and well-being of staff and the safety of its patients.

The Trust will also continue to work with local partners, including those within Bedfordshire, Luton and Milton Keynes ICS (Integrated Care System), in its response to COVID-19, and as part of wider provision of health services for the population of Milton Keynes.

1.2.11 Environmental Sustainability

As part of the DHSC's HIP Programme, the Trust commissioned an Energy and Infrastructure Strategy to support the objective of moving to Net Carbon Zero (NCZ) in line with national NHS objectives. To achieve the objectives of the Energy and Infrastructure Strategy, there is a need to significantly increase electrical capacity purchased from the National Grid's NCZ sources, and to minimise energy consumption on-site. This is a key part of the sustainability drive to secure the future of the Trust, and the Strategy will inform more detailed plans for 2021-22 and beyond.

In line with the Trust's commitment to reduce minimise energy consumption and reduce carbon emissions the environmental impact of any development on the site is assessed as part of the business case process. The Trust has also upgraded its medium voltage generation plant to comply with emissions regulations and is installing photovoltaics roof panels.

Please see below for the key objectives and deliverables associated with the Trust's objective commitment to reduce its environmental impact and develop as a good corporate citizen:

Objective 10 Develop as a Good Corporate Citizen	Key Deliverables
Reduce environmental impact through improved employee wellbeing	• Green travel plan; • Engaging staff in sustainability planning; • Increasing electrical vehicle charging points across the site; • Improving the Estate to provide better care and working environments and a reduced carbon footprint; • Increasing flexible working
Engage staff and patients to increase use of car share schemes, public transport and in reducing energy consumption	• Evidence engagement of and communication with staff around green travel options and energy usage with the aim to reduce energy consumption, including encouraging uptake of the cycle to work scheme, and increased power points for electric car charging; • Continually review transport services across the site as a critical strand of the estates development programme
Increase opportunities for staff to engage in recycling, energy saving initiatives and community project involvement	• Provision of recycling banks across the Trust, including clothes and textiles; • Extension of existing furniture recycling programme
Engaging staff to reduce food wastage	• Review of food provision to ensure quality, healthy eating options and waste minimisation

In addition, the Trust is committed to reducing carbon emissions as part of the national sustainability agenda.

The following table shows CO_2 performance per annum to date:

Year	CO_2 emissions
2012/13	11,183 Tonnes
2013/14	10,508 Tonnes
2014/15	9,786 Tonnes
2015/16	9,426 Tonnes
2016/17	9,660 Tonnes
2017/18	9,728 Tonnes
2018/19	9,075 Tonnes
2019/20	9,241 Tonnes
2020/21	6,557 Tonnes

There is an increased reliance on the Trust's medium voltage generators and its combined heat and power plants, both of which provide more efficient power and heating to the hospital and can export electricity back to the grid.

For 2021/20 the Trust signed up to a 100% renewable electricity contract through Crown Commercial Services. The continued decarbonisation of UK Electrical Power Generation with the capacity in the market for large consumers to buy from 100% renewable should see a further overall reduction in the CO2 emissions at MKUH of approximately 20-25% in 2021/22. The remainder of our emissions are largely made up from Gas, with no effective NCZ alternative currently available although options to deliver this are in the Infrastructure and Energy Strategy

The Trust continued to be part of a joint waste management contract with the two other acute Trusts within the ICS footprint, which has meant significant increases in the amount of recycling and diversion away from landfill.

1.2.12 Social and Community Issues

At the last census collection (2013), the stated population for Milton Keynes was estimated to be 255,700, and in 2015, the Office of National Statistics estimated the population to have reached 261,750. By way of context, in 1967 Milton Keynes was designated as a new town, with the area having a population of 60,000. In particular, the last two decades has seen double digit growth; the historical trend between 2001 and 2013 showed a population increase of 43,000 - a growth of 20.2% compared with a growth rate of 8.9% for England during the same period. Milton Keynes was the 20th fastest growing local authority in England between 2005 and 2015 with a growth of 17.1 per cent. With increased housing being built, more families are expected to move to the area, with Milton Keynes Council predicting a population of 500,000 by 2050.

The Population Bulletin 2013/14 outlined that the high population growth is expected to continue into the future and in addition there is anecdotal evidence which suggests that in all likelihood the population will increase at the same pace over the next decade. Current estimations suggest that the population of Milton Keynes will reach 308,500 by 2026. This is an increase of 46,750 people or 18 per cent between 2015 and 2026. It is further projected to reach 500,000 by 2050.

The two components of population growth are natural change and net migration; natural change refers to the difference between births and deaths and net migration refers to new residents arriving less any residents leaving the city. Natural change (difference between births and deaths) will add an average of 2,000 people to the population each year from 2015 to 2026. Net migration is the main driver of population growth peaking at 5,100 in 2019. This is driven by the planned house building to support migration from other parts of the UK, which is likely to be enhanced as part of the Cambridge-Milton Keynes-Oxford corridor development.

The age profile of the Milton Keynes population is younger than that for England as a whole.

Between 2001 and 2011 the ethnic diversity (represented by those from an ethnic group other than "white" British) **increased from 13.2% to 26.1%**

22.6% of the Milton Keynes population are aged under 16 compared with 19.0% in England. The number of 25 to 64 year olds is projected to increase from 143,800 to 161,200, a rise of 12 per cent between 2015 and 2026. This age group represents the biggest proportion of all age groups throughout the years. 12.1% of the Milton Keynes population are aged 65+ compared with 17.3% in England. Looking forward however, the 65 to 79 year olds are projected to increase from 25,600 to 36,900, a rise of 44 per cent between 2015 and 2026. Although this age group does not represent the highest proportion of the population, the percentage increase is significant and the associated rise in demand for healthcare services will be substantial.

Between 2001 and 2011 the ethnic diversity (represented by those from an ethnic group other than "white" British) increased from 13.2% to 26.1%, compared to 20% in England. No data is currently available to provide a context to the change in ethnicity over the next 10 years, but if historical trends are to be taken into account, healthcare services will need to be planned in such a way as to reflect this change in ethnicity, with a particular focus on the health and well-being agenda.

The change in the ethnic make-up and the emergence of different cultural communities has resulted in the people of Milton Keynes holding a wide range of religious beliefs; 62.1% of people in Milton Keynes have a religious identity. Incorporating religious insights into the planning and the delivery of care can ensure services take seriously the values and beliefs of the population. The Trust therefore recognises that pastoral and spiritual care is an integral part of any health need assessment, and that these are best considered on an individual basis.

Disproportionate levels of population growth in Milton Keynes when compared to England have also resulted in significant pockets of deprivation and poverty. Around 18% of the child population live in low-income families and furthermore there has been an 18% increase in children taken into care since 2012. The wards of Eaton Manor and Woughton are classed in the top 10% of most deprived wards in England when measured against the deprivation indicators of income, employment and education.

In addition to the population growth, the Trust has a catchment area which is wider than the boundaries of the Milton Keynes Unitary Authority, bringing in patients from parts of Northamptonshire and the market towns of Buckingham and Leighton Buzzard.

Furthermore, there is demand for healthcare services from employees of the large number of major organisations who commute from outside the Trust's catchment area. The Trust is therefore actively working with its commissioners to address and meet the healthcare needs of all those currently using its services and those likely to do so in the future. A significant element of this work, in conjunction with other local health and care partners has involved a focus on developing plans to divert as many patients as possible away from the hospital setting. This will ultimately ensure that the Trust's services are focused only on those patients who require such intervention, and that appropriate services are developed within the primary and community settings to support those patients who do not immediately need to use secondary services.

1.2.13 Human Rights issues

The Trust takes account of the provisions of the Human Rights Act 1998, insofar as they relate to the provision of healthcare, as well as the NHS Constitution. The Trust pays particular attention to the NHS' seven key principles. With regard to principle 1 (the NHS provides a comprehensive service available to all), the Trust ensures that its service provision is based entirely on clinical need and priority. The Trust has in place a Patient Access Policy, last updated in March 2019, which sets the standards to be followed in relation to waiting list management and restates the commitment to and expectation of a maximum of 18 weeks' waiting time from referral to the start of treatment.

The Trust is also guided by principle 4 (the patient will be at the heart of everything the NHS does). In this regard, in 2019/20 the Trust devised a new Patient Experience Strategy to help ensure that patients' experience of accessing care at the Trust guides changes and improvements to service delivery. Feedback received via the various patient surveys and the Friends and Family Test also gives good indications of the level of patient satisfaction with the Trust's services.

The Trust is cognisant of the human rights of both current and prospective members of staff in carrying out its work. The requirement within the Human Rights Act that there be no discrimination in the application of human rights on any ground informs the Trust's approach to engaging with its staff. Following the Trust's investment in a newly established Head of Equality, Diversity and Inclusion role, 2020/21 saw the strengthening of staff networks, such as the Women's Network, and the establishment of others such as the Black, Asian and Minority Ethnic (BAME) network and the Faith and Belief Network. The networks are critical to improving the collective voice of the organisation and have also been involved in the delivery of actions aligned to the various statutory Equality, Diversity and Inclusion reports. within the organisation. The main remit of the Head of Diversity, Equality and Inclusion is to ensure that the career goals and progression of under-represented groups remain high on the Trust's workforce agenda.

The Trust also ensures that its suite of human resources policies reflects both the content and spirit of the Human Rights Act.

1.2.14 Overseas Operations

The Trust has had no overseas operations in the reporting period.

Professor Joseph Harrison
Chief Executive

2

Accountability Report

2.1 Directors' Report

The directors are responsible for preparing the Annual Report and Accounts and consider the Annual Report and Accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess Milton Keynes University Hospital's performance, business model and strategy.

Milton Keynes University Hospital Foundation Trust (the Trust) has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles set out in the 2012 version of the UK Corporate Governance Code.

The Board of Directors considers that it was compliant with the provisions of the revised Monitor NHS Foundation Trust Code of Governance, apart from the three exceptions set out on page **XX**.

2.1.1 Composition of the Board of Directors

The Board of Directors comprises full-time Executive and part-time Non-Executive Directors. Executive Directors are employees of the NHS Foundation Trust, led by the Chief Executive, and are responsible for the day-to-day management of the Trust.

Non-Executive Directors are not employees, but officers, and they bring to the Board an independent perspective and it is their role to challenge decisions and proposals made by the Executive Directors, and to hold the Executive Directors to account.

The role of the Board, led by the Chair, is to provide effective and proactive leadership of the Trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided and ensuring that the Trust is well-governed in every aspect of its activities.

The description below of each of the current directors' areas of expertise and experience demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that the directors bring to the Trust.

The composition of the Board of Directors at 31 March 2021 is detailed below:

Non-Executive Directors	
Alison Davis	**Chair *(from February 2021)***
Andrew Blakeman	Non-Executive director (Senior Independent Director)
Helen Smart	Non-Executive director
Heidi Travis	Non-Executive director
Nicky McLeod	Non-Executive director
Haider Husain	Non-Executive Director
John Lisle	Non-Executive Director
Dr Luke James	Associate Non-Executive Director (non-voting)

Executive Directors	
Professor Joseph Harrison	**Chief Executive**
John Blakesley	Deputy Chief Executive
Nicky Burns-Muir	Director of Patient Care and Chief Nurse
Dr Ian Reckless	Medical Director and Deputy Chief Executive
Emma Livesley	Director of Operations
Danielle Petch	Director of Workforce
Terry Whittle	Director of Finance *(from February 2021)*
Kate Jarman	Director of Corporate Affairs *(non-voting)*
Jacqueline Collier	Director of Transformation & Partnerships *(non-voting) (from March 2021)*

Other Board Members during 2020/21	
Simon Lloyd	Chairman *(till January 2021)*
Professor John Clapham	Non-Executive Director *(till June 2020)*
Michael Keech	Director of Finance *(till November 2020)*
Sophia Aldridge	Director of Finance *(Interim from November 2020 – February 2021)*

> *"The role of the Board, led by the Chair, is to provide effective and proactive leadership of the Trust"*

2.1.2 Biographies of Board Directors

Biographies for individuals who were serving as directors on the Board as at 31 March 2021 are detailed below. The Board of Directors is confident that it has within it the appropriate mix of skills and depth of experience to lead the Trust appropriately. The Board considers all the Non-Executive Directors to be independent as they were appointed to their roles through open competition and are not employees of the Trust. The Register of Interests can be found on the Trust website: **www.mkuh.nhs.uk**

Alison Davis, Chair

Alison joined the Trust in February 2021 as Chair.

Alison started her career as a State Registered Nurse, working in the acute sector eventually specialising in renal dialysis and transplant. Later, while studying law she spent several years as an agency nurse working in acute, community and nursing home settings.

Alison has been a Non-Executive Director in various NHS and Foundation Trust organisations; for 11 years she was a Chair in mental health, learning disability and community NHS Trust services. She has broad experience in governance, quality and patient safety, equality, diversity and inclusion. She is also strongly committed to patient/ service user, staff and stakeholder engagement. In her most recent appointment with Essex Partnership University Foundation Trust, she held the post of Senior Independent Director.

Alison has been involved in a number of charities and social enterprises during her career.

Andrew Blakeman, Non-Executive Director
(Senior Independent Director from 1 March 2018) (Chair, Audit Committee)

Andrew joined the Trust in February 2016 for a three-year period and is currently in his second term of office. He is a Chartered Accountant and has worked for BP for over 20 years in a variety of senior financial roles, most recently as Chief Financial Officer for BP's UK petrol station business. Andrew was a non-executive director on the board of NHS Blood & Transplant from 2008 to 2016 and was Chair of the Governance and Audit Committee, which covered audit, risk, quality and clinical governance. He also sits on the Quality and Clinical Governance Committee of Public Health England. He lives in Oxfordshire.

Helen Smart, Non-Executive Director
(Chair, Quality and Clinical Risk Committee)

Helen joined the Trust in March 2018. A nurse and health visitor by background, she has worked across the NHS since 1986, and has held a variety of senior Executive roles, including as Executive Director of Nursing and Operational Director for Learning Disability Services at Northamptonshire Healthcare Trust, Deputy Director of Commissioning for Primary Care at NHS Bedfordshire and Director of Community Services and Lead Nurse for South Essex Partnership University NHS Foundation Trust, a role she retired from in July 2017. Since then, Helen has been operating in an interim consultancy capacity, working with the North Central London STP as Programme Director for the Care Closer to Home programme across five CCGs, and is currently at Hertfordshire Partnership Foundation Trust. She has also worked for the Department of Health, and in advisory roles for the CQC and at a Governmental level. She lives in South Northamptonshire.

Heidi Travis, Non-Executive Director
(Chair, Finance and Investment Committee)

Heidi joined the Trust in March 2018. She joined Sue Ryder in March 2010 as Director of Retail, and took on the role of Chief Executive in September 2013. Previously, Heidi had worked as a business consultant developing small businesses. Before that, she spent 25 years at Marks & Spencer, most recently as an executive in group planning and strategy as well as managing a buying group. Heidi also worked as a lay member of the Aylesbury Vale CCG until 2013. She became a non-executive director for Bucks PCT (now Buckinghamshire Healthcare NHS Trust) in 2008 and chairs a Bucks speech and language therapy group. She lives in Milton Keynes.

Nicola (Nicky) McLeod, Non-Executive Director

Nicky joined the Trust in February 2019. She qualified as a general nurse in London, and later went on to work in sales and marketing roles within the pharmaceutical industry. 11 years later, she moved back into direct healthcare, taking up a role in Cygnet Health Care, an independent mental health care provider. After 11 years in that organisation, she became its Chief Operating Officer, with responsibility for 22 hospitals nationally. Nicky has a focus and a passion for organisational culture based on values and extensive experience in inpatient specialist mental health services. She lives in Northamptonshire.

Haider Husain, Non-Executive Director

Haider joined the Trust in April 2020. He has held senior positions in a variety of multi-national companies in the technology sector, including GE Healthcare and Microsoft. He has a passion for quality, and has previously been an ISO auditor, Six Sigma Blackbelt and is currently a British Standards Institute committee member for Healthcare Organisation Management. Haider serves as the Chief Operating Officer for Healthinnova, which specialises in transformational healthcare technology. He holds a BSc in Medical Informatics, and a Master of Informatics. Haider is married to a nurse, has a young son and lives in Bedfordshire.

John Lisle, Non-Executive Director

John joined the Trust in April 2020. For the past decade John has worked in the NHS, most recently as Chief Executive of East Berkshire Clinical Commissioning Group and previously managed services at Imperial College Healthcare NHS Trust. He was a non-executive director of Buckinghamshire Primary Care Trust and chaired Fitness to Practise panels for the General Social Care Council. Prior to this John followed a career in the Pharmaceuticals industry, including as Chief Executive of both stock exchange-listed and private companies and National Business Director for GlaxoSmithKline in the UK. John graduated from Cambridge University, with published research in virology, and is also a qualified accountant.

Professor Joseph Harrison, Chief Executive

Joseph joined the Trust as chief executive in February 2013. He was formerly chief executive at Bedford Hospital, and has 25 years' experience of working in the acute sector of the NHS, covering both big teaching hospitals and district general hospitals. His roles have included a range of senior operational and corporate positions at several London hospitals, and he has a track record of improving patient services and performance.

John Blakesley, Deputy Chief Executive

John has over 30 years' experience in the NHS. His career started in pathology, before moving into general management. He has undertaken a range of executive director roles as director of performance and delivery and deputy chief executive as well as director of market management (commissioning for a large PCT). In addition, John has experience of the commercial sector with a specialised surgical company. He has a particular interest in using information systems to improve patient care and decision-making.

Nicky Burns-Muir, Director of Patient Care and Chief Nurse

Nicky joined the Trust in 2016 as Deputy Chief Nurse. Prior to this Nicky worked as a senior nurse for 10 years in district general hospitals as well as tertiary trusts. She has undertaken many roles in her career including Head of Nursing for Cancer at Great Ormond Street Hospital. Nicky has an MBA from Exeter University and a master's degree in Leadership in Health from Kingston University. Nicky is also a trained coach and uses her coaching style to champion leadership and professional standards in Nursing, Midwifery and Therapies in order to drive high quality care and patient experience.

Dr Ian Reckless, Medical Director and Deputy Chief Executive

Ian was appointed as Medical Director in April 2016. He trained at St George's Hospital Medical School, London and undertook postgraduate training in the Oxford area. Ian worked as Special Adviser to the Healthcare Commission in 2004 and was Special Assistant to the Chief Medical Officer in 2005/06. He was appointed Consultant Physician and Senior NIHR Research Fellow at the Oxford Radcliffe Hospitals NHS Trust, and he later held the roles of

Associate Medical Director (Quality) and Clinical Director, Neurosciences at the successor Oxford University Hospitals NHS Foundation Trust. He continues to undertake clinical work both at Milton Keynes and in Oxford, where he remains Honorary Consultant Stroke Physician / Senior Clinical Lecturer at the John Radcliffe Hospital. He also contributes to the work of the Isle of Wight Clinical Commissioning Group as secondary care doctor on the Governing Body. Ian has a particular interest in postgraduate education, having previously served as Training Programme Director, and has authored books on general medicine, and the interface between medicine and the law.

Emma Livesley, Director of Operations

Emma joined MKUH from Nottingham University Hospital where she was interim Deputy Chief Operating Officer. She has a wealth of NHS experience which started in Public Health and migrated into operational and management experience in the acute provider sector. She was Director of Operations at University Hospitals Coventry and Warwickshire and held senior management roles in Calderdale and Huddersfield FT and East and North Hertfordshire NHS Trust, the Royal Free, Guys and St Thomas' London. Prior to her appointment in Nottingham, Emma also spent 18 months with NHS Improvement in regulation. Emma's passion is building high quality operational teams who deliver the best services for patients through partnership working and embracing the transformation agenda.

Kate Jarman, Director of Corporate Affairs

Kate has substantial experience as a communications professional and company secretary and has worked on and with boards in the acute health sector and police and criminal justice agencies. Before joining Milton Keynes University Hospital as Director of Corporate Affairs with responsibility for integrated governance and assurance, membership and corporate communications, Kate spent a number of years at Bedford Hospital, latterly as associate director of corporate affairs and communications and company secretary. Kate is passionate about staff and patient engagement, leadership, culture and about developing integrated governance systems to support the delivery of safe, effective, high quality care.

Terry Whittle, Director of Finance

Terry joined the team in February 2021. Prior to joining Milton Keynes, he was Director of Financial Performance for the Royal Free London NHS Foundation Trust, responsible for Barnet Hospital, Chase Farm Hospital and Group Clinical Services. Terry is an alumnus of the NHS graduate programme and has a breadth of experience from senior finance roles in general, specialist and teaching hospitals. He has worked at a regional level as Head of Finance for NHS Improvement in London, as well as in a national capacity for the Department of Health and Social Care in England. Terry is a chartered accountant, with an undergraduate degree in chemistry and a masters degree in Healthcare Leadership. He is a member of the HFMA Policy and Research Committee. Terry is a keen advocate for staff development and ensuring resources support quality care provision and value for taxpayers.

Danielle Petch, Director of Workforce

Danielle joined the Trust as Director of Workforce in July 2018 from Rotherham NHS

Foundation Trust. She has also previously worked at a PCT and a London teaching hospital.

Danielle holds an MBA from Durham University and a BSc (Hons) in computer science from the University of St Andrews and has completed the NHS Leadership Academy's Nye Bevan programme. Throughout her career, Danielle has led on a variety of initiatives to maximise workforce efficiency and staff experience. She is passionate about the efficient delivery of HR services, including making the best use of technology to drive service development. Danielle won an HPMA Award in 2018 for this work. Her strategic focus is to recruit and develop the workforce required today got the future.

Jacqueline Collier, Director of Transformation & Partnerships

Jacqueline joined the Trust in March 2021. She moved back into the NHS after developing a depth of knowledge and experience over the last 12 years working in healthcare consulting where she led teams to deliver large scale hospital productivity and transformation programmes. In 2015, her work was recognised as she was awarded two national consulting awards - Performance Improvement Consultant of the Year and Overall Management Consultant of the Year, both awards across all sectors. Jacqueline is an alumnus of the NHS Graduate Management Training Scheme and worked for a period in operational management after completing the scheme. She has a 1st Class BSc in Biomedical Science from Sheffield University and an MSc in Healthcare Leadership and Management. Jacqueline is passionate about developing and supporting people to deliver sustainable change which will improve the experience of our patients.

2.1.3 Balance of Board Members and Independence

At the end of the financial year 2020/21, the Board of Directors comprised:

- Chair of the Trust
- Six further voting Non-Executive Directors
- One non-voting Associate Non-Executive Director
- The Chief Executive
- Six further voting Executive Directors
- Two non-voting Executive Directors

As at 31 March 2021, 53% of the Board of Directors were female (there were nine female and eight male Board members).

The Board of Director does not have its full complement of voting Non-Executive Directors as the replacement for Professor John Clapham, the representative from the University of Buckingham who retired from the Board in June 2020, was yet to take up their seat.

The Board of Directors considers that the balance of skills and experience of its members is complete and appropriate to address the operational and economic challenges the Trust expects to face over the next few years.

2.1.4 Non-Executive Director Appointments

The appointment of non-executive directors of the Trust is the responsibility of the Council of Governors. A Non-Executive Appointments Committee of the Council has been established, and its membership comprised of:

- Alan Hastings (lead Governor, publicly elected) (Chair)
- Clare Hill (publicly elected)
- Amanda Anderson (publicly elected)
- Andrew Buckley (appointed, MK Business Leaders representative)
- Simon Lloyd (Chairman of the Trust) (till January 2021)
- Alison Davis (Chair of the Trust) (from February 2021)

When there is a non-executive director vacancy on the Trust Board the Non-Executive Appointments Committee will meet to draw a shortlist of candidates from those who respond the advert placed by the Trust. The Non-Executive Appointments Committee will then invite the shortlisted candidates to attend stakeholder discussions and events and to be interviewed. The Non-Executive Appointments Committee will recommend the selected to the full Council of Governors for review and approval. If approved by the Council of Governors, the recommended candidate will be appointed as a non-executive director of the Trust.

A non-executive director may resign from their roles by giving the agreed period of notice in writing to the Chairman and the Council of Governors, and the Chairman may resign by giving notice to the Council of Governors. In addition, the Chairman or any non-executive director may be removed from office on the approval of three quarters of the members of the Council of Governors.

The Non-Executive Appointments Committee did not meet in 2020/21.

2.1.5 Board, Board-level Committee and Directors' Performance and Effectiveness Review

The Board of Directors meets regularly and has a formal schedule of matters specifically reserved for its decision. This includes high-level items relating to the Trust's strategy and how this is operationalised, its business plans and budgets, regulations and control, and the annual report and accounts. The Board delegates other matters to the executive directors and senior management as appropriate.

Meetings of the Board of Directors follow a formal agenda, which includes reports and updates on operational performance and against quality indicators set by the Care Quality Commission (CQC), NHS Improvement and by management, strategic issues, financial performance, and clinical governance. The performance measures include the amount of time that patients are required to wait to be treated at the ED, lengths of stay, the effectiveness of processes for infection control, patient experience measures, including the timeliness within which complaints are handled, and the results of the Friends and Family Test. The Board also benchmarks its performance against that of other Trusts of a similar size and configuration.

The Executive and Non-Executive Directors recognise the importance of evaluating the performance and effectiveness of the Board of Directors as a whole, the sub-committees of the Board of Directors, and of individual directors. The performance of individual directors is assessed over the course of the year in terms of:

- Attendance at Board and Board committee meetings
- The independence of individual non-executive directors
- The effectiveness of the contributions of each executive and non-executive director to the business of the Board and its committees, both in and out of meetings
- The Board's effectiveness in providing a strategic direction to the Trust and its ability to provide the lead requisite leadership.

In respect of individual appraisals:

- The Chairman undertakes the appraisal of the Chief Executive and Non-Executive Directors;
- The Chief Executive undertakes the appraisal of the Executive Directors;
- The Senior Independent Director undertakes the appraisal of the Chairman, having sought feedback from the rest of the Board of Directors, the Trust Secretary and from the Governors and key stakeholders
- The Chief Executive discusses and reviews the executive directors' appraisals with the Chairman and the Remuneration Committee.

The process for the appraisal of the Chairman and the Non-Executive Directors has been approved by the Council of Governors. Governors evaluate the performance of the Board of Directors as a whole in terms of meeting its targets and communicating with its staff, members and stakeholders.

The result of the evaluation process of the Board of Directors' performance in respect of the year ended 31 March 2021 was that the Board collectively and the directors individually were deemed to have performed well.

Improvements made to the overall quality of information provided have led to richer and more in-depth discussions on the key issues, and a greater level of assurance to the committees and the Board.

The Board of Directors ensures that the principles set out in the Well-Led Framework not only inform their work but are also embedded across the organisation. For example, the Board receives regular reports on all aspects Trust performance and ensures that these address each of the eight Key Lines of Enquiry as set out in the Framework. Further detail about the Trust's approach to ensure that its services are Well-Led is set out in the Annual Governance Statement later on in this report.

2.1.6 Attendance at Board, Board Committee and Council of Governors meetings

	Board of Directors (6)	Audit Committee (4)	Charitable funds Committee (4)	Finance & Investment Committee (10)	Quality & Clinical Risk Committee (4)	Remuneration Committee (3)	Workforce Development Assurance Committee (4)	Council of Governors (3)
Alison Davis (from February 2021)	1	1	1	2	1			1
Andrew Blakeman	5	4			4	3		1
Danielle Petch	5					2	4	1
Emma Livesley	4			2	1			0
Haider Husain	6	4	2			3	2	2
Heidi Travis	6		3	10		3		3
Helen Smart	6	4			4	2	3	2
Dr Ian Reckless	6			6	4		1	3
Professor Joseph Harrison	6			5	3	3		1
John Blakesley	4	3						1
Professor John Clapham (till June 2020)	1					2		
John Lisle	6		2	9	3	3		1
Kate Jarman	5	4	3		4			1
Mike Keech (till November 2020)	4	3	2	6				1
Nicky Burns-Muir	4				2		3	
Nicky McLeod	5	0	0	0	4	3	4	2
Simon Lloyd (Chairman till January 2021)	5	2	2	8	2	3	0	2
Sophia Aldridge (November 2020 – February 2021)	2	1	2	6	0	0	0	0
Terry Whittle (From February 2021)	1	1	0	2	1	0	0	1
Jacqueline Collier (From March 2021)	0	0	0	0	0	0	0	0
Dr Luke James	6	0	0	0	0	2	0	1

2.1.7 Detail of Company Directorships and Other Significant Interests Held by Directors or Governors

Members of the Board of Directors and the Council of Governors did not hold any other non-executive directorships or commitments that are disclosable under the NHSI Monitor Code of Governance.

2.1.8 Board Register of Interests

The Trust maintains three registers of interests. The first includes interests of all directors; the second interests of the Council of Governors, and the third relates to members of staff regarded as Decision Makers within the organisation but are not members of the Board of Directors. The register relating to Decision Making staff contains only their job titles and not their names. All three registers are held on the Trust website.

An annual report is made to the Trust Board regarding the interests of executive directors and non-executive directors. In addition, executive and non-executive directors are required to declare any potential conflict of interest that they may have in respect of any item on a Trust Board or Board Committee agenda. In the event that it is decided either by the Trust Board Chair or the Chair of the Board Committee that a conflict does in fact exist, the Board or Committee member would be instructed to excuse themselves from the discussion of that particular item.

2.1.9 Audit Committee

The Audit Committee's key role is to ensure that the Trust has an adequate and effective system of internal controls. The Committee focuses on the establishment and maintenance of controls that are designed to give the Board reasonable assurance that the Trust's resources are safeguarded, waste and inefficiency limited, and that reliable information is produced to demonstrate that value for money is constantly sought.

The key responsibilities delegated by the Board to the Committee are to:

- Ensure the effectiveness of the organisation's governance, risk management and internal control systems,
- Ensure the integrity of the Trust's financial statements, the Trust's Annual Report and in particular the Annual Governance Statement, and
- Monitor the work of internal and external audit and ensure that any actions arising from their work are completed satisfactorily.

The Audit Committee is chaired by Andrew Blakeman, a Non-Executive Director of the Trust. As indicated above, Mr Blakeman has relevant financial experience, and therefore has the skills and knowledge to effectively perform this role. During the course of 2020/21, the other permanent members of the Committee were Helen Smart and Haider Husain.

The Committee met virtually on four occasions during 2020/21. At each meeting it considered the work of the internal audit function, the work of the external auditors, including the framework within which they conduct the audit of the Trust's financial statements and its Quality Report indicators, and any issues that they wished to raise both in the course of the audits and following the conclusion of their work. The Committee also considered the work of the Trust's Counter Fraud team, taking account of fraud trends that the Trust needs to be aware of, and steps being taken to raise fraud awareness across the Trust. It also considered a list of all debts that are to be written off; updates to the International Financial Reporting Standards and accounting policies, and the Trust's overall approach to risk management, including consideration of the Board Assurance Framework and Corporate Risk Register.

During 2018/19, the Trust engaged the services of RSM as its internal audit provider, and the Audit Committee agreed the ongoing internal audit work plan as put forward by the firm. It also received draft and final reports of their reviews, including reviewing management responses, and it ensured that recommendations arising out of reviews carried out by the previous internal audit providers were being carried forward. With regard to the external audit function, the Committee agreed with the external auditor the nature and scope of the of the audit as set out in their annual plan, discussed the auditors' evaluation of the audit risks and assessment of the Trust, and the impact of this on the audit fee set.

During the year, the Committee maintained its focus on quality of the data that the Trust generates and relies on in support of its operational activities. At its meetings in 2020/21, the Committee received and gave detailed consideration to updates received on the steps being taken to improve the accuracy of Referral to Treatment (RTT) counting, and the recording of pathway clock stops, and the correctness of the clock start and stop times for patients attending the ED. This was in line with the action plan emerging from findings from the external audit providers in their testing of performance indicators as mandated by NHS Improvement.

The Audit Committee received regular updates from the Trust's counter-fraud providers during 2020/21. The particular focus was on fraud prevention, the building up of awareness among staff as to what constituted, and steps to be taken to combat it. The Trust also continued to develop a more proactive approach to ensuring that payment is recovered from overseas patients who are not entitled to free care.

The Audit Committee received assurance through the Head of Internal Audit Opinion on the Trust's internal control environment and approach to identifying, assessment and mitigation planning to risks. This was supported by in year and year end reviews.

The Audit Committee reviews auditor independence both as part of its scrutiny of the annual report and accounts, and as part of its annual review of the auditors' work. The Committee has also engaged regularly with the external auditors throughout the year, including in private session. The Committee is satisfied that to the best of its knowledge, there are no issues that compromise the external auditors' independence. The Chair of the Committee regularly discusses the effectiveness of both internal and external auditors with the Director of Finance.

Deloitte have provided external audit services to the Trust since April 2012 when it was engaged on a five-year contract. In December 2016, the Council of Governors commenced the process, through an open procurement competition, of appointing new auditors. In May 2017, the Council of Governors agreed that Deloitte would be reappointed as the Trust's external auditors with effect from July 2017.

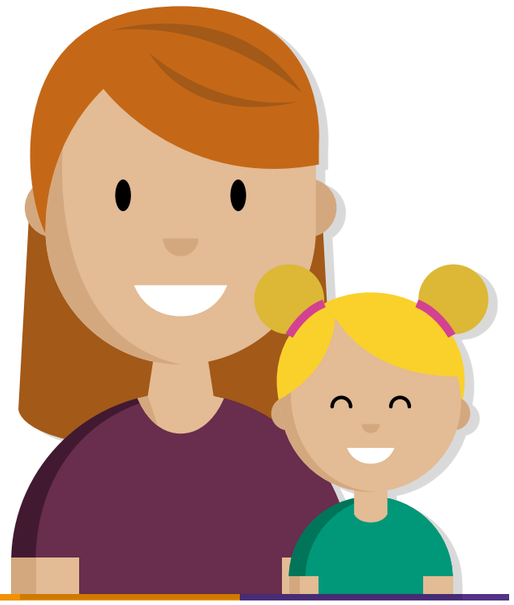
For the 2020/21 audit, the Trust incurred statutory audit fees of £108,000 (including irrecoverable VAT) and £19,200 other auditor remuneration (including irrecoverable VAT).

The following steps were taken during 2020/21 to ensure that auditor objectivity and independence is safeguarded:

- At each meeting of the Audit Committee attended by the external auditors they were asked to declare any interests that they may have in any of the items on the agenda. No such declarations were made.
- The external auditors have confirmed their compliance with the APB Ethical Standards for Auditors, and do not consider that their professional judgement or objectivity has been compromised.
- The Trust and the auditors ensured that fees for the provision of non-audit services by the external auditors did not exceed 70% of the audit fee, as mandated by the updated Auditor Guidance Note 1 issued in December 2016. The external auditors also did not perform any of the prohibited non-audit services set out in the guidance note. Details of the fees that were charged for non-audit work have been disclosed in the external auditors' report, and no further fees were charged.
- The external auditors have continued throughout the year to review their independence and ensure that appropriate safeguards are in place. These include the rotation of senior partners and professional staff, and the involvement of additional partners and professional staff to carry out reviews of the work performed and to advise as necessary.

2.1.10 Remuneration Committee

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chairman and comprises all the non-executive directors. The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the chief executive and the executive directors. The Chief Executive and the Director of Workforce attend the meeting but leave when discussions about their own positions are to be held. The Remuneration Committee met on three occasions in 2020/21.



2.2 Council of Governors

The Council of Governors is responsible for representing the interests of NHS Foundation Trust members, the public, and members of staff, and together with partner organisations of the Trust, it shares information about key decisions with the membership.

The Board of Directors reports to the Council of Governors on the performance of the Trust and its progress against agreed strategic and corporate objectives and consults on its future direction. In particular, the Council of Governors holds the Non-Executive Directors to account for the performance of the Board. Developing and maintaining effective relationships with the Non-Executive Directors have remained a key priority in 2020/21.

Governors report matters of concern or interest raised at local health events or constituency meetings to their counterparts and to the directors. Members of the public have the opportunity to raise questions addressed to the Governors, Directors or any other staff members in attendance at the local health events or Council of Governor meetings.

All Non-Executive and a number of Executive Directors are asked to attend the Council of Governors' meetings to gain an understanding of Governors' and Members' views, answer questions raised and also to update Governors about the activities of the Board and its Committees. Other staff often also attend to provide assurance or to report on progress on matters of interest.

To enable the Council of Governors to effectively exercise their statutory duties, the Board of Directors ensures that the Council receives the Annual Report and Accounts, is consulted on the content of the Quality Account and receives management reports detailing Trust performance in all areas.

Due to the COVID-19 pandemic, all engagement with members of the Trust and of the public by the Council of Governors were paused during the course of 2020/21.

2.2.1 Membership of the Council of Governors

The Council of Governors is chaired by the Trust Board Chair. It consists of thirteen Governors elected by public members of the Trust (two vacancies as at 31 March 2021) and representing different geographical constituencies, six Governors elected by staff of the Trust (one vacancy as at 31 March 2021), and four appointed Governors (no vacancies as at 31 March 2021).

The table at Appendix 2 (page 115 lists the Governors and their attendance record at the three Public Council of Governors meetings that took place in the year.

Considering its status as a University Trust, the Constitution has been updated to allow for a representative from the University of Buckingham to join the Council of Governors as an appointed Governor. Discussions about this are being held with the university.

2.2.2 Register of Governors' Interests

A register of Governors' interests is maintained by Milton Keynes University Hospital NHS Foundation Trust and is published on the Trust website.

"Members of the public have the opportunity to raise questions addressed to the Governors, Directors or any other staff members in attendance at the local health events or Council of Governor meetings."

2.2.3 Lead Governor

The Council of Governors are required nominate one from among their number to take on the role of Lead Governor. The Lead Governor's formal role is to act as a point of contact with NHS Improvement in the extreme and unlikely event that serious concerns emerge about the Board leadership of the Trust, or the processes used for appointing the Chairperson or Non-Executive Directors, such that NHS Improvement is contemplating using its formal powers to remove the Chairperson or Non-Executive Directors. At MKUH, the Lead Governor also acts as Vice-Chair of the Council of Governors, and may chair meetings of the Council in the Chair's absence. The Lead Governor normally also chairs the Non-Executive Appointments Committee. Alan Hastings, a publicly elected Governor representing the Bletchley constituency, is in his second term as the Lead Governor.

2.2.4 Elections

In 2020/21 elections were held for the following seats on the Council of Governors.

Date	Constituency (see Appendix 1 for key)	Result
February 2021	**PUBLIC:** : Emerson Valley, Furzton, Loughton Park	Jordan Coventry (elected)
February 2021	**STAFF:** Scientists, Technicians and Allied Health Professionals	Yolanda Potter (elected)
February 2021	**STAFF:** Nurses and Midwives	Elizabeth Maushe (elected) Tracy Rea (elected)
February 2021	**STAFF:** Non-Clinical Staff Groups (Admin & Clerical, Estates, Finance. HR, Management).	Emma Isted (elected) Pirran Salter (elected)

The Trust commissioned the services of UK Engage to undertake the election process.

2.2.5 Governor Development

Milton Keynes University Hospital NHS Foundation Trust is committed to supporting the members of the Council of Governors in carrying out their roles effectively. However, throughout 2020/21, as a result of the COVID-19 pandemic restrictions, Governors were unable to visit the hospital site or attend internal or external meetings face to face, severely limiting the activities they would normally expect to participate in. Nevertheless, Council of Governors and associated meetings continued to be held virtually.

Development and knowledge-building opportunities were similarly curtailed but the Governors were able to hold virtual informal discussions with the Chairs of Board Committees and other Non-Executive Directors. These discussions helped to provide assurance on the performance of the Board of Directors.

Additionally, the Trust supported engagement by the current lead Governor with his counterparts across the East of England region, with a view to gaining and sharing best practice and new ideas, particularly in relation to member engagement and development. Governors were also involved with and contributed to groups across the hospital that seek to improve the experience of patients with specific needs, including those with a learning disability and others with impaired mobility. Other activities that the Governors participated in included the attendance at the virtual site infrastructure meetings and the review of patient literature.

In January 2021, a bespoke event for newly appointed Governors and a refresher for all Governors was provided by NHS Providers through GovernWell, an organisation which works to equip all NHS Foundation Trust Governors with the skills required to undertake their role. The session provided a comprehensive overview of the structure of the NHS – the statutory role and responsibilities of Governors; an overview of NHS finance; the importance of quality in healthcare and key skills to hold the Board to account effectively.

In 2020/21 the Council of Governors meetings included presentations on topical issues within the Trust. Governors received summary reports of the deliberations at Board Committee meetings. The Chairman and Chief Executive also updated Council meetings on key messages from Board meetings and kept Governors abreast of important developments within the wider NHS.

Governors met informally as an engagement group, specifically to develop their approach to engaging effectively with Foundation Trust members within their constituencies and help grow the overall size of the Trust membership. There is an Engagement Strategy in place, for which the group is responsible for progressing, and members of Trust staff may be called upon to help support its implementation. Due to the COVID-19 pandemic, such opportunities for engagement were also curtailed but the intention is to increase these opportunities as soon as it is deemed safe to do so.

2.2.6 Attendance at Council of Governor Meetings

The Council of Governors, in line with the Trust's Constitution, formally met three times during the year, (excluding the Annual Members' Meeting held in September 2020). Details of Governors' attendance at the three Council of Governors meetings held in 2020/21 are included in Appendix 2 (page **XXX**).

2.3 Membership

Milton Keynes University Hospital NHS Foundation Trust is committed to establishing and growing an effective membership, and during 2020/21, a number of additional steps have been taken to improve engagement and increase membership.

In 2020/21 work has continued to secure the Trust's membership community by addressing natural attrition and increasing its demographic diversity. Efforts continue to ensure that the database properly reflects the true number of eligible staff and public members. This has enabled efficient, effective communication to be made in the most convenient way to members and broadened the involvement of the public membership. A summary newsletter highlighting key developments of the key points of the Annual Report was also produced.

The Trust currently has **5372 public members** and **3054 staff members** on its membership register. The total membership is therefore **8426**.

2.3.1 Number and Analysis of Members

	2020/21	2019/20
Public constituency		
At year start 1 April	5382	5464
New members	28	0
Members leaving	38	78
At year end 31 March	5372	5382
Staff constituency		
At year start (1 April)	2997	2722
At year end (31 March)	3054	2997
Public constituency: Age (years)		
0-16	0	1
17-21	20	17
22+	2095	2072
Not declared	3257	3292
Public constituency: Ethnicity		
White	4213	4221
Mixed	85	81
Asian or Asian British	342	373
Black or Black British	247	246
Other	71	37
Not declared	414	424
Public constituency: Gender		
Male	2097	2104
Female	3275	3278

2.3.2 Membership Constituencies

The Trust has staff and public constituencies and has also appointed a number of Governors to represent local stakeholders with whom it works in partnership. The Trust Constitution enables all members of staff who have been appointed to a post for a minimum of twelve months to automatically become members unless they decide to opt out of membership. Members of the public living within the Trust's catchment area who are over the age of 14 and not employed by the Trust are entitled to become public members, and the Trust has been actively working to attract as many local residents as possible to become members and have an involvement with the hospital. To stand for election to become a Governor, applicants must be aged 16 years or over.

The areas of the public constituency and the number of current members is shown below:

Public Constituency
Bletchley and Fenny Stratford, Denbigh, Eaton Manor and Whaddon
Emerson Valley, Furzton, Loughton Park
Linford South, Bradwell, Campbell Park
Hanslope Park, Olney, Sherington, Newport Pagnell North, Newport Pagnell South, Linford North
Walton Park, Danesborough, Middleton, Woughton
Stantonbury, Stony Stratford and Wolverton
Outer catchment area: - (Buckingham, Winslow, Leighton Buzzard, Linslade, Woburn Sands, Hanslope, Old Stratford, Beachampton, The Horwoods, The Brickhills, Woburn)
Extended catchment area, that includes the remainder of the county area of Northamptonshire, Buckinghamshire and Bedfordshire (not already covered in the outer catchment area) the unitary council area of Luton and the district council areas of Cherwell, Oxford City and South Oxfordshire.

The Trust currently has 5372 public members and 3054 staff members on its membership register. The total membership is therefore 8426.

2.3.3 Membership Recruitment and Engagement

The Trust has continued to make efforts to grow and engage with its membership, with members of the Council of Governors, through their engagement, taking an active role in recruiting new members.

2.3.4 Contacting the Council of Governors

Anyone wishing to contact the Council of Governors or enquire about becoming a member can do so in writing or by using a dedicated membership email address: **Foundation.Members@mkuh.nhs.uk**

Contact can also be made directly by telephoning the Trust Secretariat Office on **01908 996234**.

2.4 Patient Care

The Trust has continued to improve care quality and patient services, with examples in the performance and quality reports. The Trust monitors quality and key targets closely, with detailed narrative and data available in the performance report and dashboard.

2.4.1 Care Quality Commission Inspections and Action Plans

The Care Quality Commission (CQC) is the regulatory organisation which inspects services providing health and social care across England. Every NHS hospital is required to be registered with the CQC to provide care services and are required to maintain specified standards to retain registration. The role of the CQC is to monitor service quality and act where standards fall below the essential standards threshold. The assessment includes review of a range of external and internal information regarding the Trust.

Milton Keynes University Hospital NHS Foundation Trust is fully registered with the CQC and has a current registration without conditions. No enforcement action has been taken against the Trust during April 2020 and 31st March 2021. The Trust has not participated in any inspections by the CQC during the reporting period.

During April and May 2019, the Trust received an unannounced CQC inspection which focused across 4 key areas, urgent and emergency care, surgery, medical care and maternity. Medical care increased its safe rating good from a requires improvement rating in 2016); in Surgery, 'safe' was regraded from 'good' to 'requires improvement'. In urgent and emergency care, the rating for 'well-led' was amended from 'good' to 'requires improvement.' All other inspected areas maintained their previous ratings. All other areas were not inspected during this period and retain their rating of Good.

Overall Ratings for Milton Keynes University Hospital:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

During the CQC inspection 2019/20 the Trust received feedback highlighting outstanding practice including in medical care wards ensuring promotion of patient independence, participation in group activities and proactively delivering care in a way that demonstrated equality and accessibility.

During the inspection, the Trust took immediate action to ensure recommendations were addressed.

- In urgent and emergency care:
- The service took action to ensure that immediate life support and paediatric immediate life support training compliance was in line with Trust targets.
- The service took action to ensure that staff are complaint with hand hygiene and personal protective equipment guidelines providing staff with additional training.
- A system was developed and implemented to ensure that all emergency equipment checks are done in line with Trust policy.
- Additional patient risk assessment training was provided to staff.
- The service to action to ensure compliance with local and national audits.

This has been implemented to ensure compliance.

In relation to surgery core service:

- A robust plan of action was implemented to ensure compliance in basic life support training for all staff and safeguarding training compliance for medical staff is in line with targets.
- Enforcement of procedure for checking controlled drugs and accurate records maintained.
- Enforcement of staff compliance with personal protective equipment, safe handling of dirty instrumentation and bare below the elbow's guidelines.

Areas of compliance or enforcements actions:

The Trust received no notifications of compliance or enforcement actions following this inspection.

2.4.2 Improvements in Patient/ Carer Information

The Trust uses the Patient Accessible Information Standard and continually seeks opportunities to improve patient and carer information to improve access to care and services and support decision-making.

2.4.3 Information on Complaints Handling

The Trust's process in relation to the handling of complaints is robust. The Trust's website provides very clear advice to patients and their families on how they can raise concerns and complaints. Concerns and complaints can be raised with the Patient Advice and Liaison Service (PALS) who will liaise with the complainant to ensure their complaint is dealt with in the most appropriate way and in accordance with the seriousness of the complaint whilst taking account as to how the complainant wishes to receive their response. If an informal response is required then the complaint will be taken forward by the PALS service, The Complaints team will become involved where there is a need for a formal investigation followed by a formal response. The purpose of complaints and PALS is to co-ordinate and administrate the investigation, response and resolution of any complaint within statutory timeframes. The Trust ensure patients and their families are involved and empowered throughout the complaints process and that valuable lessons learned from complaints are taken forward by staff, acted upon, and improvements made to services as a result.

2.4.4 Stakeholder Relations

The Trust's policy is to engage, involve and consult with the public, patients, carers and other stakeholders on improving the care we provide. We do this by finding out what our patients and other stakeholders think about the care they have received and, through our Council of Governors, asking for views on our longer-term plans. Members are not just informed of issues regarding the Trust but are actively involved in shaping services. The involvement of the public, patients, carers and other stakeholders has been limited this year due to the COVID-19 pandemic. Next year, as restrictions allow, a full programme of engagement will recommence with an emphasis on engaging with those groups that we have not previously engaged with.

Milton Keynes Clinical Commissioning Group

The Trust has established a working relationship with the CCG for contract negotiations and longer-term health care planning.

Health and Adult Social Care Select Committee

The Chief Executive, the Chair and Governors have continued to keep the elected representatives of Milton Keynes Council and in particular, the Health and Adult Social Care Committee appraised of service issues at the Trust. The Council have continued to support the strategic direction of the Trust. In addition, the Council has a new representative on the Council of Governors, Councillor Andy Reilly.

Health and Wellbeing Board

The Chief Executive represents the Trust on the Health and Wellbeing Board and reports any issues back to the Trust Board and Governors, as appropriate.

Milton Keynes Safeguarding Partnership – MK Together

The Chief Nurse represents the Trust on the MK Together multiagency group, who oversee the safeguarding arrangements for adults and children across Milton Keynes with representatives from the Council, Police, voluntary sector and independent inspection and regulation services.

Healthwatch Milton Keynes

Throughout 2020/21 collaboration continued as appropriate between the Council of Governors and Healthwatch Milton Keynes. The remit of both the Council of Governors and Healthwatch is complementary; both bodies representing the health interests and concerns of and people of Milton Keynes and surrounding areas.

Healthwatch Milton Keynes' CEO sits as an appointed Governor on Milton Keynes Hospital's Council of Governors. Healthwatch Milton Keynes regularly supports the hospital with volunteers to undertake 15 steps and PLACE assessments. In 2020-21 all activity planned to undertake at, or in collaboration with Milton Keynes Hospital paused as result of the COVID-19 pandemic. During this period Healthwatch Milton Keynes continued to liaise with the Trust, patient experience staff and the PALs team to ensure patients were supported with advice and information about accessing health services when they needed help. Healthwatch Milton Keynes supported the distribution of key messages from Milton Keynes hospital so that the public and patients were fully informed about the work of the Trust during the pandemic.

2.4.5 Other Patient and Public Involvement Activity

The Trust has a diverse range of patient and public involvement activity and has significantly developed opportunities for involvement throughout the year. Examples include the '15 Steps Challenge initiative; engagement workshops and public meetings on the STP/ICS; PLACE assessments; and patient and carer stories at the Trust Board.

Better Payments Practice Code and Public Contracts Regulation

The Trust's policy is to pay its suppliers in accordance with its contractual terms and has, in most case, complied with the Better Payments Practice Code. The Trust's achievement of the BPPC target has increased in the year and above the target for payment within 30 days, invoices paid within 30 days were 95% (55,863 in volume) and 95% (£148,724, 334 in value). The split between NHS and Non-NHS invoiced is detailed below:

(Not subject to audit)

For the Year Ended 31st March 2021			
	Number of Invoices Paid within 30 days	**Total Number of Invoices Paid**	**% Number paid within 30 days**
NHS	1,835	2,186	84%
Non-NHS	54,264	56,770	96%
Total	**56,099**	**58,956**	**95%**
	Value of Invoices Paid within 30 days	**Total Value of Invoices Paid**	**% Value paid within 30 days**
NHS	5,440,010	7,255,495	75%
Non-NHS	144,144,173	148,994,329	97%
Total	**149,584,183**	**156,249,824**	**96%**

NB: The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. There were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest Act 1998 (2019/20 £0).

Public Contracts Regulations 2015: Regulation 113(7) Statutory Disclosure			
Financial Year 2020/21	**Percentage of commercial invoices paid within 5 days**	**Percentage of commercial invoices paid within 30 days**	**Total Amount of potential commercial liability from April 2020 £**
Full Year	13%	95%	124,620.00

(Not subject to audit)

For the Year Ended 31st March 2020			
	Number of Invoices Paid within 30 days	**Total Number of Invoices Paid**	**% Number paid within 30 days**
NHS	1,545	2,343	66%
Non NHS	53,532	65,304	82%
Total	**55,077**	**67,647**	**81%**
	Value of Invoices Paid within 30 days	**Total Value of Invoices Paid**	**% Value paid within 30 days**
NHS	4,901,898	8,720,071	56%
Non NHS	123,232,620	137,395,379	90%
Total	**128,134,517.62**	**146,115,450**	**88%**

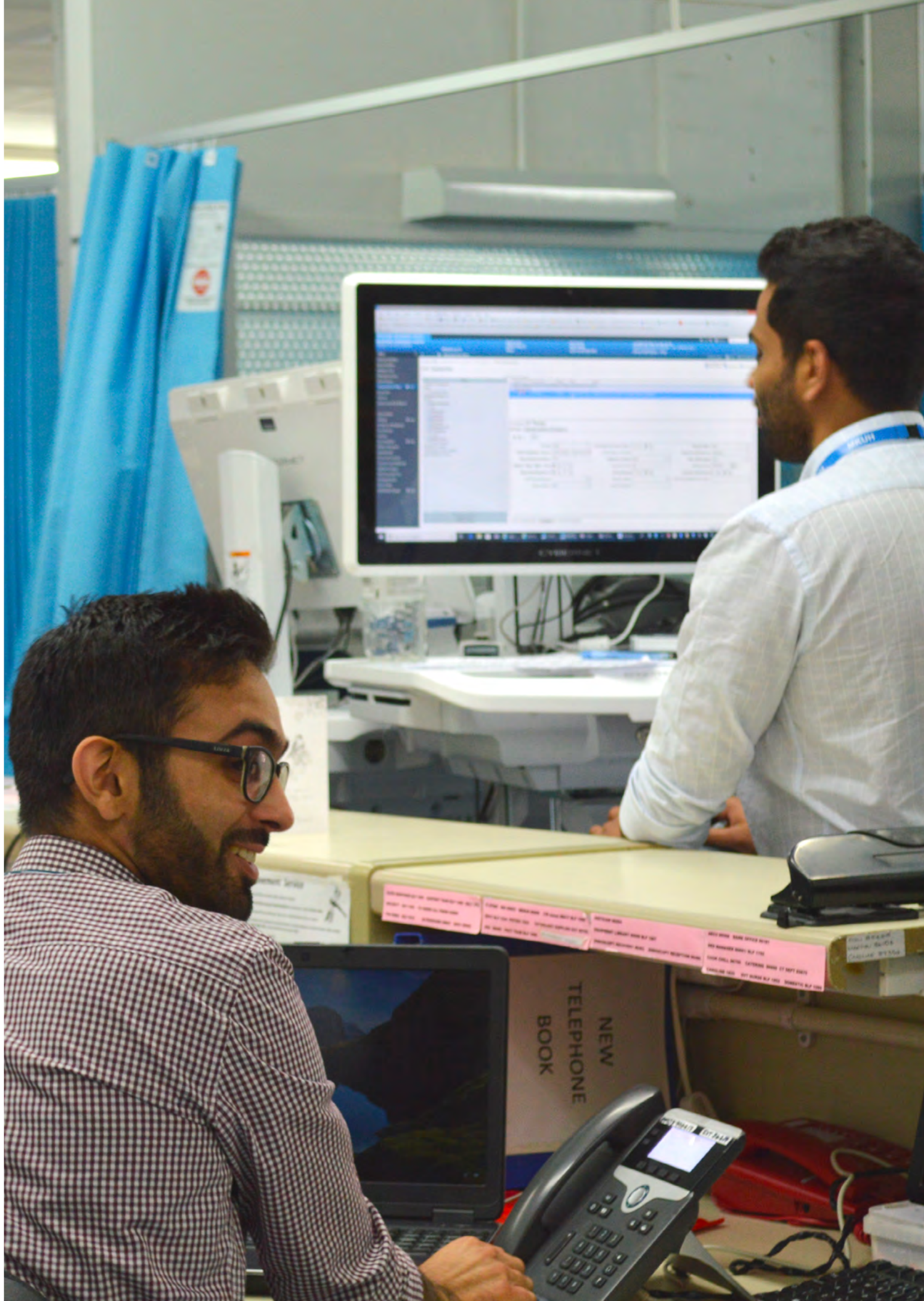
NB: The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. There were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest Act 1998 (2019/20 £0).

Income Disclosures Required by Section 43 (2A) of the NHS Act 2006

Income disclosures are included in the notes to the accounts. The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

2.5 Statement as to Disclosure to the Auditors

The Executive and Non-Executive Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. They also confirm that they each have taken all reasonable steps to make themselves aware of any relevant audit information and to establish that Deloitte LLP is made aware of such information.



2.6 Remuneration Report

The Remuneration Report describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration, as required by the Companies Act 2006, Regulation 11 and Schedule 8 of the Large and Medium-Sized Companies and Groups (Accounts and Reports) Regulations 2008, and the NHS Foundation Trust Code of Governance.

The Remuneration Report comprises three parts:

1. Annual statement on remuneration
2. Senior managers' remuneration policy
3. Annual report on remuneration

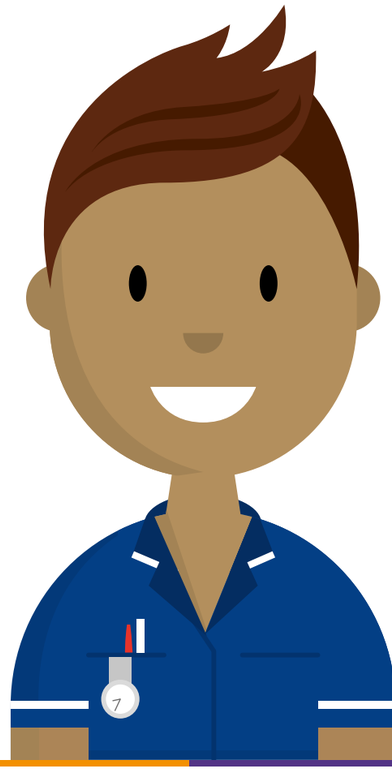
2.6.1 Annual Statement on Remuneration

For the period until 31 March 2021 there were no Trust Board members employed via non-payroll means.

A number of Board level changes took place in 2020/21. Michael Keech left his role as Director of Finance in November 2020 and was replaced by Sophia Aldridge on an interim basis till February 2021. Terry Whittle joined the Trust as the substantive Director of Finance in February 2021.

There were eight Non-Executive Directors and nine Executive Directors on the Board of Directors in 2020/21. Professor John Clapham, the representative from the University of Buckingham, retired from the Board in June 2020 and as at 31 March 2021, his replacement from the University was yet to take up their seat.

In 2020/21 Executive salaries were agreed by the Remuneration Committee taking into account national guidance.



2.6.2 Senior Managers' Remuneration Policy

Future Policy Table					
Item	**Salary/Fees**	**Taxable Benefits**	**Annual Performance Related Bonus**	**Long Term Related Bonus**	**Pension Related Benefits**
Support for the short and long term objectives of the Foundation Trust	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives	None disclosed	None paid	None paid	Ensure the recruitment and retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid in even twelfths	None disclosed	None paid	None paid	Employee and employer contributions
Maximum payment	As set out in the Accounts	None disclosed	None paid	None paid	Not applicable
Framework used to assess performance	Trust appraisal system	None disclosed	None paid	None paid	Not applicable
Performance measures	Tailored to individual posts	None disclosed	None paid	None paid	Not applicable
Amount paid for minimum level of performance and any further level of performance	Salaries are agreed on appointment and set out in the contract of employment	None disclosed	None paid	None paid	Not applicable
Explanation of whether there are any provisions for recovery of sums paid to directors or provisions for withholding payments	Any overpayments may be recovered	None disclosed	None paid	None paid	Not applicable

The Trust undertakes routine review and benchmarking of its Very Senior Manager remuneration to assure itself of parity with sector comparable Board level positions. Any subsequent changes required are approved and noted through the Trust's Remuneration Committee. Input is received from NHSE/I for any posts which rise above £150,000 per annum for reasons other than cost of living increases.

Non-Executive Directors are appointed on fixed terms contracts, normally three or four years in length, and they do not gain access to the Pension Scheme as a result of this engagement. The fee payable to Non-Executive Directors is set out in the table on pages **XX**. They do not receive any other payments from the Trust.

2.6.2.1 Service Contract Obligations and Policy on Payment for Loss Office

All Executive Directors are employed on permanent or fixed term contracts and are required to give six months' notice to terminate their contract. In line with NHS Employers' guidance, the notice period for the Trust's Very Senior Managers (VSMs) is six months. Terms of each of the Non-Executive Directors are given in the details of the Board members from page **XX**. Payment for loss of office is covered within contractual notice periods and standard employment policies and legislation.

2.6.2.2 Trust's Consideration of Employment Conditions

Other members of staff who are not Board members are employed on agenda for change terms and conditions and any percentage pay increases are applied in accordance with national agreements. The Remuneration Committee agrees senior managers pay and conditions following consideration of benchmarking information on comparable roles. Employees of the Trust are not consulted on senior manager remuneration.

2.6.3 Annual Report on Remuneration

In line with the Secretary of State for Health's request in his letter of 2 June 2015, the Chief Executive personally scrutinised and approved the remuneration of Very Senior Managers (Executive Directors) to ensure that they are necessary and justifiable.

The Remuneration Committee is a sub-committee of the Trust Board. It is chaired by the Trust Chair and comprises all the Non-Executive Directors (see their details on pages **XX-XX**).

The Committee meets as required, but its terms of reference recommend that this should be at least twice a year. Its main role is to agree the salaries and remuneration packages of the Chief Executive and the Executive Directors. The Chief Executive and Director of Workforce attend the meeting but leave when discussions about their own positions are to be discussed. The Remuneration Committee met on three occasions in 2020/21. Information on attendance is contained within the Directors' Report.

The Trust reviewed its remuneration practice relating to executive directors during 2019/20 and has an agreed remuneration policy and strategy. The policy reflects recent practice of not linking director pay progression to individual performance and of not having performance related bonuses. When considering proposals on remuneration the Remuneration Committee adopts the same principles on diversity and inclusion as set out in paragraph 2.8.11 of the Staff Report. Both local and national benchmarking information regarding remuneration will continue to be provided to the Remuneration Committee. Further, in line with the Secretary of State for Health's letter of 2 June 2015 to chairs of NHS Trusts, the Trust reviews the amounts paid to directors to ensure that they are necessary and justifiable. The Chairman personally scrutinises and approves any new very senior manager appointment in the Trust.

The Committee reviewed the NHS pension arrangements for senior clinical staff. As the existing NHS pension arrangements were not considered to be suitable for all staff, the Committee approved the introduction of a split employment option with pension contribution reward alternative for certain categories of eligible staff whereby an individual would be allowed to enter into two separate contracts allowing the individual to remain opted-in to the pension for one contract and to opt-out for the other which would allow flexibility to control pension growth and associated benefits. This was introduced on a non-contractual basis and can be removed at any time.

The remuneration and expenses for the Chair and Non-Executive Directors are determined by the Council of Governors, taking account of the guidance issued by organisations such as NHSI and NHS Providers. In 2019/20, the Council reviewed the remuneration of Non-Executive Directors as it had remained at the same level for five years. The Council agreed that the remuneration of Non-Executive Directors should increase from £12,000 a year to £13,000 a year from 1 March 2020. The Council agreed that the remuneration of the Trust Board Chairman should increase from £45,000 to £47,100 upon the appointment of the next Chair. The Council also agreed that an additional responsibility allowance of £2,000 should be introduced for the Chair of the Audit Committee and for the Senior Independent Director, with the proviso that if those posts are held by the same individual only one additional responsibility allowance of £2,000 should be paid.

Details of remuneration, including salaries and pension entitlements of the Board of Directors are published in section 4.5 of the annual accounts. Details on the median/mid-point and highest paid director are included in section 4.6 of the annual accounts.

In 2020/21 and 2019/20 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £8,473 to £213,696 (2019/20 from £12,000 to £207,500)

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

The Trust's highest paid Director was the Chief Executive and the previous year's highest paid Director was the Chief Executive.

The details of other remuneration, travel and assistance for directors and non-executive directors are attached in table 1.

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

With the exception of benefits payable under the NHS pension scheme in respect of early retirement (whether this might be actuarially reduced, or ill-health related), no further benefit is payable to a senior manager in the event of their early retirement. Furthermore, no service contract obligations apply which could give rise to, or impact on, remuneration payments or payments for loss of office.

The Trust notes that NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related Cash Equivalent Transfer Values (CETVs) set out on pages **XX** and **XX** of this report do not allow for any potential future adjustments that may arise from this judgement.

In preparing its senior managers' remuneration policy, the Trust has benchmarked itself against other medium sized acute trusts and has taken account of national guidance on senior managers' pay.

The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff. The Trust has a policy in place that reviews the employment status of contractors to assess if the contractor is an employee or self-employed as per HMRC's assessment criteria. The Trust's policy is not to employ anyone through their own company is they do not meet the self-employment status.

2.6.4 Tenure and notice periods of Board of Directors

Non-Executive Directors

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Alison Davis	Chair	Feb 2021	Jan 2024	1 month
Andrew Blakeman	Non-Executive Director	Feb 2016	Mar 2022	1 month
Helen Smart	Non-Executive Director	March 2018	Feb 2024	1 month
Heidi Travis	Non-Executive Director	March 2018	Feb 2024	1 month
Nicky McLeod	Non-Executive Director	February 2019	Jan 2022	1 month
Haider Husain	Non-Executive Director	April 2020	March 2023	1 month
John Lisle	Non-Executive Director	April 2020	March 2023	1 month

Executive Directors

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Professor Joseph Harrison	Chief Executive	Feb 2013	N/A	6 months
Nicola Burns-Muir	Director of Patient Care and Chief Nurse	April 2019	N/A	6 months
Emma Livesley	Director of Operations	September 2019	N/A	6 months
Dr Ian Reckless	Medical Director	April 2016	N/A	6 months
John Blakesley	Deputy Chief Executive	Apr 2014	N/A	6 months
Danielle Petch	Director of Workforce	July 2018	N/A	6 months
Terry Whittle	Director of Finance	Feb 2021	N/A	6 months
Kate Jarman	Director of Corporate Affairs	May 2014	N/A	6 months
Jacqueline Collier	Director of Transformation & Partnerships	March 2021	N/A	6 months

Other Board members during 2020/21

Name	Appointment	Date of Appointment	Unexpired Term	Notice period
Simon Lloyd	Chairman	May 2015	Jan 2021	1 month
Professor John Clapham	Non-Executive Director	March 2018	June 2020	1 month
Sophia Aldridge	Interim Director of Finance	November 2020	February 2021	1 month
Michael Keech	Director of Finance	December 2016	November 2020	6 months

2.6.5 Directors' Remuneration Report Statement 2020/21 (subject to audit)

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

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

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

Directors' Remuneration 2020/21

Name and Title	Year Ended 31 March 2021					
	Salary (bands of £5,000) £000	**Taxable Benefits** (To the nearest £100) £000	**Annual Performance Related bonuses** (Bands of £5,000) £000	**Long term Performance Related bonuses** (Bands of £5,000) £000	**Pension Benefits** (Bands of £2,500) £000	**Total** (Bands of £5,000) £000
Professor Joseph Harrison Chief Executive Officer	210-215	0	0	0	0	210-215
Mike Keech (to November 2021)* Director of Finance	90-95	0	0	0	40-42.5	130-135
Sophia Aldridge (from November 2020 to February 2021) Interim Director of Finance	45-50	0	0	0	0	45-50
Terry Whittle (from February 2021)** Director of Finance	10-15	0	0	0	2.5-5	15-20
John Blakesley*** Deputy Chief Executive	105-110	0	0	0	0	105-110
Danielle Petch Director of HR & Workforce Development	135-140	0	0	0	0	135-140
Ian Reckless Medical Director	200-205	0	0	0	55-57.5	255-260
Emma Goddard Director of Service Development	0	0	0	0	0	0
Kate Jarman Director of Corporate Affairs	110-115	0	0	0	27.5-30	140-145
Caroline Hutton Director of Clinical Services	0	0	0	0	0	0
Emma Livesley Director of Operations	115-120	0	0	0	92.5-95	210-215
Nicola Burns-Muir** Director of Patient Care/ Chief Nurse	135-140	0	0	0	172.5-175	310-315

**The value of the pension benefit is calculated as at 31 March 2021. As a result, the pension benefit for Mike Keech reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following his departure from the Trust on 9th November 2020, the value shown is the pro-rata of the full year benefit.*

***The value of the pension benefit is calculated as at 31 March 2021. As a result, the pension benefit for Terry Whittle reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following his commencement with the Trust on 24th February 2021, the value shown is the pro-rata of the full year benefit.*

**** In addition to the salary remuneration recorded for John Blakesley in the table above, additional salary is received from the Trust wholly owned subsidiary ADMK Ltd.*

***** The salary amount for Nicola Burns-Muir in 2020-21 included additional payments of £14k relating to untaken annual leave sold back to the Trust.*

Directors' Remuneration 2020/21 (continued)

Name and Title	Year Ended 31 March 2021					
	Salary (bands of £5,000) £000	**Taxable Benefits** (To the nearest £100) £000	**Annual Performance Related bonuses** (Bands of £5,000) £000	**Long term Performance Related bonuses** (Bands of £5,000) £000	**Pension Benefits** (Bands of £2,500) £000	**Total** (Bands of £5,000) £000
Jacqueline Collier (from March 2021) Director of Partnerships & Financial Efficiency	0-5	0	0	0	0	0-5
Simon Lloyd (to January 2021) Chairman	35-40	0	0	0	N/A	35-40
Alison Davis (from Feb 2021) Chair	5-10	0	0	0	0	5-10
Haider Hussain Non-Executive Director	10-15	0	0	0	N/A	10-15
Andrew Blakeman Non-Executive Director	10-15	0	0	0	N/A	10-15
John Lisle Non-Executive Director	10-15	0	0	0	N/A	10-15
Helen Smart Non-Executive Director	10-15	0	0	0	N/A	10-15
Heidi Travis Non-Executive Director	10-15	0	0	0	N/A	10-15
John Clapham (to June 2020) Non-Executive Director	0-5	0	0	0	N/A	0-5
Nicola McLeod Non-Executive Director	10-15	0	0	0	N/A	10-15

Directors' Remuneration 2019/20

Name and Title	Year Ended 31 March 2020					
	Salary (bands of £5,000) £000	**Taxable Benefits** (To the nearest £100) £000	**Annual Performance Related bonuses** (Bands of £5,000) £000	**Long term Performance Related bonuses** (Bands of £5,000) £000	**Pension Benefits** (Bands of £2,500) £000	**Total** (Bands of £5,000) £000
Professor Joseph Harrison Chief Executive Officer	205-210	0	0	0	2.5-5	210-215
Michael Keech Director of Finance	135-140	0	0	0	40-42.5	175-180
Lisa Knight (to end April 2019)* Director of Patient Care / Chief Nurse	5-10	0	0	0	147.5-150	155-160
John Blakesley Deputy Chief Executive	120-125	0	0	0	0	120-125
Nicky Burns-Muir (from end April 2019) Director of Patient Care/Chief Nurse	105-110	0	0	0	245-247.5	350-355
Danielle Petch Director of Workforce	115-120	0	0	0	0	115-120
Ian Reckless Medical Director	190-195	0	0	0	0	190-195
Emma Goddard (on secondment all year) Director of Service Development	115-120	0	0	0	0	115-120
Kate Jarman Director of Corporate Affairs	110-115	0	0	0	57.5-60	170-175
Caroline Hutton (on secondment from Feb 2020) Director of Clinical Services	130-135	0	0	0	17.5-20	150-155
Emma Livesley (from Sept 30, 2019) Director of Operations	55-60	0	0	0	7.5-10	60-65
Simon Lloyd Chairman	45-50	0	0	0	N/A	45-50
Tony Nolan (to March 31, 2020) Non-Executive Director	10-15	0	0	0	N/A	10-15
Andrew Blakeman Non-Executive Director	10-15	0	0	0	N/A	10-15
Parmjit Dhanda (to Feb 29, 2020) Non-Executive Director	10-15	0	0	0	N/A	10-15
Helen Smart Non-Executive Director	10-15	0	0	0	N/A	10-15
Heidi Travis Non-Executive Director	10-15	0	0	0	N/A	10-15
John Clapham Non-Executive Director	10-15	0	0	0	N/A	10-15
Nicola McLeod Non-Executive Director	10-15	0	0	0	N/A	10-15

** The value of the pension benefit is calculated as at 31 March 2020. As a result, the pension benefit for Lisa Knight reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following her departure from the Trust on 24th April 2019*

Pension Benefits 2020/21

Name and Title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2020 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2021* £000	Employer's contribution to stakeholder pension £000
Mike Keech Director of Finance (to Nov 2020)	2.5-5	0	10-15	N/A	75	16	113	12
Terry Whittle Director of Finance (from 24th February 2021)	0-2.5	0-2.5	20-25	40-45	265	4	303	2
Nikki Burns-Muir Director of Patient Care	7.5-10	17.5-20	45-50	135-140	811	168	997	18
Caroline Hutton Director of Service Improvement	2.5-5	0-2.5	50-55	105-110	915	45	980	20
Kate Burke Director of Corporate Services	0-2.5	0	20-25	30-35	260	10	286	16
Emma Goddard Director of Service Improvement	0	0	15-20	N/A	187	0	193	9
Ian Reckless Medical Director	0-2.5	2.5-5	45-50	105-110	709	35	771	11
Emma Livesley Director of Operations	5-7.5	7.5-10	30-35	65-70	470	75	562	17

**Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.*

***Pension benefits and related CETVs do not allow for a potential future adjustment for some eligible employees arising from the McCloud judgement.*

Please note: The table only reflects the Executives who are currently in the pension

Pension Benefits 2019/20

Name and Title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in pension lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2019 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2018 (Bands of £1,000) £000	Real Increase in Cash Equivalent Transfer Value (Bands of £1,000) £000	Cash Equivalent Transfer Value at 31 March 2019 (Bands of £1,000) £000	Employer's contribution to stakeholder pension (Bands of £1,000) £000
Professor Joseph Harrison* Chief Executive Officer	0-2.5	0	30-35	70-75	1,094	0	920	20
Mike Keech Director of Finance	2.5-5	0	5-10	N/A	52	3	74	19
Lisa Knight** Director of Patient Care / Chief Nurse	0-2.5	0-2.5	55-60	135-140	969	8	1,115	0
Nikki Burns-Muir Director of Patient Care	10-12.5	40-42.5	35-40	110-115	557	221	797	15
Caroline Hutton Director of Service Improvement	0-2.5	0	45-50	100-105	859	22	900	19
Kate Burke Director of Corporate Services	2.5-5	2.5-5	20-25	30-35	211	29	255	16
Emma Goddard Director of Service Improvement	0	0	15-20	N/A	174	1	184	4
Ian Reckless Medical Director	0	0	40-45	100-105	773	0	698	13
Emma Livesley Director of Operations	0-2.5	0	25-30	55-60	448	3	462	8

**The cash equivalent transfer value as at 31 March 2020 is calculated in accordance with the 1995 section of the NHS pension scheme rules under which pension entitlement is based on the highest pensionable salary in the last three years*

***The value of the pension benefit is calculated as at 31 March 2020. As a result, the pension benefit for Lisa Knight reflects an entitlement to additional NHS pension accrued whilst employed by another NHS organisation following her departure from the Trust on 24th April 2019*

**** Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.*

Directors' Expenses 2020/21 (not subject to audit)

Name and Title	Year Ended 31 March 2021	
	Other non-taxable expenses (To the nearest £100) £	Travel & Subsistence (To the nearest £100) £
Professor Joseph Harrison Chief Executive Officer	400	100
Mike Keech (to November 2020) Director of Finance	0	0
Sophia Aldridge (from November 2020 to February 2021)	0	0
Terry Whittle (from February 2021)	0	0
John Blakesley Deputy Chief Executive	0	0
Danielle Petch Director of HR & Workforce Development	0	100
Dr Ian Reckless Medical Director	100	0
Emma Goddard (to December 2020) Director of Service Development	0	0
Kate Jarman Director of Corporate Services	0	0
Caroline Hutton Director of Operations	0	0
Emma Livesley Director of Operations	0	0
Nicola Burns-Muir Director of Patient Care/Chief Nurse	0	0
Jacqueline Collier (from March 2021) Director of Transformation & Partnerships	0	0
Simon Lloyd (to January 2021) Chairman	0	0
Alison Davis (from February 2021) Chair	0	0
Haider Husain Non-Executive Director	0	0
Andrew Blakeman Non-Executive Director	0	0
John Lisle (from April 2020 to March 2021) Non-Executive Director	0	0
Helen Smart Non-Executive Director	0	0
Heidi Travis Non-Executive Director	0	0
Professor John Clapham (to June 2020) Non-Executive Director	0	0
Nicola McLeod Non-Executive Director	0	0

Directors' Expenses 2019/20 (not subject to audit)

Name and Title	Year Ended 31 March 2020	
	Other Remuneration (To the nearest £100) £	Travel & Subsistence (To the nearest £100) £
Professor Joseph Harrison Chief Executive Officer	400	2,500
Mike Keech Director of Finance	0	800
Nicola Burns-Muir Director of Patient Care/Chief Nurse	0	0
John Blakesley Deputy Chief Executive	200	100
Lisa Knight (to April 2019) Director of Patient Care/Chief Nurse	0	0
Danielle Petch Director of Workforce	0	500
Dr Ian Reckless Medical Director	600	800
Emma Goddard (on secondment all year) Director of Service Development	0	800
Kate Jarman Director of Corporate Affairs	0	0
Caroline Hutton (on secondment from February 2020) Director of Clinical Services	0	0
Emma Livesley (from Sept 2019) Director of Operations	0	100
Simon Lloyd Chairman	0	100
Tony Nolan Non-Executive Director	0	1,100
Andrew Blakeman Non-Executive Director	0	0
Parmjit Dhanda (to February 2020) Non-Executive Director	0	700
Helen Smart Non-Executive Director	0	100
Heidi Travis Non-Executive Director	0	0
Professor John Clapham Non-Executive Director	0	0
Nicola McLeod Non-Executive Director (from Feb 2019)	0	400

2.6.6 Governor Expenses

Governors are permitted to claim an allowance of £10 for any meeting of the Council of Governors they attend or an external meeting that they attend on behalf of the Trust e.g. Healthwatch Milton Keynes Executive. Details of the claims made in 2019/20 are below:

Governor Expenses 2019/20

Governor	Amount £
Alan Hastings (lead governor)	129.98
Total	**129.98**

As, all in-person engagements with members of the Trust and of the public, as well as on-site meetings were paused in 2020/21 due to the COVID-19 pandemic, Governors did not claim any expenses.

Professor Joseph Harrison
Chief Executive

10 June 2021

2.7 Staff Report

This section of the report provides information on staff, including staff numbers, costs and key workforce performance information.

2.7.1 Analysis of Staff Costs

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the FTC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

(Subject to audit)

Staff costs			2020/21	2019/20
	Permanent	Other	**Total**	Total
	£000	£000	**£000**	£000
Salaries and wages	155,019	1,632	**156,651**	138,536
Social security costs	15,985	0	**15,985**	14,803
Apprenticeship levy	742	0	**742**	694
Employer's contributions to NHS pensions	16,579	0	**16,579**	15,321
Pension cost - other	7,214	0	**7,214**	6,656
Other employment benefits	13	0	**13**	0
Temporary staff	0	2,796	**2,796**	8,957
Total gross staff costs	**195,552**	**4,428**	**199,980**	**184,967**

Staff Costs	Permanently Employed £000	Other £000	Total £000
Employee expenses – staff	194,238	4,428	198,666
Employee expenses – executive directors	1,314	0	1,314
Total	**195,552**	**4,428**	**199,980**

2.7.2 Analysis of Average Staff Numbers

The table below shows a breakdown of our average workforce by staff group as at 31 March 2021.

	Assignment Category				
Staff Group	**Fixed Term Temp**	**Non-Exec Director / Chair**	**Permanent**	**Zero Hour Locum / Bank**	**Total Headcount**
Add Prof Scientific and Technic	8	-	105	35	149
Additional Clinical Services	34	-	594	445	1,073
Administrative and Clerical	38	6	761	110	916
Allied Health Professionals	7	-	179	24	210
Estates and Ancillary	0	-	363	43	406
Healthcare Scientists	0	-	84	22	106
Medical and Dental	185	-	270	322	778
Nursing and Midwifery Registered	24	-	1,069	226	1,319
Grand Total	**297**	**6**	**3,426**	**1,226**	**4,955**

Average number of employees (WTE basis) (subject to audit)

			2020/21	2019/20
	Permanent	**Other**	**Total**	**Total**
	Number	Number	Number	Number
Medical and Dental	469	32	**501**	473
Administration and Estates	671	99	**770**	704
Healthcare assistants and other support staff	800	140	**940**	986
Nursing, midwifery and health visiting staff	894	163	**1,057**	1,066
Scientific, therapeutic and technical staff	262	21	**283**	267
Healthcare science staff	76	6	**82**	79
Total average numbers	**3,172**	**461**	**3,633**	**3,575**

The following is a breakdown of staff by gender:

Staff	Female	Male	Total
Directors	9	9	18
Other Senior Managers	0	0	0
Employees	3008	795	3803
Total	**3017**	**804**	**3821**

As at 31 March 2021, the Trust Board comprised eight non-executive directors (four male and four female) and nine executive directors (four male and five female).

"The health and wellbeing of our staff continues to be a top priority for the Trust, in terms of improving workforce effectiveness and its effect on patient care and experience."

2.7.3 Absence rate for year to 31/03/2020:

Sickness Absence 2020/21

Trust Absence 12 months to 31 March 2020	Cumulative Abs (WTE)	Cumulative Avail (WTE)	Cumulative % Abs Rate (WTE)	Short Term % Abs Rate (WTE)	Long Term % Abs Rate (WTE)	No of Episodes
All Staff Groups	56,759	1,179,960	4.81%	2.09%	2.72%	7,077

The top ten reasons for Trust sickness absence are now reported routinely to the Trust across a number of levels for visibility and action planning. Vast improvements have been made to the reportable level of 'unknown' absence to enable the Trust to better understand its absence causation and to support remedial intervention as required. This has been achieved through advances in the rollout and use of the Trust's e-Rostering system, an improved return to work process and reinforcement of stronger procedural guidance from the Sickness Absence and Attendance policy.

The health and wellbeing of our staff continues to be a top priority for the Trust, in terms of improving workforce effectiveness and its effect on patient care and experience. By focusing on 'hotspot' areas of sickness absence, the Trust has been able to bring about conclusions to long term individual cases, reduce intermittent absence levels and identify areas of best practice to champion and from which to learn.

The impact of the COVID-19 pandemic on the Trust's sickness absence levels has been sustained throughout 2020/21. The Trust experienced rising short term absence alongside the patterns of the first and second waves across the nation. Consquently, as at the end March 2021, the Trust's sickness absence level was considerably above its target of 4% in 2020/21, however, this figure has previously been consistently below that of the previous two financial years. It is anticipated that the Trust will be able to return to similar levels as the effect of the pandemic continues to decline through supportive management in line with policy.

2.7.4 Expenditure on consultancy

The Trust incurred £44k relating to consultancy services.

2.7.5 Staff Policies and actions applied during the Financial Year

Workforce Strategy (2018 to 2021)

To deliver the Trust's challenging agenda in line with the NHS Long Term Plan, an integrated approach to patient care, workforce management, organisational development and workforce planning is essential. Approved in October 2018, the Trust's Workforce Strategy and Plan set out the strategic framework for various aspects of the MKUH workforce and plan for delivery, ownership and governance, respectively. On an annual basis, objectives for the year ahead are agreed with Trust Board, in line with the Workforce Strategy, with time bound activities to support their delivery.

The 2018-2021 Workforce Strategy focuses on recruiting and retaining the Workforce, providing a healthy engaged workforce and ensuring workforce efficiency is maximised, enabled by three key workstreams:

- Attract, recruit, retain and develop talented staff who embody our values
- A healthy workplace with effective employee engagement and wellbeing
- Maximise productivity through innovative & efficient workforce and infrastructure

During summer 2020/21, the NHS People Plan was released, building on the aspirations of the Interim People Plan from June 2019. The Trust was proudly featured early in the People Plan in respect of how it supports retention through wellbeing, the flexible working agenda and the impact of its enhanced benefits and formulated a local delivery plan in tandem with its Workforce Strategy and Plan. The Trust has benefitted from its early work in the course of the Workforce Strategy, such that the majority of it and further deliverables arising from the NHS People Plan have also been realised over the course of the year. Alongside delivery at local level, the Trust has actively supported the BLMK ICS in the realisation of its system people plan and the Trust has been able to derive benefit from number of support mechanisms via the ICS.

The delivery of both strategies is monitored by the Workforce Development and Assurance Committee, a sub-committee of the Trust Board, and by the Workforce teams via its Workforce Board.

The Workforce Strategy aims to ensure an engaged and well trained workforce is available in the short, medium and long term. Alongside the Workforce Strategy delivery actions business as usual processes take place to ensure the right staff are available in the right place, at the right time.

The strategy and business as usual actions include:

1. Enhanced and focused recruitment campaigns to recruit to hard to fill roles, as well as high turnover roles such as Health Care Assistants, Band 5 Nurses and administrative and clerical
2. Development and integration of new and emerging roles, such as Nursing Associates and Advanced Clinical Practitioners
3. Regular review and monitoring of safe staffing levels, including the use of the Safer Care Tool for regular establishment reviews
4. Robust rostering practices, including the use of Check & Challenge meetings to scrutinise rosters and support improvements
5. Recording and monitoring of Care Hours Per Patient Day (CHPPD), reported to Board as part of the Board Nursing Staffing Report
6. Short, medium and long term workforce planning practices to develop and staff service models, now and in the future
7. Design and implementation of retention initiatives, including enhanced benefits offering, career pathways, transformative working practices
8. Enhanced wellbeing package, promoting and improving the health of our workforce
9. Comprehensive learning, development and education packages and use of central funding and apprenticeships to ensure training is widely available.
10. Widening participation – supporting the Trust to source growing amounts of colleagues from 'hard to reach' groups and through a variety of means (e.g. apprenticeships, NHS Ambassadors, voluntary services and underrepresented groups).

The above listed activities support the NHSI Developing Workforce Safeguards recommendations, ensuring the wards as staffed safely and that staffing levels are monitored and adjusted as required and that the Trust is managing not only the workforce of today but also planning for the workforce of tomorrow.

Our Recruitment and Selection policy ensures that full and fair consideration is given to applications for employment made by disabled people and across the full range of protected characteristics. All jobs are advertised on the national NHS jobs website, promoting flexibility of employment from day one, and via our electronic

recruitment system which not only promotes equal opportunities at recruitment stages, but also allows disabled candidates to declare known or suspected conditions and suggest how we might overcome these by adjusting our selection activities. Such conditions are made known to recruiting managers by the recruitment team after the shortlisting process has taken place to ensure that the risk of discrimination is minimised.

The Trust has various means of supporting employees to continue their employment and receive training and retraining in the event that they should become disabled persons during their Trust employment. A comprehensive Sickness Absence and Attendance policy, 'Working with Disabilities' guidance and the newly adopted Disability Passport provide policy and procedural guidance in this regard and managers, colleagues and interventions, such as adjustments to working roles and redeployments, are supported and facilitated by specialist Occupational Health, HR Advisor and HR Business Partner input. External agencies, such as Access to Work are also engaged on a case-by-case basis, where it is believed that the Trust, its managers or its colleagues could benefit from expert technical or financial support.

The Trust's Appraisal and Statutory and Mandatory training framework provide that training, career development and promotion of disabled employees are facilitated through individualised actions and personal development plans that are aligned to the Trust's core values. Such an approach promotes equal opportunities through promotion of learning and development and it also seeks to reduce the impact of potential inequalities caused by the condition or disability of an individual in a supportive way. All Trust policies have an Equality Impact Assessments undertaken during the policy consultation process, ensuring that the Trust has due regard of particular issues and has considered implementation of mitigating actions in respect of all protected characteristics.

In terms of engagement, the Trust uses various means of communication to our workforce. Such an approach ensures no group is left without receiving key messages. The discussions and outcomes of Trust meetings, such as Trust Executive Group, are cascaded through to colleagues in person and via email, monthly and weekly email newsletters are produced and posted on a vastly improved intranet site concurrent to messaging via a popular and prevalent mobile phone instant messaging system.

The Trust has made best use of advances in use of technology; 'all user' emails are routinely used in addition to a variety of on-site and web based Chief Executive's live Q&A sessions along with use of the Trust's YouTube channel to promote key messages and intiatives with colleagues and service users alike. More recently, the Trust has made more use of local surveys via its web based applications, e.g. health and wellbeing and staff benefits surveys, Staff Friends and Family test. The fouth annual Event in the Tent in May 2020 was held via 'Live' sessions which were also recorded for colleagues who could not be in attendance. Such engagement activities have become increasingly important in 2020/21 as the Trust has sought to celebrate its successes, meaningfully engage its staff and ensure that mission critical information is disseminated at scale and pace in the midst of the pandemic e.g. use of Personal Protective Equipment, the repurposing of ward areas, information, COVID-19 related studies, testing and staff helplines.

The Trust has a long standing Recognition Agreement with staff side partners; this was reviewed and strengthened in 2020/21. The Recognition Agreement provides the governance framework for the monthly Joint Consultative and Negotiation Committee (JCNC) meetings which are chaired on an alternate basis by the Staff Side Chair and the Director of Workforce. The Medical and Dental Joint Local Negotiating Committee (JLNC) also falls under the governance framework of the JCNC. The staff side relationship was greatly strengthened in 2020/21 as the Trust supported a weekly informal meeting to supplement the formal meeting structure. The focus of the informal meetings was on information sharing and a desire to deal with any COVID-19 related concerns as soon as possible.

A full and comprehensive review of all workforce policies and procedures commenced in 2016/17 under the guidance of the JCNC to ensure that we seek to align to regional policy/direction or differentiate in order to set us apart, depending on specific need/aim or purpose (e.g. becoming an employer of choice in the region). In 2020/21 the Trust reviewed and/or approved 11 of its 42 Workforce, Education, Learning and Medical and Dental policies. 4 innovative policies were approved; Domestic Abuse, Agile Working, Protected Working Time and Employee Passport policies. 3 further innovative workforce policies are currently under development as we seek to support and develop our workforce in-line with the Workforce Strategy and Trust Objectives.

The COVID-19 pandemic required the Trust to approach its support mechanisms to colleagues through revised policies in a different way – principles of agile and home working, additional sick pay and pay during periods of isolation, extended carry over and selling of annual leave and quarantine flexibilities were additional measures that supported colleagues during the pandemic, some of which have remained in place for greater benefit.

Furthermore, the Trust's Management of Organisational Change Policy provides framework agreed in partnership with Staff Side colleagues for consultations where organisational change is required. In this way, early Staff Side involvement in organisational change programmes is sought, in order to capitalise on consultation opportunities in a meaningful way with our colleagues and their representatives. Together these ensure that we seek the views of our workforce in a holistic and inclusive way, demonstrating our ongoing commitment to partnership working.

The Trust has numerous policies and procedures with regard to countering fraud and we work routinely with Counter Fraud specialists to support our efforts in this regard. The Trust has a comprehensive set of Standing Financial Instructions (SFIs) and a standalone counter fraud and reporting policy, including the involvement and roles of internal and external auditors. Separate to these, the Trust has its own Gifts, Donations and Hospitality Declarations policy in addition to specific clauses in the standard Trust contract of employment covering this area.

2.7.6 Staff Side Time Spent on Union Facilities

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force in April 2017. The regulations require that NHS employers publish certain information about trade union officials and facilities time. The following tables show facilities activity and cost among the unions that are recognised by the Trust over the course of 2019/20. These figures are collated and reported to the Trust's Joint Consultative and Negotiation Committee (JCNC).

Table 1 – Relevant union officials

Table 1 outlines the total number of MKUH employees who were relevant union officials during 2020/21

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
25	21.12

Table 2 – Percentage of time spent on facility time

Table 2 outlines the number of MKUH employees who were relevant union officials employed during the 2020/21 who 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%	2
1-50%	23
51%-99%	
100%	

Table 3 – Percentage of pay bill spent on facility time

Table 3 provides the percentage of the MKUH total pay bill spent on paying employees who were relevant union officials for facility time during 2020/21

Description	Figures
Total cost of facility time	£42,798.18
Total pay bill	£1,423,622.48
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	3.01%

Table 4 – Paid trade union activities

Table 4 provides the number hours spent by employees who were relevant union officials during 2020/21 on paid trade union activities, expressed as a percentage of total paid facility time hours.

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:

(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

2.54%

2.7.7 Health and Safety Performance and Staff Health and Wellbeing

In line with our strategic workforce direction for 2020/21, an ongoing greater focus on supporting our colleagues through core Occupational Health services and Staff Health and Wellbeing promotion and activities was continued. With the onset of the global COVID-19 pandemic, the Trust's attention in this regard was turned to the immediate provision of support and advice to colleagues, following the Trust's leading involvement in the Wuhan repatriation in Milton Keynes in February 2020.

A Covid Staff Health support helpline staffed, over 7 days with extended operating hours, by colleagues across the Workforce Directorate and supported by clinical colleagues who were required to work from home due to their Clinically Extremely Vulnerable status. This enabled close monitoring of colleagues suffering with COVID-19 via welfare calls and that there was a quick route to support and/or PCR testing in line with government criteria. The average number of welfare calls each day has been as high as 143 during the first wave. Almost 15,800 outgoing calls have been made to MKUH staff since March 2020.

The team also owned the Trust's PCR testing (swabbing) process across various locations across the Trust to ensure that colleagues and household members could have quick, direct and responsive access to testing in line with government criteria and as required to support advice to enter isolation and/or a quick return to the workplace. Over 3150 swabs have been taken since the start of the pandemic. Each postive result triggers a local incident investigation in line with national guidance on nosocomial transfer of infection.

The Trust continues to participate in COVID-19 research studies as capacity allows. In April 2020, the Trust participated in an NHS England initiative to swab asymptomatic staff. The majority of the first 500 booking slots were filled within the first hour of the call centre opening. The Trust increased capacity shortly thereafter and over 1000 staff were swabbed during the 2 day event. The Trust also participated in two research based antibody screening programmes. Close to 1300 staff were screened in the first programme, followed by a further 2700 staff in the second.

All staff were asked to complete a COVID-19 individual risk assessment; MKUH was the first Trust to reach 100% of staff assessed or opted out. The risk assessments were carried out by the staff member and their manager and for staff with certain medical conditions, these were reviewed by the Divisional Triumvirate and then forwarded to the Trust Risk Assessment Panel, which consists of an Executive Director, Occupational Health and HR. This panel reviews the Divisional recommendation and then makes the final recommendation as to whether the staff member may continue with no adjustments, be moved to a lower risk area, either in the department, Division or elsewhere in the Trust, or work from home.

It emerged during the pandemic that BAME colleagues across the NHS were more severely impacted by COVID-19 than other backgrounds. There was a national response published in relation to this and the Trust followed this guidance. In addition to this MKUH held BAME Q&A sessions and engaged with the local British Association of Physicians of Indian Origin (BAPIO) Lead and the Medical Advisory Committee (MAC) to discuss the issues. Following this early engagement, the formation of the MKUH BAME network was accelerated

Following feedback from BAME engagement events any colleagues who were BAME, over 55 years of age and in an aerosol generating procedure area, or over 60 and in an aerosol generating procedure area were invited to have a risk discussion with the Occupational Health Physician. An appeal process was also developed to review cases further.

The outcome of the risk assessment panel requires colleagues to continue as normal, move to a lower risk area or work from home (during shielding times only). Any colleagues who are unable to adhere to the outcome in their regular work area are passed to the COVID-19 redeployment pool who identify an alternative suitable work location.

To date, close to 1,500 risk assessment forms have been reviewed by panel and new starters now receive a risk assessment as part of their onboarding process.

The Trust commenced its participation in asymptomatic Lateral Flow Testing in December 2020. This required an extensive supply and distribution exercise in collaboration with colleagues from Receipt and Distribution and Workforce. Training videos, a user guide and a QR code-based reporting system were developed internally and any positive results are routinely picked up by the call handling team and booked for a PCR test/swab within 16 hours.

A Staff Hub was created as a safe space for colleagues to take some time for themselves, to relax, recharge, reflect and process their feelings alone or with colleagues This was particularly valuable given the quick progress and volume of COVID-19 suffering within the Trust alongside the various issues caused by isolation, childcare and

associated difficulties outside of work. In a similar vein, a quiet room was also created for colleagues to use in the ED. Baskets of essentials and small treats were collated and delivered to each ward and department to ensure that colleagues were refreshed and hydrated during this time.

Care Support Circles were established to support returning colleagues and their managers to return to the Trust environment following shielding. The Trust undertook a series of engagement events, led by the Director of Workforce, to ensure their concerns were heard and that they were briefed about and reassured that all necessary steps to safeguard a safe and Covid secure return to the workplace could take place; including full workplace risk assessments.To ensure these team members did not feel alone Care Support Circles were formed to provide a peer support mechanism. These were very well received and a similar model is being put in place for those suffering with the condition Long Covid.

Alongside the Long Covid Clinic being formed in enabling management and self referrals to the Occupational Health team, a Long Covid Support Group has also commenced to bring together suffers of Long Covid and provide support and practical advice for the management of their condition. The Trust's Therapies team collaborates with the group and individuals providing specialist advice about reasonable adjustment for workplaces.

In December 2020, the Trust became the first Covid vaccination site in the ICS and was one of the first in the country. The Trust has consistently delivered a high number of vaccinations since the centre opened on 8 December 2020, delivering close to 35,000 vaccinations until 30 March 2021. Hosting the centre at MKUH was a real benefit for the MKUH workforce as it allowed them easy and fast access to the vaccine.

The SH&WB department undertakes both pre-employment and employment fitness for work assessments. It also provides an immunisation/ screening programme to ensure staff are protected against infectious and communicable diseases in line with Department of Health guidance.

The service continues to routinely support the Trust with the management of sickness absence and providing advice in relation to health conditions which may have an impact upon an individual's health at work or vice versa. Through an Employee Assistance Programme, the Trust offers a number of support to staff on a free and confidential basis, including; emotional and psychological support such as counselling and financial and legal advice. The Trust's health and wellbeing strategy was refreshed in 2020, several key features are planned including a staff physiotherapy early intervention service for colleagues suffering with musculoskeletal complaints. In pilot, the service has been overwhelmingly well received by colleagues and helped many to return to work sooner than they would have done without such intervention, enabling the Trust to reduce its temporary staffing usage. The Trust successfully achieved vaccination of 88.5% of its frontline health care colleagues were vaccinated against the flu virus – the campaign was brought to an early close due to the onset of the COVID-19 mass vaccination programme. During the Flu campaign Weekly uptake of flu vaccinations was reported on a weekly basis to the executive team and socialised with the Trust via the CEO weekly newsletter (jab-o-meter) and Social Media channels.

The Trust now has over 70 trained Mental Health First Aiders (MHFAs) who can be called upon in the first instance to help signpost colleagues to appropriate support if required.

To support the spiritual needs of our staff of all faiths and beliefs, the Multi Faith Room and Chapel offers a quiet space for reflection at all times. Considerable work was undertaken to remodel the space to create separate prayer rooms for our Muslim colleagues, with separate washing facilities for men and women.

The Wellbeing steering group has been revised and meets on a monthly basis, led by our Director of Workofrce with quarterly reporting to the overarching senior Workforce Board and also to the sub-Trust Board, NED chaired, Workforce and Development Assurance Committee. In 2019/20 the group enlisted more Health and Wellbeing Champions and sought to oversee delivery of the Trust's Health and Wellbeing Strategy with staff side support. The revised strategy sets out our intent to engage with partners to ensure that the wellbeing of our workforce underpins excellent performance through education, prevention and effective management of health conditions.

The Trust has used various means of communicating developments (payslip attachments, email, health and wellbeing events, Event in the Tent, quarterly newsletter, workforce website) and the service has delivered a series of monthly activities in support of health and wellbeing education and prevention.

The Trust's 2020 National Staff Survey results confirm that it continues to improve the health and wellbeing of our organisation. This is underpinned by an improved staff benefits package which was rolled out during 2019/20, enhanced in 2020/21 which included free car parking, free tea and coffee, improved terms of special leave and discounted gym memberships.

2.7.8 Staff Survey Results

Statement of approach for staff engagement

Staff engagement is a key enabler of delivery of patient care and the experience of our Trust and its services. As such, the Trust aspires to improve its staff survey outcomes on an annual basis as it provides valuable insight into areas of progress and where we can improve through development.

The 2020 Staff Survey for MKUH was undertaken between September and November 2020 as part of the Trust's Protect and Reflect Event – colleagues were provided with the opportuntiy to book into protected time slots to support completion of the survey and get their flu jab. Running both enabled colleagues to maximise their time away from the workplace. The survey was coordinated by our provider Quality Health and initial responses were received in December and provide an indication of positive or negative increases from the staff survey conducted in 2019.

There were 5 sections of the survey, 19 comparable questions with a total of 81 total sub-set questions (excluding equality monitoring information). This year, there was an additional section covering the pandemic.

Section	Questions
Your job	1 – 7 c
Your managers	8 a – 9 d
Your health, well-being and safety at work	10 a – 17 c
Your organisation	18 a – 19 d
The COVID-19 pandemic	20 a – 20 d
Background information (equality monitoring)	22 a – 28

We had a response rate of 45.5%

The Trust has consistently achieved a higher response rate that its comparators since the 2016 survey

Summary of Performance – results from the 2020 staff survey

The MKUH response rate for the 2020 staff survey was 45.5%, a 10% decrease from 2019. The overall national response rate for 2020 was 47%. MKUH was above the average response rate of 43.3% against its benchmarking group in 2020. The Trust has consistently achieved a higher response rate that its comparators since the 2016 survey.

The national staff survey has ten theme areas derived from 81 sub-set questions. The 2020 staff survey included an additional section to capture staff experience during the pandemic which was an interventional construct by NHS England & Improvement to understand how better to improve conditions for our people at times of crisis or distress. Analysis of both survey themes and questions have been looked at to assess areas for improvement. Changes and significant differences from our 2019 results and against our benchmark group have also been analysed.

44 of the 81 questions (56%) asked in the survey had significant improvement in weighting compared to the Trust's benchmark group and there was no significant worsening in our results in 2020. The Trust also scored significantly better in three themes – Theme 2: Health and Wellbeing; Theme 5: Quality of Care; Theme 9: Staff Engagement. The Trust scored one theme significantly worse than the benchmark group – Theme 7: Staff Environment (Violence).

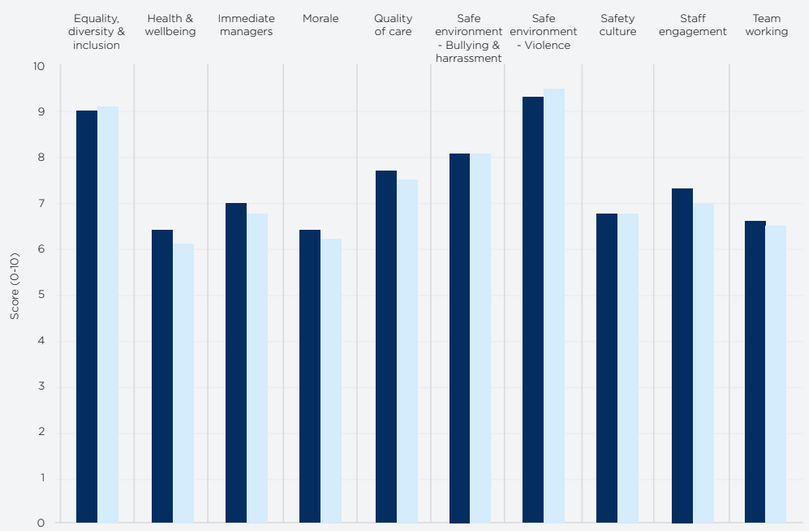
The table below shows the theme scores over the last 3 years.

	2020		2019		2018	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	9	9.1	9	9	8.9	9.1
Health & wellbeing	6.4	6.1	5.8	5.9	5.9	5.9
Immediate managers	7	6.8	6.8	6.8	6.8	6.7
Morale	6.4	6.2	6.2	6.1	6	6.1
Quality of appraisals	Not asked in 2020		5.6	5.6	5.3	5.4
Quality of care	7.7	7.5	7.6	7.5	7.5	7.4
Safe environment – bullying & harassment	8.1	8.1	7.9	7.9	7.9	7.9
Safe environment – violence	9.3	9.5	9.3	9.4	9.4	9.4
Safety culture	6.8	6.8	6.7	6.7	6.7	6.6
Staff engagement	7.3	7	7.1	7	7	7
Team Working	6.6	6.5	6.5	6.6	Not previously asked	

The table below shows the 10 theme scores for 2020

A positive foundation in staff experience

2020 NHS staff survey results. **Above average** results. **Trending up** (esp. wellbeing, managers, safety culture)



Trust	9	6.4	7	6.4	7.7	8.1	9.3	6.8	7.3	6.6
Benchmarking Group	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7	6.5

Overall Staff Engagement

Staff engagement is measured across three themes: Motivation, Improvement (Ability to contribute to improvements) and advocacy (recommendation of the organisation as a place to work/receive treatment).

9 questions contribute to the overall staff engagement score, across the three themes with all 9 questions showing a significant improvement from 2019 scores. Compared to the 43 organisations in the sector within Quality Health the Trust was 13th out of 43 organisations.

		2018	2019	2020
Staff Motivation				
Q2a	I look forward to going to work	60%	63%	**66%**
Q2b	I am enthusiastic about my job	75%	76%	**79%**
Q2c	Time passes quickly when I'm working	76%	76%	**77%**
Staff's ability to contribute to improvements				
Q4a	There are frequent opportunities for me to show initiative in my role.	73%	71%	**75%**
Q4b	I am able to make suggestions to improve the work of my team or department	73%	72%	**76%**
Q4d	I am able to make improvements happen in my area of work	54%	56%	**59%**
Whether staff would recommend MKUH as a place to work or receive care				
Q21a	Care of patients and service users is my organisation's top priority	78%	82%	**84%**
Q21c	I would recommend my organisation as a place to work	63%	66%	**74%**
Q21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	68%	70%	**76%**

Statement of key priority areas and how they will be measured.

Action plans to address areas of concern

The 2021 action plan incorporates and builds upon the elements which have worked well in previous years. It also includes the priorities which we think are most important to improve upon, which are questions which were decreasing in scores or in the 20% lowest percentiles.

1. Utilise the Staff Survey Goes Large approach, as rolled out pre-COVID-19 to share and review department level data with each team.

   This will be taken forwards by Divisional and Corporate HRBPs with managers for each Directorate, CSU and/or team.

2. Establish a working group to explore issues around staff hours and review additional training for managers to better manage staff and allocating work fairly. This will include analysis of eRostering utilisation and efficiency and use of focus groups in particular areas of exemplar practice and/or to understand further means of improvement.

3. Identify the location of spikes in violent incidents from patients and the public by drilling down into data including Datix incident reporting outputs.

   Once identified, an action plan will be undertaken with the HRBP for the area. Work will also take place in partnership with the Health and Safety Committee and teams on Trust-wide approaches to reduce violence in accordance with the national Violence Reduction and Prevention Strategy and in-line with deliverables outlined in the Trust's Delivery Plan of the NHS People Plan.

4. Embed and consolidate actions taken at a Trust level to maintain staff engagement levels, celebrate success and review practices continually.

   Continue with publicity of results and actions such as Acute User, Joe's Weekly, Executive Q&As, Staff Events, Rewards, "You Said, We Did", wordclouds and visuals from staff survey and other engagement activities e.g. the Living our Values programme, to ensure alignment and consistency of messaging.

5. Begin to plan to next year's survey.

   Repeat this year's success of the Protect and Reflect event, working from the summer 2021 onwards to ensure that all colleagues get time in their diaries to attend the event, get their flu / seasonal vaccination(s) and complete their survey following ongoing engagement in line with point 4, above.

6. Feedback and progress reports will be shared with Workforce Board and updates to the Workforce Development and Assurance Committee throughout 2021.

Conclusion

The results from this year's staff survey are encouraging with significant improvements across the overall survey, with a strong lead on wellbeing, quality of care and staff engagement against the backdrop of the most difficult circumstances that the Trust has experienced in recent times. There is however more work to do on our journey to take MKUH from good to outstanding. The improvement work planned in this regard complements the Trust's Organisational Development approach and aligns with its local NHS People Plan delivery plan.

In particular to identify which area(s) of the Trust is a) experiencing violence from patients, relatives or the public and in what form and b) where staff are undertaking additional duties. The RAG and free-text reports that will be made available to the Trust in early May will assist with this deep-dive analysis to then form an action plan which the HR Business Partners will take forwards with the Triumvirates, Directorate departmental leads.

A review of formal grievance and discrimination cases will be undertaken with a focus on equality and inclusion with the ambition of significantly reducing our bullying and harassment score in the 2021 survey. This work will run with the co-development of the Respectful Resolution module of the Trust's Living our Values Programme in 2021/22.

There are also further improvements to continue to raise the profile and accessibility to the executive team through Live Q&A sessions and other staff engagement events such as Event in the Tent, the Living our Values Programme and Quality Improvement events.

Monitoring arrangements

Staff Survey action plans are monitored through the Workforce Board, Workforce Assurance Committee and reports are received to executive team meetings and Trust Board.

2.7.9 Off-Payroll Engagements

The Trust has not engaged any off-payroll arrangements in 2020/21.

Table 1: For all off-payroll engagements as of 31 Mar 2021, for more than £245 per day and that last for longer than six months	2020/21
	Number of engagements
No. of existing engagements as of 31 Mar 2021	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two \and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2020 and 31 Mar 2021, for more than £245 per day and that last for longer than six months	2020/21
	Number of engagements
Number of new engagements, or those that reached six months in duration, between 01 Apr 2020 and 31 Mar 2021	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2020 and 31 Mar 2021	2020/21
	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	18

NB: The Trust has a policy of using its own payroll for the purposes of employment. Where engagement is required that is off-payroll, this is facilitated through national framework agency providers only. In the event that any further off-payroll arrangements are required, the Trust uses a comprehensive risk assessment form and the HMRC personal service company assessment tool which both seek to test the nature of the engagement, whether the individual is aware of their obligations in respect of payment of tax and require them to provide assurances in this regard before they are engaged. Following completion of the risk assessment, approval is sought of the director of finance and director of workforce in order to finalise the arrangement.

2.7.10 Exit Packages

No exit packages were agreed by the Trust in 2020/21, whether through compulsory redundancy, voluntary redundancy, or any other type of agreed exit package.

2.7.11 Equality, Diversity and Inclusion

The Trust has a longstanding commitment to ensuring that our services and employment practices are fair, accessible and appropriate for all patients, visitors and carers in the community we serve, as well as the talented and diverse workforce we employ. The Trust Board receives a comprehensive annual report of equality and diversity information, the last of which was in 2020.

The Trust remains committed to providing an environment equally welcoming to people of all backgrounds, cultures, nationalities and religions. Our 'We Care' values were developed following extensive Trust-wide consultation and engagement into a suite of new values in 2018/19 to help us to achieve this aim.

The Executive Workforce lead and the patient services lead for Equality, Diversity and Inclusion are both members of the Workforce and Development Assurance Committee which is responsible for overseeing equality, diversity and inclusion for the Trust and through which Trust Board is informed.

Supporting the local staff survey outcomes, regional and national requirements (Workforce Race Equality Standard and Equality Delivery System 2 and Public Sector Equality Duty of the Equality Act 2010, an equality, diversity and inclusion forum was established in 2015 to oversee this sphere of activity and acts as a steering group for both our workforce and patient care and experience. This work is now led by the Head of Equality of Diversity and Inclusion and engagement with Milton Keynes Council and the Bedfordshire, Luton and Milton Keynes joint CCG has been built into activities with mutual benefits resulting from our approach in this regard.

The Trust is an accredited 'Disability Confident' Employer and was an active participant in the formative stages of the Workforce Disability Equality Standard prior to its introduction in April 2019. The Trust's Disablity Network was launched in 2018/19 to support staff engagement and ensure that underrepresented colleagues can have peer support and a collective voice within the organisation.

In 2019/20, MKUH Pride network was established to support LGBTQ+ colleagues and a Women's Network was also established to better support the female workforce. Following the Trust's investment in a newly established Head of Equality, Diversity and Inclusion role, 2020/21 has seen the strengthening of these networks in addition to the establishment of the Black, Asian and Minority Ethnic (BAME) network and the Faith and Belief Network. The networks are critical to improving the collective voice of the organisation and have also been involved in the delivery of actions aligned to the various statutory Equality, Diversity and Inclusion reports (including WDES, WRES and the Trust's Gender Pay Gap) which can be found here:
https://www.mkuh.nhs.uk/about-us/public-documents/equality-and-diversity

The equality, diversity and inclusion agenda of the Trust supports all of the protected characteristics and is recognised as being critical to retention and the experience of our staff. In this regard, the Trust has further been accepted onto two national improvement fora to support its development of equality, diversity and inclusion. Both are due to commence in 2021/22 having been paused to allow the system to focus on its COVID-19 response; Diversity and Inclusion Partners and the WRES Experts Programme (Cohort 4).

Investment has been supported in 2020/21 as the Trust seeks to improve its breadth of understanding and influence on the diversity of its colleagues. A cultural intelligence programme has been commissioned with external experts to work with key stakeholders in the Trust's leadership and management teams; this work will commence in 202/22. A further development planned for 2021/22 is the realisation of the Inclusion Leadership Council, the concept for which was approved by the Trust in 2020/21, This will further strengthen network based engagement through Board level interaction and ensure that an ongoing driving factor of the Trust's decision making has bases in collaboration with the views of its stakeholders.

2.7.12 Workforce Resourcing

In 2020/21 the Trust has continued to pursue automation and use of electronic systems to improve the efficiency of its resourcing activity. Over the last year, under the Workforce Strategy and Plan and the NHS People Plan, specific improvements have been made to the onboarding of staff, reward packages, time to hire and staff retention have been delivered with a positive impact on quality feedback, retention, turnover and staff engagement metrics. As at the end of the financial year, the Trust's turnover rate was an improving 7.1% against its threshold of 10%. Similarly, the Trust's stability rate was 87.7% ending the year long improvement trend on an all-time high.

- High volume recruitment has continued throughout the pandemic
- Reduced Health Care Assistant vacancies considerably
- Achieved 100% implementation of e-Rostering
- Extensive work ready day one programme which ensures new staff attend induction on their first day and have ID and smartcards/IT logins
- Monthly systems and compliance reporting to capture recruitment metrics and transformational initiatives
- Engaged with underrepresented groups in our community to promote our permanent and temporary roles
- Monthly monitoring and review of 'hard to recruit and/or retain' posts, and review of recruitment and retention premia.
- Application of evidence based enhanced bank rates in critical areas in order to reduce reliance on high cost agency alternatives
- Continued use of social media to increase visibility of campaigns, open days and the #TeamMKUH brand. Extensive use of Facebook, Twitter and Instagram and key roles are published to LinkedIn
- Development of the staff benefits portal, these include a car leasing scheme, purchase of electrical goods, enhanced Employee Assistance Programme and counselling and health and wellbeing support.

The Trust continues to build its reputation as a regional employer of choice and views its resourcing challenge as an opportunity to reach out to our community and build a diverse workforce which reflects the community we serve. The Trust issues an increasing number of honorary contracts to visitors who want to find out more about the work we do in the Trust, along with placements of students, work experience, observerships and apprenticeships helping to build regional reputation and promote the employment offering.

The HR Services and HR Systems team were established in 2020/21 to support full interoperability with hospital administrative systems to streamline process, reduce inefficiency and reduce cost, achieving this by further improvements to use of e-Rostering, wider visibility of shifts and sustained recruitment of temporary administration and clinical staffing to support the Trust during the pandemic. These were supported by two new appointments in year, the Head of Resourcing and the Head of HR Systems and Compliance. Such measures have allowed the Trust to once again meet its agency ceiling financial targets throughout 2020/21.

2.7.13 Statutory and Mandatory training

Statutory training is that which an organisation is legally required to provide as defined by law or where a statutory body has instructed organisations to provide training based on legislation.

Mandatory Training is that which is determined essential by an organisation for the safe and efficient running in order to reduce organisational risks, comply with policies, and meet government guidelines.

MKUH Mandatory training competencies are mapped to the Core Skills Training Framework

There has been a steady improvement in statutory and mandatory training – the table below shows the compliance rate by year and at the end of each quarter.

	Q1	Q2	Q3	Q4
2014/2015	81%	81%	85%	87%
2015/2016	86%	87%	88%	89%
2016/2017	89%	89%	90%	91%
2017/2018	91%	89%	90%	89%
2018/2019	90%	89%	90%	93%
2019/2020	93%	92%	94%	94%
2020/2021	94%	95%	95%	97%

Mandatory training is reported at Workforce Board, Workforce and Development Assurance Committee (quarterly) and Trust Executive Group (monthly). During 2020 ESR self-service has been developed with all training except Manual Handling (Level 2) and Resuscitation now accessible via its e-Learning platform. The Trust consequently no longer uses workbooks routinely and the movement to e-Learning has been of particular timely use during the pandemic. The Trust has also adopted use of the national principles of the pay progression framework to support increasing levels of compliance into 2021/22.

2.7.14 Learning & Development

Appraisal compliance was sustained in 2020/21 despite the impact of COVID-19 on our workforce. The appraisal system has been enhanced by the addition of Health and Wellbeing Conversations as per the NHS People Plan, the advent of 'mini-appraisals' at 6 months for new starters and the Trust's Probationary Period Policy.

The table below illustrates that although the annual appraisal compliance rate at the end of each quarter:

	Q1	Q2	Q3	Q4
2018/2019	84%	85%	85%	85%
2019/2020	95%	91%	93%	94%
2020/2021	92%	92%	90%	95%

The Trust was allocated £400,000 by NHS England and Health Education England with eht aim of providing a £1,000 training budget over the next three years for each nurse, midwife and AHP in addition to investments made locally. This is important funding to support our staff to ensure they continue to be able to develop the skills to deliver high quality care for patients.

A wide variety of personal development programmes and workshops were paused throughout the pandemic due to the deployment of colleagues across the Trust to support the clinical workforce and, where relevant, distancing requirements. These offerings, ranging from yearlong leadership programmes to one-day functional skills workshops are open to all staff to attend will resume through a blended approach to delivery in 2021/22.

2.7.15 Widening Participation

Apprentice numbers continued to grow at a steady rate in 2020/21 and an Apprenticeship Strategy was developed to support further increases beyond 2021/22. The Nurse Associate programme has moved to a new provider, the University of Northampton. Following internal recruitment 6 new apprentices enrolled in March 2021. External recruitment has been deferred until Autumn 2021 due to the pandemic, however, 9 externally recruited apprentices posts have been advertised during Q4; the highest number to date.

Cara Crotty, Communications Apprentice, was awarded MKUH 'Apprentice of the Year' 2020 and this story was featured by the apprenticeship provider **MK College** and the Trust's social media accounts .

An 'Apprenticeship Achiever' Virtual Ceremony took place on 14 April 2021, with 20 'achievers' for 2020/21 invited. Each delegate received a keepsake and be recognised during the ceremony by a member of the Executive Team.

The Apprenticeship Team continuously evaluates the service provided and the latest initial results indicate that over 88% of apprentices felt they were well supported, with 63% stating 'extremely well supported'. Apprentices also stated that the teams is 'kind & professional', 'an ongoing support network 'and that the team 'always answer questions & willing to help'.

Work Experience / Schools

Due to the impact of government restrictions on schools throughout 2020/21, a pilot virtual careers event was rescheduled for April 2021. The Learning & Development Team has continued to collaborate with the Talent for Care Team and has become part of Health Education England WEX (Work Experience Network). This has included participating in Q&A Sessions with students enrolled with organisations such as Uptree, a careers and employability charity. Discussions have begun about the future of work experience and what can be offered in the interim while face-to-face restrictions are in place.

Princes Trust

Workforce and OD Teams have collaborated with the Princes Trust on an employability project. Individuals enrol on a 3-week programme, during which they will receive a Trust bespoke session delivered by the Trust's Apprenticeship Manager and gain support in applying for Trust vacancies; HCA roles in this instance. Participants are guaranteed an interview following the programme. The Pilot group comprised 12 people aged 18-30 who were not in work with conditional offers made to 50% of participants. The aspiration is to roll this out amongst other entry level, hard to access or hard to recruit posts/areas and proactively engage and promote vacancies and roles with the local community.

Over 88% of apprentices felt they were **well supported,** with 63% stating **'extremely well supported'**

3

Code of Governance Disclosures

Monitor Code of Governance

Milton Keynes University Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers that it was compliant with the provisions of the revised Monitor NHS Foundation Trust Code of Governance, with the following three exceptions:

Provision	Explanation for non-compliance
A.5.6 The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	The Council of Governors raise concerns at their regular meetings which members of the Board of Directors attend. In addition, the lead governor meets with the chairman and can raise issues on behalf of the Council. The senior independent director also meets informally with governors to discuss issues and governors can raise concerns through these meetings.
B2.4 The chairman or an independent non-executive director should chair the nominations committee.	The Council of Governors believe that the Non-Executive Director appointment committee (formally the Nominations Committee) should be chaired by a member of the Council of Governors, as the Council of Governors has a responsibility for the appointment of Non-Executive Directors. This has been in effect since 2008/9 and is reflected in the Trust's Constitution.
B2.9 An independent external adviser should not be a member of or vote on the nominations committee(s)	The Nominations Committee has always valued the input of the independent external adviser, particularly as the Trust has usually selected a serving Chair or non-executive director of another trust to act in this capacity.

As per 'The NHS Foundation Trust Code of Governance' (updated July 2014),

'the board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.'

3.1 NHS England/NHS Improvement Oversight Framework

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

The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

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

3.2 Single Oversight Framework - Segmentation

As of March 2021, the Trust is in Segment 2 of the Single Oversight Framework. Current segmentation information for NHS Trusts and Foundation Tis published on the NHS Improvement website.

3.3 Statement of the Chief Executive's responsibilities as the Accounting Officer of Milton Keynes University Hospital NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the

Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National

Health Service Act 2006 has given accounts directions which require Milton Keynes University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Milton Keynes University Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

As far as I am aware, there is not relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Professor Joseph Harrison
Chief Executive

10 June 2021

4

Annual Governance Statement 2020/21

Annual Governance Statement 2020/21

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Milton Keynes University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Milton Keynes University Hospital NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Leadership of the Risk Management Process:

Board of Directors

The Board of Directors (Board) has overall responsibility for the identification and effective management of principal risks to the achievement of the Trust's strategic objectives. These risks are captured on and managed through the Board Assurance Framework (BAF). The Trust has ten primary strategic objectives; namely:

1. Improving patient safety
2. Improving patient experience
3. Improving clinical effectiveness
4. Delivering key targets
5. Developing MK at PLACE
6. Developing robust and innovative teaching and research
7. Being well-governed and financially viable
8. Improving workforce effectiveness
9. Making the best of the estate
10. Being innovative and sustainable

The breadth of these objectives means that the BAF contains a broad spectrum of risks of which the Board has oversight.

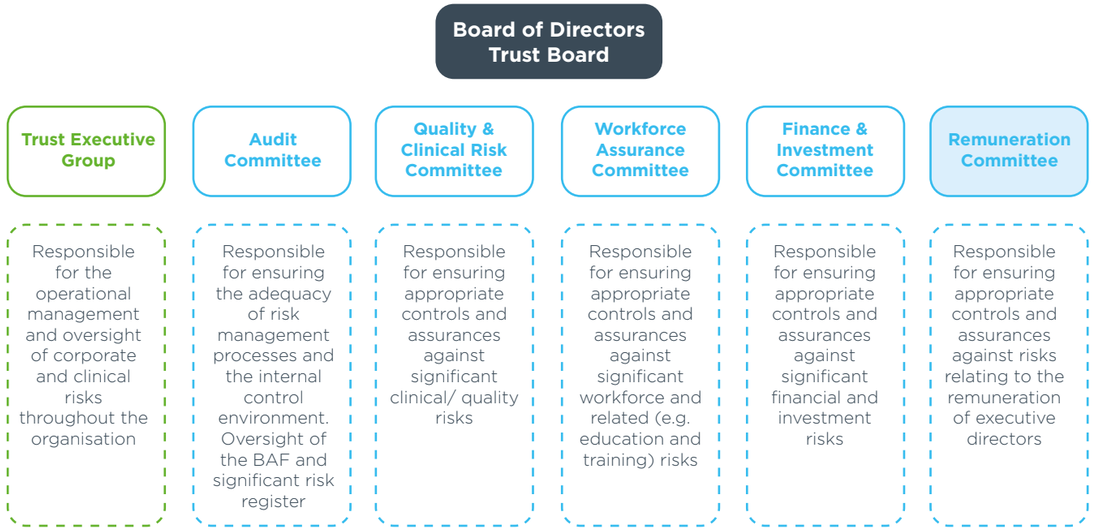
Board Committees

The Board delegates the testing of assurance and management controls on the BAF to its Committees.

Each Committee is responsible for risks to the achievement of objectives within its terms of reference.

In addition, the Quality and Clinical Risk Committee has a wider oversight role on the effective management of clinical risk.

The Audit Committee has a wider oversight role on the effective management of corporate risk and provides assurance to the Board on the adequacy of the systems and processes surrounding the management of risk throughout the organization.



Executive Leadership and Management Oversight

The Director of Corporate Affairs is the executive lead for risk management. The Trust's Senior Information Risk Owner (SIRO) is the Deputy Chief Executive, who is responsible for, and oversees all information risks within the Trust. The Trust's Caldicott Guardian is the Medical Director, who is ultimately responsible for the correct use of patient identifiable information. Both the SIRO and the Caldicott Guardian have undertaken the required training to discharge their responsibilities effectively.

All directors and divisional managers have a leadership responsibility for risk management within their own areas and are accountable to the trust Board via general and specific reports.

The Trust has an established Risk and Compliance Board (RCB) which meets monthly and is chaired by the Director of Corporate Affairs. The RCB reviews risks rated 15 and above on the significant risk register (SRR). It challenges the control measures and actions being taken; assesses risk score; approves corporate risks; reviews linked risks across specialties/ departments and divisions; reviews the aggregated risk profile; and reports each month to the Management Board.

Divisional and departmental risk registers are also reviewed on a rotational basis to ensure that the risks are relevant and appropriate, that risks are being effectively identified, assessed, mitigated and managed. The RCB receives reports on the number of overdue incidents, audit compliance, trust documentation and reports on other compliance reports e.g. CQC/ regulatory guidelines and other relevant statutory, legislative, or regulatory compliance requirements or guidance. This is also reported to the Trust Executive Group.

During the last year, dealing with the COVID-19 pandemic, risk management has included managing a dynamic risk environment of pressing operational risks. These have been managed through the Bronze/ Silver/ Gold incident command structure, that is a requirement during a Level 4 national incident (and is described and prescribed through the Emergency Preparedness Response Framework). This has led to different governance arrangements for risk, with intense daily management, in addition to routine reporting and management (as in 'normal' times).

Equipping and Training Staff to Manage Risk and Learning from Good Practice

The identification, assessment and management of risk is the responsibility of all staff. The Trust's mandatory training programme, which forms part of the staff induction, includes responsibilities and processes relating to risk management which encompasses fire safety, health and safety and clinical risk. Levels of compliance with mandatory training are reported to the Board as part of the monthly performance dashboard. Further guidance on risk management issues is disseminated to staff through briefing systems either electronically including the intranet or via meetings.

Learning from Good Practice

The Trust's central risk management team work effectively with the Trust's internal auditors to continually challenge and improve risk management processes as part of the annual development and audit programme. The central risk team holds regular dedicated sessions on improving practice; using external reports on good practice and industry recommendations to facilitate ongoing improvements to risk management. This includes and involves divisional risk and governance leads.

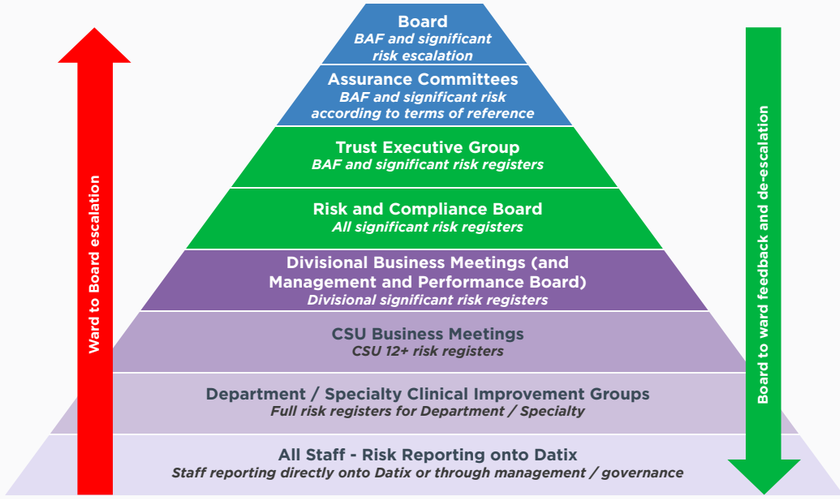
Organisationally, good practice and learning identified through risk assessments and incidents is shared through routine communications, training, meetings, briefing and de-briefing sessions and committees.

The Risk and Control Framework

Risk Management Strategy

Risk management is an integral part of the Trust's management, governance structure and internal control processes. It is the process through which the Trust identifies, assesses and analyses the risks inherent to and arising from its activities; whether clinical or non-clinical, including strategic, financial, workforce or any other; and ensures robust and effective controls and assurances are in place.

The Trust has a Risk Management Strategy (updated and approved in the reporting period), which sets out a delegated governance structure through which risks are monitored and managed. It sets out a systematic process for the identification, recording and management of risk through its specialty, divisional and significant risk registers and clearly defines the escalation and de-escalation of risk as detailed in the diagram below:



The Risk Management Strategy sets out how risk appetite is determined, with the Board of Directors setting risk appetite against the Trust's ten strategic objectives during annual risk appetite development and review.

Quality Governance Arrangements

The Trust operates within the NHS Foundation Trust statutory and regulatory environment and its quality governance arrangements are regularly reviewed to ensure compliance with relevant regulatory (and other legal or professional) standards. This includes the NHS Improvement and Care Quality Commission combined Well-Led Framework. The Trust was inspected under the Well Led Framework by the CQC and NHS Improvement in 2019 and received a rating of Good overall. The Trust has undertaken work with Deloitte during 2020 to complete an independent assessment against the Well Led Framework. This work was paused due to the COVID-19 pandemic and re-visited in March 2021 with a view to re-starting with a post-pandemic review.

The Trust has a well-defined quality governance structure in place, designed to provide 'ward to Board' visibility, reporting and assurance across the quality agenda.

The executive and the Trust Board seek information and assurance on compliance. Improvements in the reporting period include an assurance rating against performance information reported to the Board, based on data quality confidence levels. The Trust also has an established Data Quality Compliance Board to provide scrutiny, challenge and assurance on all aspects of data quality which reports to the Audit Committee.

The Trust ensures compliance with CQC registration requirements is monitored and assessed through its governance structure. This

includes compliance monitoring at the Risk and Compliance Board; proactive assessment through the Clinical Quality Board; proactive assessment through the clinical divisional management; and independent peer review (e.g. Healthwatch enter and view). Compliance is assured through the Quality and Clinical Risk Committee.

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

The Board has sought assurance on the management of risks to data security, with reports and presentations to the Audit Committee and to the Board during 2020/21. Data security (compromise through deliberate attack; and breach through inadequate controls) are risks on the Board Assurance Framework which are actively monitored and assurance-assessed through the Board sub-committees.

Major Risks

The Board Assurance Framework reflects the principal risks against the achievement of the Trust's strategic objectives, including clinical and non-clinical risk. The following risks were identified on the Board Assurance Framework at the end of the 2020/21 financial year:

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
1	Quality & Clinical Risk Committee	Director of Operations	If the Trust's ED does not have adequate staffing and estate capacity, and effective escalation plans, it will not be able to maintain patient safety during periods of overwhelming demand.	4x3=12	4x2=8	• Clinically and operationally agreed escalation plan. • Adherence to national OPEL escalation management system. • Clinically risk assessed escalation areas available. • Surge plans, COVID-specific SOPs and protocols have been developed.
2	Quality & Clinical Risk Committee	Medical Director	If an effective reporting, investigation and learning loop is not established and maintained, the Trust will fail to embed learning and preventative measures following serious incidents/ Never Events.	4x3=12	4x2=8	• Improvement in incident reporting rates. • Serious Incident Reporting Group (SIRG) reviews all evidence and action plans associated with Significant Incidents. • Trust-wide communications in place. • Debriefing systems in place. • Training available. • Appreciative Inquiry training programme started (December 2020).
3	Quality & Clinical Risk Committee	Medical Director	If the Trust is unable to accurately predict demand (for example, relating to the COVID-19 pandemic) and re-purpose its resources (physical, human and financial) with agility, the Trust will fail to manage clinical risk during periods of sustained or rapid change in the level or type of demand.	4x3=12	4x2=8	• Board approved major incident plan and procedures. • Rigorous monitoring of capacity, performance and quality indicators. • Established command and control governance mechanisms. • Gold (Daily) Level 3/4 Incident management.
4	Quality & Clinical Risk Committee	Deputy CEO	If the Trust does not carefully manage its significant digital change programme, then the delivery of clinical services will be impaired.	4x2=8	4x2=8	• Robust governance structures in place with programme management at all levels. • Clinical oversight through the Clinical Advisory Group (CAG).
5	Quality & Clinical Risk Committee	Director of Operations	If the Trust is unable to provide capacity to match demand for elective care, (such as for cancer and screening programmes), there is a risk that this could lead to patient harm.	5x4=20	5x2=10	• Compliance with national guidance. • Granular understanding of demand and capacity requirements with use of national tools. • Robust oversight at Board, and Board Committees. • Agreement of local standards and criteria for alternative pathway management – clinical prioritisation and validation. • Long-wait harm reviews • Use of the Independent Sector. • Extension of working hours and additional WLI to compensate capacity deficits through distancing and IPC requirements. • Additional capacity being sourced, and services reconfigured.
6	Quality & Clinical Risk Committee	Medical Director	If the Trust does not establish and maintain effective capacity management processes it will be unable to cope with high demand for ITU and inpatient care during a public health crisis (or due to the COVID -19 pandemic).	5x2=10	5x2=10	• Real time visibility of regional demand/ capacity. • Increased capacity across the hospital. • Increased capacity for ITU. • Clear escalation plans.
7	Quality & Clinical Risk Committee	Medical Director	If the radiotherapy pathway provided until 2019/20 in Milton Keynes by Genesis Care (under contract with OUH) is not replaced, the access and experience of patients on clinical oncology (radiotherapy) pathways will continue to be negatively impacted.	4x4=16	4x2=8	• Contingency for the provision of treatment to patients in Oxford and the ongoing provision of palliative and prostate radiotherapy at Linford Wood or in Northampton • Promotion of agreement between OUH and Northampton General Hospital to facilitate access to facilities at Northampton for those who prefer treatment in this location. • Promotion of rapid options appraisal and decision making at OUH and MKUH in relation to a medium to long term solution for radiotherapy provision on site at Milton Keynes University Hospital (build, operation, governance etc.) and route to capital funding. • Proactive communications strategy in relation to current service delivery issues.

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
8	Quality & Clinical Risk Committee	Chief Nurse	If the Trust does not effectively work with patients and families in delivering care and positive patient experience the national patient surveys may not demonstrate improvement.	4x4=16	4x2=8	• Corporate Patient and Family Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: a. Patent Experience Strategy b. Learning Disabilities Strategy c. Dementia Strategy d. Nutrition steering group e. Catering steering group f. Domestic planning group g. Discharge steering group h. Induction training • Quarterly Patient Experience Board, monthly Patient experience operational meetings and supporting substructure of steering groups.
9	Quality & Clinical Risk Committee	Chief Nurse	If the Trust does not effectively work to use feedback from complaints and PALS contacts to inform learning and embed related changes patient experience will not be improved.	4x3=12	4x2=8	• Corporate Patient and Family Experience Team function, resources and governance arrangements in place at Trust, division and department levels, including but not limited to: i. Patent Experience Strategy j. Learning Disabilities Strategy k. Dementia Strategy l. Nutrition steering group m. Catering steering group n. Domestic planning group o. Discharge steering group p. Induction training • Quarterly Patient Experience Board, monthly Patient experience operational meetings and supporting substructure of steering groups.

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
10	Quality & Clinical Risk Committee	Director of Corporate Affairs	If clinical audit requirements are not completed the Trust will fail to meet the requirements of clinical compliance regimes including the National Institute for Health and Care Excellence (NICE).	4x4=16	4x2=8	• Designated audit leads in CSUs/ divisions. • Clinical governance and administrative support - allocated by division. • Recruited additional clinical governance post to medicine to support audit function (highest volume of audits) • Audit programme being simplified, with increased collaboration and work through the QI programme. • Audit compliance criteria being segmented to enable focus on compliance with data returns; opportunity for learning/ changing practice and communication/ engagement. • Monthly review of all compliance requirements, including NICE and policies.
11	Audit Committee	Director of Operations	If the Trust is unable to establish robust governance around data quality processes, there is the risk that this could lead to patient harm, reputational damage and regulatory failure.	4x3=12	4x2=8	• Robust governance around data quality processes including executive ownership. • Audit work by data quality team • More robust data input rules leading to fewer errors.
12	Trust Executive Group	Director of Operations	If the Trust does not establish and maintain effective capacity management processes it will be unable to achieve waiting time targets due to seasonal emergency pressure (or further COVID -19 surges).	5x4=20	5x2=10	• Winter escalation plans to flex demand and capacity. • Plans to maintain urgent elective work and cancer services through periods of peak demand. • Agreed plans with local system. • National lead if level 4 incident, with established and tested plans. • Significant national focus on planning to maintain elective care.
13	Finance and Investment Committee	Director of Finance	If the Trust does not successfully appoint an external audit services provider in 2021 then the Trust will not be able to meet its statutory obligations	5x3=15	5x2=10	• The Trust is looking to extend its current External Audit Contract by a year through a direct award for its current external auditors
14	Finance and Investment Committee	Director of Finance	If the Trust does not maintain investment in its IT infrastructure and systems, then all operational systems will be severely affected by IT failures such infiltration by cyber criminals.	5x3=15	5x2=10	• 2 dedicated cyber security posts • Good network protection from cyber security breaches such as Advanced Threat Protection (ATP) – A part of the national programmes to protect the cyber security of the hospital. • All Trust PCs less than 4 years old

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
15	Finance and Investment Committee	Director of Finance	There is a risk that delays in the business case approvals process (including regulatory approvals), and/ or delays in capital funds being made available (through PDC financing or other sources) prevent the Trust from being able to progress its entire capital programme in 2020/21 leading to a missed opportunity in the event funds cannot be carried forward to future years.	4x3=12	4x2=8	• Capital prioritisation process in place (through the Trust's Capital Control Group (CCG) and Clinical Board Investment Group (CBIG) to ensure the Trust prioritises its capital schemes its resources effectively. • Alternative funding sources identified to support continued investment in the Trust's estate and physical infrastructure in line with requirements in the event that funding is not made available. • Close working with regulator partners to ensure the Trust is supported through the approvals process and any delays can be escalated through the NHS regional finance/capital teams.
16	Finance and Investment Committee	Director of Finance	If the future NHS funding regime is not sufficient to cover the costs of the Trust, then the Trust will be unable to meet its financial performance obligations or achieve financial sustainability.	4x3=12	4x2=8	• Payment by Results (PbR) contracts replaced with block contracts (set nationally) for clinical income. • Top-up payments available where COVID-19 leads to additional costs over and above block sum amounts (until September 2020). • Financial controls remain in place for approval of additional spend above budgeted levels. • Re-focus of transformation programme to ensure continued productivity and efficiency improvements.
17	Finance and Investment Committee	Director of Finance	There is a risk that as a result of the COVID-19 pandemic the Trust incurs additional costs, has a reduction in income or is unable to deliver services efficiently leading to financial position being unsustainable.	4x4=16	4x3=12	• Monitoring of the Trust's waiting list through divisional meetings, executive performance meetings, and Trust board sub-committees (including the Finance and Investment Committee). • Recovery plans developed in accordance with guidance issued by NHS England and NHS Improvement, including financial forecast to assess the impact of increasing activity alongside COVID-19 measures. • Financial incentive scheme in place to provide additional funding for performing activity in excess of baseline levels set by regulators. • Capital and revenue bids submitted to regulators in order to provide additional finance resource to create additional capacity to increase activity volumes at the Trust.

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
18	Finance and Investment Committee and Quality & Clinical Risk Committee	Director of Finance	Insufficient capacity in the Neonatal Unit to accommodate babies requiring special care	4x3=12	4x2=8	• Reconfiguration of cots to create more space. • Additional cots to increase capacity. • Parents asked to leave the Neo Natal Unit during interventional procedures, ward rounds, etc to increase available space. • HIP2 funding for new Women and Children's Hospital announced
19	Workforce & Development Assurance Committee	Director of Workforce	If the Trust does not retain staff, then posts will be vacant resulting in workforce shortages across the hospital or increased temporary staffing expenditure.	4x3=12	4x2=8	• Variety of organisational change/staff engagement activities, e.g. Event in the Tent. • Schwartz Rounds and coaching collaboratives. • Learning and development programmes • Health and wellbeing initiatives, including P2P and Care First • Staff recognition - staff awards, long service awards, GEM • Leadership development and talent management • Succession planning • Enhancement and increased visibility of benefits package • Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience /environment.
20	Workforce & Development Assurance Committee	Director of Workforce	If the Trust does not recruit to vacancies in the short term (0-18 months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.	4x2=8	4x2=8	• Active monitoring of workforce key performance indicators. • Targeted overseas recruitment activity. • Apprenticeships and work experience opportunities. • Exploration and use of new roles to help bridge particular gaps. • Use of the Trac recruitment tool to reduce time to hire and candidate experience. • Rolling programme to recruit pre-qualification students. • Use of enhanced adverts, social media and recruitment days • Rollout of a dedicated workforce website • Review of benefits offering and assessment against peers • Creation of recruitment "advertising" films • Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience/ environment. • Targeted recruitment to reduce hard to fill vacancies.

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
21	Workforce & Development Assurance Committee	Director of Workforce	If the Trust does not recruit to vacancies in the long term (19+ months) then there will be workforce shortages across the hospital and/or increased temporary staffing expenditure.	4x2=8	4x2=8	• Monitoring of uptake of placements & training programmes. • Targeted overseas recruitment activity. • Apprenticeships and work experience opportunities. • Expansion and embedding of new roles across all areas. • Rolling programme to recruit pre-qualification students. • Use of enhanced adverts, social media and recruitment days. • Review of benefits offering and assessment against peers. • Development of MKUH training programmes. • Workforce Planning • Recruitment and retention focussed workforce strategy and plan to fill vacancies, develop new roles and deliver improvement to working experience / environment. • International workplace plan. • Assisted EU staff to register for settled status and discussed plans to stay/ leave with each to provide assurance that there will be no large-scale loss of EU staff post-Brexit.
22	Workforce & Development Assurance Committee and Quality & Clinical Risk Committee	Medical Director	If the Trust is unable to maintain a compliant training environment, 11 postgraduate training posts remain under threat of removal by Health Education England (HEE).	4x3=12	4x2=8	• Heavy involvement from clinical leaders outside the department. • Change in clinical leadership model within the service. • Formative external review (Berendt consulting) • Close liaison with HEE Thames Valley Head of School. • Developmental work with consultant body and other senior clinicians in relation to vision and agreement of an ambitious forward-looking programme of work. • Agreement around further investments within the department to improve the working lives of trainees and the quality of the training environment.

No.	Oversight Committee	Executive Lead	Risk Description	Current Risk Rating	Target Risk Rating	Risk Mitigations
23	Workforce & Development Assurance Committee	Director of Workforce	If the Trust does not maintain stocks of Personal Protective Equipment (PPE) and continue implementing the enhanced infection control measures it will be unable to maintain a safe working environment during the COVID-19 pandemic	4x3=12	4x2=8	• Incident command structure in place. • Oversight on all critical stock, including PPE. • Immediate escalation of issues with immediate response through Gold/ Silver. • National and regional response teams in place.
24	Workforce & Development Assurance Committee	Director of Workforce	If the Trust does not implement and progress staff health and wellbeing initiatives, there is the risk of staff burning out during or due to the COVID-19 pandemic	5x4=20	5x2=10	• Significant staff welfare programme in place, with mental health, physical health and support and advice available. • Staff Hub in use. • Remote working wellness centre in place. • 12 weeks of wellbeing focus January 2021 to March 2021.

The Board Assurance Framework is actively scrutinized in every Board sub-Committee and at the Board. The Board usually holds a minimum of two risk and assurance plenary sessions every year to enable risk appetite to be effectively reviewed and assessed and for principal risks against the achievement of the Trust's strategic objectives to be assessed and reviewed holistically. This includes risks to compliance with the Trust's licence; and compliance assessments and risks are also embedded in Board reporting. The Board formally reviews compliance against its licence during its annual declarations and in line with statutory and regulatory requirements.

Every principal risk has an executive risk owner, responsible for the active and ongoing management of that risk; including assessment of risk likelihood and severity (5x5 matrix), proximity, controls, assurance of controls (three lines of defence) and additional mitigating actions required. The executive director presents the risks they take ownership for at the relevant Board sub-Committee (all risks are assigned to a sub-Committee). The sub-Committee chair includes his/ her views on assurance and any matters for escalation to the Board in the upward report from the sub-Committee to the Board. The Board then reviews both the sub-Committee reports on risk; the Board Assurance Framework and corporate risk profile and is able to challenge executive risk owners at each meeting.

The Trust self certifies against the Corporate Governance Statement, required under NHS Foundation Trust Condition 4 (8)(b)] based on information and assurance received at the Board and its sub-Committees.

COVID -19 and the Risk and Control Environment

The Trust's responded earlier than most others to the emerging global COVID -19 pandemic when it assumed responsibility with NHS England and Improvement for opening and running a repatriation centre for British nationals returning from Wuhan Province in China at the beginning of February 2020. The facility at the Kents Hill Hotel and Conference Centre in Milton Keynes, saw the Trust staff and run an isolation centre for more than 100 guests for over a fortnight, working with NHS England and Improvement, Public Health England, the Foreign Office, the Department of Health and Social Affairs, Milton Keynes Council, Milton Keynes CCG and a plethora of other statutory and voluntary agencies.

The Trust established a Gold - Silver - Bronze command structure, which is the recognised hierarchical framework for managing major incidents and operations across emergency services and public bodies, to run the Kents Hill facility; and retained this command structure for the duration of the COVID-19 response (declared a Level 4 national incident by NHS England and Improvement and the UK Government on 3 March 2020).

The command cells have met multiple times a day to manage the COVID -19 response effectively in the 12 months since.

The Trust adapted its governance structure to ensure that the command structure could work as set out in its major incident and emergency planning policies, ensuring clear reporting and decision-making structures and processes both for the pandemic and in remaining day-to-day business. The Trust also responded to changes in the regulatory and national control environment – for example on procurement – to ensure compliance. The Trust has been able to respond promptly and effectively throughout the crisis, with its established command structures and control environment adapting and working effectively throughout.

The Trust has adopted all national guidance around the suspension of routine planned activity and so business continuity and service impact has been thoroughly assessed, planned and is in line with all other acute Trusts. The Trust has enabled significant numbers of staff to work from home through a responsive digital operational plan, which has enabled business continuity across support functions.

Overall, the Trust has responded quickly and effectively to an unprecedented healthcare emergency and would like to recognise the extraordinary efforts of its staff in enabling acute hospital provision and service continuity for the Milton Keynes community.

Incident Reporting

In addition to the framework for risk management; the Trust places a strong emphasis on incident reporting; evidenced through a year-on-year improvement in the percentage of staff feeling confident to report incidents.

The Trust has a Serious Incident Review Group, which meets weekly, to provide objective review of potential serious incidents and moderate harm incidents. The Trust has also established 'summits' for falls and pressure ulcers to ensure rapid dissemination of learning and understanding of causal or contributory factors. This is embedded in the Trust's governance structure; reporting upwards to Board sub-Committees (Management and Performance Board; Trust Executive Group, Quality and Clinical Risk Committee) and to the Board; and downwards through the divisional and clinical specialty unit structures to ensure appropriate briefing and learning.

Stakeholder Involvement in Risk Management

The Trust recognises that effective risk management relies on contributions from outside the organisation as well as from within, and there are therefore arrangements in place to work collaboratively with key external stakeholders and partner organisations, including Milton Keynes CCG, Milton Keynes Council and Healthwatch Milton Keynes. The Trust also contributes to the identification and management of risk in the Bedfordshire, Luton and Milton Keynes Integrated Care System. These arrangements cover operational and strategic issues such as service planning and commissioning, performance management and scrutiny, research, education and clinical governance. Commentary and issues arising from this engagement are captured within the Trust's risk processes and taken into account in the risk grading matrix referred to above.

These and other stakeholders have opportunities to raise issues relating to risks which impact upon them, including:

a. Patients and public

- Participation in the "15 steps" process (an assessment of patient areas by patients, non-executive directors and Governors)
- Involvement with and by the Milton Keynes Health and Wellbeing Board
- Attendance at the Trust's Annual Members' Meeting
- Structured and ad hoc engagement with and from Healthwatch MK
- Patient-Led Assessments of the Care Environment (PLACE)
- Representation from Milton Keynes Council, Healthwatch MK, MKCCG and community groups on the Council of Governors
- Patient stories delivered at Board meetings

b. Staff

- Messages emerging from the annual staff survey
- Chief Executive weekly Q&As and live online events
- Questions submitted by members of staff to the Chief Executive via the "Ask Joe" section of the Trust intranet
- Quarterly staff magazine
- Annual Event in the Tent
- Appointment of Freedom to Speak Up Guardians in January 2017 as conduits through whom staff may raise concerns and make protected disclosures under the Public Interest Disclosure Act 1998

c. Health partners

- Regular performance review meetings with the system partners, including other providers, CCGs, GPs, Ambulance Trusts and Local Authorities with whom the Trust has working relationships
- Active involvement in the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care System, which involves all of the NHS commissioner and provider organisations, as well as local authority social care providers across the three areas
- Attendance at the Milton Keynes Health and Wellbeing Board and Integration Board

The Foundation Trust has published on its website an up-to-date **register of interests, including gifts and hospitality**, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS22 guidance.

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

Control measures are in place to ensure that all the organisation's obligations under **equality, diversity and human rights** legislation are complied with, including completion and publication of the Workforce Racial Equality Standards.

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

The Foundation Trust is fully compliant with the registration 22 **https://improvement.nhs.uk/resources/developing-workforce-safeguards/74** requirements of the Care Quality Commission.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS23 guidance.

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

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

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

Review of Economy, Efficiency and Effectiveness of the Use of Resources

Information Governance

The Trust has regular liaison with the Information Commissioner's Office to ensure that any incident meeting the criteria for reporting is reported and investigated in a timely way. There have been no serious incidents reported in this reporting year. The Trust has a publication scheme and information about how it complies with the General Data Protection Regulations, Freedom of Information Act and other relevant legislation on its website.

Data Quality and Governance

Data quality is inherently a risk that will always exist to some degree and the challenge is to minimise the impact of this risk through appropriate governance arrangements and the development of a learning culture. The Trust has over the last few years increasingly recognised the importance of data quality as a key component to support the continuous delivery of improved patient care and clinical quality. Consequently, data quality is built into the Trust objectives and an Executive Director has responsibility for leading on the over-arching delivery of continued improvement in data quality, supported by the other Executive Directors and governance committees.

The Trust has implemented a series of major clinical and administrative information systems designed to improve the richness and completeness of key information used to manage and treat patients. In normal times the Data Quality Compliance Board (DQCB) would be active in overseeing these improvements; by embedding the importance on data quality in the organisational culture and then supporting it through a new audit and compliance programme.

It is also recognised that management of data quality issues is central to any lasting change and in FY19/20 the Trust made significant progress towards strengthening teams dedicated to audit, compliance and systems and training. Having these teams in place has created a robust control for the management of data quality issues with a combination of system expertise and policy knowledge. This in turn has supported a reduction in the risks around data quality; ultimately monitored by the DQCB and the Risk and Compliance Board.

However, the start of the COVID-19 pandemic has delayed the Trust's progress and in particular in the following areas:

- the implementation of RPAS designed to help prevent clerical staff from making key data quality errors that continue to impact upon performance and operational reporting. As a precursor to the implementation of RPAS, a series of data quality scripts were used to correct existing data quality issues. Since there were potential governance and data quality issues arising from this work which would impact operational practices and patient experience, the RPAS project was also monitored by the DQCB.
- The delivery of the third phase of eCARE development (Phase C) that roles out key functionality to paediatric and theatres including anaesthetics. Phase C contains important upgrades to clinical functionality that will ultimately improve data quality.

Both these projects are now scheduled for implementation in the coming financial year.

The Trust will continue, supported by the Executive Team and associated committees and management teams to improve upon the work from last year and ensure that patients can continue to expect excellent patient care delivered using the best information possible.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and clinical risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process of maintaining and reviewing the effectiveness of the system of internal control during 2020/21 was maintained and reviewed by the Board throughout the year via:

- Reliance upon the Audit Committee for assurance that the system of internal control is sound
- Assurances from the Quality and Clinical Risk Committee on issues relating to clinical governance, clinical risk and quality governance
- The structure, nature and content of the Board meetings during 2020/21 which enabled the Board to provide adequate challenge on and fain suitable assurance in relation to issues including performance, quality and safety
- The engagement of an effective internal and external audit plan; with an internal audit programme designed to target areas where the control environment could be further developed and strengthened
- A prioritised clinical audit programme, covering national statutory and mandatory audits
- An external independent Well Led review, undertaken by Deloitte
- Regulatory review throughout the year (including a Care Quality Commission inspection)

Board of Directors

The governance framework of the Trust is defined in the information on the Trust Board and its Committees and the Council of Governors in Section 2 of the Annual Report. It explains the scope of each Committee and the issues reported to it. The attendance of Non-Executive Directors and Executive Directors at Board and Committee meetings is detailed on pages **XX and XX** of the Report.

The Audit Committee

The Audit Committee provides assurance to the Board on:

- The effectiveness of the organisation's governance, risk management and internal control systems;
- The integrity of the Trust's financial statements, the Trust's Annual Report and in particular the statement on internal control;
- The work of internal and external audit and any actions arising from their work.

The Audit Committee has oversight of the internal and external audit functions and makes recommendations to the Board and to the Nominations Committee of the Council of Governors where appropriate on their reappointment.

The Audit Committee reviews the findings of other assurance functions such as external regulators and scrutiny bodies and other committees of the Board.

The executive directors have provided all the information contained in the Annual Report and accounts. The non- executive directors have had an opportunity to comment on the draft document and the audit committee reviews the report and considers it fair, balanced and understandable.

The Finance and Investment Committee

The Finance and Investment Committee focuses on financial and investment issues and takes an overview of operational activity and performance against national and local targets.

Internal Audit

The Audit Committee agrees an annual risk based internal audit plan and receives reports on the outcomes of the reviews of the system of internal control during the course of the financial year.

RSM (appointed in May 2018) are the providers for internal audit and for 2020/21 the Head of Internal Audit opinion was substantial assurance with the organisation having an adequate and effective framework for risk management, governance and internal control.

In 2020/21 RSM completed 7 internal audit reports which covered the following areas:

- Capital Expenditure
- Estates Management
- Key Financial Controls
- Financial Planning and Delivery
- Governance
- Risk Management
- Data Security and Protection Toolkit

External Audit

Deloitte LLP, the external auditor provides assurance to the Trust on an ongoing basis by attending all Audit Committee meetings and by undertaking the annual audit of the Accounts and Annual Report. For 2020/21, the external auditor has concluded that the financial statements give a true and fair view of the state of the Trust's affairs and have been properly prepared in accordance with the accounting policies directed by NHS Improvement, and in accordance with the National Health Services Act 2006.

Conclusion

My review confirms that Milton Keynes University Hospital NHS Foundation Trust has a generally sound system of governance that supports the achievement of its policies, aims and objectives, and no significant internal control issues have been identified.

Professor Joseph Harrison
Chief Executive

10 June 2021

As Accountable Officer, I am satisfied the Accountability Report is a fair and balanced account of the areas that it covers.

Professor Joseph Harrison
Chief Executive

10 June 2021

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Appendices

Appendix 1: Constituencies and Governors 2020/21

		Constituency	No.	Governors
PUBLIC (ELECTED)	A	Bletchley & Fenny Stratford, Denbigh, Eaton Manor & Whaddon	2	Babs Lisgarten
				Alan Hastings
	B	Emerson Valley, Furzton, Loughton Park	2	William Butler
				Jordan Coventry
	C	Linford South, Bradwell, Campbell Park	2	Ekroop Kular
				Akin Soetan
	D	Hanslope Park, Olney, Sherington, Newport Pagnell	2	Brian Lintern
				Alan Hancock
	E	Walton Park, Danesborough, Middleton, Woughton	2	Niran Seriki
				Clare Hill
	F	Stantonbury, Stony Stratford, Wolverton	2	Ann Thomas
				Robert Johnson-Taylor
	G	Outer catchment area	2	Lucinda Mobaraki
				VACANT
	H	Extended area	1	VACANT
APPOINTED STAFF (ELECTED)	I	Doctors and Dentists	1	Raju Thomas Kuzhively
	J	Nurses and Midwives	2	Elizabeth Maushe
				Tracy Rea
	K	Scientists, technicians and allied health professionals	1	Yolanda Potter
	L	Non-clinical staff groups e.g. admin & clerical, estates, finance, HR, management	3	Emma Isted
				VACANT
				Pirran Salter
	N	Milton Keynes Business Leaders	1	Andrew Buckley
	O	Healthwatch Milton Keynes	1	*Maxine Taffetani/ Tracy Keech
	P	Community Action:MK	1	Clare Walton
	Q	Milton Keynes Council	1	Andy Reilly

**Tracy Keech covering Maxine Taffetani's maternity leave.*

Appendix 2: Council of Governors' Attendance

	14 April 2020	15 July 2020	26 November 2020	18 March 2021	Total
Babs Lisgarten	Cancelled (COVID-19)	x	x	1	1
Alan Hastings		1	1	1	3
William Butler		1	1	1	3
Jordan Coventry				1	1
Ekroop Kular		x	x	x	0
Akin Soetan		1	1	x	2
Alan Hancock		1	1	1	3
Brian Lintern		1	1	x	2
Niran Seriki		x	1	1	2
Clare Hill		1	x	1	2
Ann Thomas		x	1	1	2
Robert Johnson Taylor		x	1	x	1
Lucinda Mobaraki		1	1	x	2
*****Amanda Anderson**		1	1		2
Raju Thomas Kuzhively		x	x	x	0
******Elizabeth Maushe**				1	1
******Tracy Rea**				1	1
******Yolanda Potter**				1	1
****Michaela Tait**		1			1
David Barber		x	x		0
******Emma Isted**				1	1
*****Pirran Salter**				1	1
Andrew Buckley		x	1	1	2
******Maxine Taffetani**		1			1
*******Tracy Keech**		x	1	1	2
Clare Walton		x	x	x	0
Andy Reilly		x	1	1	2

**The public meeting in April 2020 was cancelled due to the COVID-19 pandemic. **Michaela Tait left MKUH in September 2020 and therefore resigned from her position as staff governor. ***Amanda Anderson did not stand for re-election in February 2021, and was replaced by Jordan Coventry. ****Jordan Coventry, Pirran Salter, Elizabeth Maushe, Tracy Rea, Yolanda Potter and Emma Isted were all elected in February 2021. *****Maxine Taffetani's maternity leave was covered by Tracy Keech.*

Appendix 3: Glossary

AO	Accountable Officer	A person responsible to report or explain their performance in a given area.
BAF	Board Assurance Framework	Board document to assure the Board that risks to strategic priorities are being managed
CCG	Clinical Commissioning Group	Led by local GPs to commission services
CEO	Chief Executive Officer	Leads the day to day management of the Foundation Trust
CIP	Cost Improvement Programme	Also known as Transformation programme. This is a programme agreed by the trust at the start of the financial year, setting out the savings, usually from efficiencies, that it expects to make during the year.
CQC	Care Quality Commission	Regulator for clinical excellence
CQUIN	Clinical Quality Incentive Scheme	The CQUIN payment framework makes a proportion of providers' income conditional on quality and innovation.
Datix	Datix	Risk management system
DHSC	Department of Health and Social Care	The government department responsible for government policy on health and adult social care matters in England
Duty of Candour	Duty of Candour	Duty of candour means NHS organisations have a legal duty to inform and apologise to patients if mistakes have been made in the delivery of their care or treatment, or where moderate or severe harm has been caused.
ED	Emergency Department	Formerly known as Accident & Emergency
EPR	Electronic Patient record	Also known as eCare. The Trust's system of managing and recording interactions patients electronically
Healthwatch	Healthwatch	Local independent health and social care critical friend
HSCA	Health and Social Care Act 2012	An Act of parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
MKUH	Milton Keynes University Hospital	
MRI	Magnetic Resonance Imaging	A medical imaging technique
MRSA	Methicillin-Resistant Staphyloccus Aureus	A bacterium responsible for several difficult-to-treat infections in humans
NICE	National Institute for Health and Care Excellence	Provides national guidance and advice to improve health and social care
PALS	Patient advice and liaison service	You can talk to PALS who provide confidential advice and support to patients, families and their carers, and can provide information on the NHS and health related matters.
PLACE	Patient-Led Assessments of the Care Environment	Local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food cleanliness and general building maintenance
RTT	Referral to treatment	Used as part of the 18 week indicator
SRR	Significant risk register	Risks scored 15 and over
WTE	Whole time employees	Member of staff contracted hours for full time

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

Milton Keynes University Hospital NHS Foundation Trust

Accounts

Year Ended 31 March 2021

Independent auditor's report to the board of governors and board of directors of Milton Keynes University Hospital NHS Foundation Trust

Report on the audit of the financial statements

Opinion
In our opinion the financial statements of Milton Keynes University Hospital NHS Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 24.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative footnotes on pages 60 to 64;
- the table of pension benefits of senior managers and related narrative footnotes on pages 69 to 72;
- the table of pay multiples and related narrative notes on page 57;
- the table on staff costs on page 73; and
- the table on average number of employees (WTE basis) on page 74.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice 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 foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (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 opinion.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts , which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information
The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. 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.

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 course of 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 this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer
As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation 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 foundation trust without the transfer of the foundation trust's services to another public sector entity.

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 FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud
We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the foundation trust and its control environment, and reviewed the foundation trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the foundation trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address them are described below:

- determination of whether an expenditure is capital in nature, and for major projects the value of work completed at 31 March 2021 are subjective: we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.
- accruals, certain other payables and deferred income recorded at 31 March 2021 and the timing of their recognition at year-end is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2021*;* we tested a sample of deferred income items to supporting documentation and evaluated management's assessment as to whether the criteria for revenue recognition had been met as to 31 March 2021.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports and reviewing correspondence with HMRC and the licensing authority.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006
In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability 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

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 , we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the foundation trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources
The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.
We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, 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 respect of these matters.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

Certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report) as the national timeline for this work is 20 September 2021. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report
This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Milton Keynes University Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Jonathan Gooding (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
Date 14 June 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements
In our audit report for the year ended 31 March 2021 issued on 14 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 14 June 2021, we had not completed our work on the foundation trust's arrangements and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit
In our audit report for the year ended 31 March 2021 issued on 14 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

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

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Milton Keynes University Hospital NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Jonathan Gooding (Key Audit Partner) For and
on behalf of Deloitte LLP Appointed Auditor
St Albans, United Kingdom
2 September 2021

FOREWORD TO THE ACCOUNTS

MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Milton Keynes University Hospital NHS Foundation Trust ("the Trust") acts as an acute Hospital for Milton Keynes.

These accounts for the year ended 31 March 2021 have been prepared by Milton Keynes University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Professor Joseph Harrison

Chief Executive

Date: 10 June 2021

Statement of Comprehensive Income for the Year Ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	2.1-2.5	253,520	234,918
Other operating income	2.2	47,751	47,127
Operating expenses	3-6	(297,000)	(284,935)
		4,271	**(2,890)**
FINANCE COSTS			
Finance income	7.1	4	111
Finance expenses	7.2	(280)	(2,223)
PDC dividends payable		(3,601)	(122)
NET FINANCE COSTS.		**(3,877)**	**(2,234)**
SURPLUS/(DEFICIT) FOR THE YEAR		**394**	**(5,124)**
Other Comprehensive Income			
Will not be reclassified subsequently to surplus or deficit:			
Impairments		0	(9,878)
Revaluations		1,700	0
Fair value gains/(losses) on equity instruments designated at FV through OCI		257	0
Total other comprehensive income/(expense)		1,957	(9,878)
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**2,351**	**(15,002)**

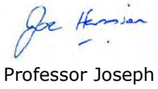
The notes to the accounts are on pages 128-165

Statement of Financial Position As at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
NON-CURRENT ASSETS			
Intangible assets	8	22,035	16,180
Property, plant and equipment	9	169,526	143,154
Other investments / financial assets	22.1	432	175
Trade and other receivables	12	598	729
TOTAL NON-CURRENT ASSETS		**192,591**	**160,238**
CURRENT ASSETS			
Inventories	11	3,680	3,394
Trade and other receivables	12	19,826	25,582
Cash and cash equivalents	13	48,765	16,286
TOTAL CURRENT ASSETS		**72,271**	**45,262**
CURRENT LIABILITIES			
Trade and other payables	14.1	(58,484)	(38,947)
Deferred Income	14.2	(14,942)	(2,272)
Borrowings	15	(202)	(131,347)
Provisions	17	(2,854)	(1,477)
TOTAL CURRENT LIABILITIES		**(76,482)**	**(174,043)**
TOTAL ASSETS LESS CURRENT LIABILITIES		**188,380**	**31,457**
NON-CURRENT LIABILITIES			
Borrowings	15	(5,614)	(5,815)
Provisions	17	(1,726)	(1,553)
TOTAL NON-CURRENT LIABILITIES		**(7,340)**	**(7,368)**
TOTAL ASSETS EMPLOYED		**181,040**	**24,089**
FINANCED BY			
Public dividend capital		259,858	105,258
Revaluation reserve	18	50,110	48,410
Financial assets at FV through OCI reserve		257	0
Income and expenditure reserve		(129,185)	(129,579)
TOTAL TAXPAYERS' EQUITY		**181,040**	**24,089**

The Financial Statements and notes on pages 128-165 were approved by the Board and authorised for issue on 10 June 2021 **and signed on its behalf by:**

Alison Davis
Chairman



Professor Joseph Harrison
Chief Executive

Terry Whittle
Director of Finance

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2021

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Financial assets at FV through OCI reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020		**105,258**	**48,410**	**(129,579)**	**0**	**24,089**
Deficit for the year		0	0	394	0	394
Revaluations		0	1,700	0	0	1,700
Public Dividend Capital received		154,600	0	0	0	154,600
Fair value gains/(losses) on equity instruments designated at FV through OCI		-	0	0	257	257
Taxpayers' and others' equity at 31 March 2021		**259,858**	**50,110**	**(129,185)**	**257**	**181,040**
Taxpayers' and others' equity at 1 April 2019		**101,356**	**58,288**	**(124,455)**	**0**	**35,189**
Deficit for the year		0	0	(5,124)	0	(5,124)
Impairments		0	(9,878)	0	0	(9,878)
Public Dividend Capital received		3,902	0	0	0	3,902
Taxpayers' and others' equity at 31 March 2020		**105,258**	**48,410**	**(129,579)**	**0**	**24,089**

Statement of Cash flows For the Year Ended 31 March 2021

	Trust	
	£000	**£000**
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating surplus/(deficit) from continuing operations	4,271	(2,890)
Operating surplus/(deficit)	**4,271**	**(2,890)**
Non-cash income and expense:		
Depreciation and amortisation	9,947	9,254
Impairments and reversals of impairments	11	7,448
Income recognised in respect of capital donations (cash and non-cash)	(840)	(2,476)
Decrease in receivables and other assets	10,164	3,431
(increase)/Decrease in inventories	(286)	183
Increase in payables	9,819	6,834
Increase in other liabilities	12,670	566
Increase in provisions	1,549	636
Net cash (generated from) operating activities	**47,305**	**22,986**
Cash flows from investing activities		
Interest received	4	111
Purchase of financial assets / investments	0	(175)
Purchase of intangible assets	(7,753)	(3,747)
Purchase of property, plant, equipment	(27,144)	(17,538)
Sale of property, plant & equipment	358	480
Receipt of cash donations to purchase capital assets	113	2,476
Net cash (used in) investing activities	**(34,422)**	**(18,393)**
Cash flows from financing activities		
Public dividend capital received *	154,600	3,902
Loans Repaid to the Department of health	(130,852)	(1,413)
Loans Received from the Department of Health	0	5,300
Capital element of finance lease rental payments	(221)	(211)
Interest on DHSC loans	(273)	(1,918)
Interest paid on finance lease liabilities	(280)	(296)
PDC dividend (paid)/refunded	(3,378)	154
Net cash generated from/ (used in) financing activities	**19,596**	**5,518**
Increase in cash and cash equivalents	**32,479**	**10,111**
Cash and cash equivalents at 1 April	**16,286**	**6,175**
Cash and cash equivalents at 31 March	**48,765**	**16,286**

* 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 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Outstanding interim loans totalling £130.9m interim loan principal as at 31 March 2020 in these financial statements have been converted to PDC in year.

NOTES TO THE ACCOUNTS

1.0 Accounting policies and other information

Basis of preparation
These accounts for the year ended 31 March 2021 have been prepared by the Trust in accordance with the National Health Service Act 2006.

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow international Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Operating Segments
The Board of Directors are of the opinion that the Trust's operating activities fall under the single heading of "Healthcare" for the purposes of segmental reporting in accordance with International Financial Reporting Standard 8.

Consolidation
From 1 April 2014, the NHS has had to apply IFRS 10,'Consolidated Financial Statements in respect of consolidating Charitable Funds. The Trust has reviewed the criteria under IFRS 10, and it meets the criteria in respect of having an interest and control of MK Hospital NHS charity and ADMK Limited (ADMK) and it directly benefits from the activities of the charitable funds and ADMK.

However, it has not consolidated the charitable funds or ADMK into these accounts because the Trust does not consider them to be material. The Charitable fund's income and expenditure represents only 0.2% of the Trusts position and ADMK only 0.6% so they are not material to the accounts of the Trust.

From the 1 April 2014, the NHS has applied IFRS 11, 'Joint Arrangements' and IFRS 12, 'Disclosure of Interests in Other Entities,' however the Trust has decided not to recognise the Milton Keynes Urgent Care Services in these accounts due to this position not being material to the Trusts accounts. See Note 10.

Critical Judgements and Key Sources of Estimation Uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from the estimates, but the underlying assumptions are regularly updated. Revisions to accounting estimates, which only affect that period, are recognised in the period in which the estimate is revised. If the revision affects both current and future periods it is recognised in the period of the revision and future periods.

Critical judgements in applying accounting policies
There were no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Key sources of estimation uncertainty
The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting year, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuations of Land and Buildings
The most significant estimate within the accounts is the value of land and buildings (£125.173m 2020/21). In accordance with International Accounting Standards, a full property valuation is carried out on the Trust's land and buildings every five years, with an interim valuation after three years. The Trust has as at the 31 March 2021 undertaken a valuation on an alternative site basis after taking advice from a RICS qualified valuer, the District Valuer Services (DVS), on suitable indices to apply to reflect changes in the building costs and local land price movements since the date of the last valuation. The Trust continues to judge it to be appropriate to use its assumptions regarding the location of a hypothetical site for the hospital when performing the modern equivalent asset valuation and as a result, it estimated that there had been an increase in the value of its assets by £1.7m which was reflected as an increase in non-current assets. The next full revaluation is due March 2024.

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

Valuations do not take into account future potential changes in market value which cannot be predicted with any certainty therefore, between valuations, management reviews the values for any material changes and make judgements about market changes and assesses whether the carrying amount does not differ materially from that which would be expected using fair value at the end of the reporting period. The review of the estate values carried out in 2020/21 resulted in an overall increase in the revaluation reserve of £1.7m.

The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has not declared any 'material valuation uncertainty' in the valuation report. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

1.1 Going concern

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

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

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.

Payment terms are standard reflecting cross government principles.

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

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

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

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

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

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

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

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

1.4 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that, the goods or services have been received. It 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 non-current assets such as property, plant and equipment.

1.5 Expenditure on employee benefits

Short –term employee benefits
Salaries, wages and employment-related payments, including termination benefits, are recognised in the period in which the service is received from employees. Annual leave entitlement is actively encouraged to be taken in the year that it is earned, however there are exceptional circumstances when the annual leave entitlement may be carried forward into the following year. Untaken leave is accrued on an average five days carry forward for medical staff, excluding junior doctors and registrars in training. All other staff are accrued based on annual data collection of untaken hours applied to their hourly rate of pay. The cost of this annual leave entitlement earned but not taken at the end of the financial year is recognised in the financial statements.

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

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

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:

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

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

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.

Employer Contributions
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 20.68% of pensionable pay.

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. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

Scheme Liabilities
The liabilities of the pension scheme as at 31 March 2020 were £653.2 billion. The national deficit of the scheme was £19.4 billion as per the last scheme valuation by the Government Actuary as at 31 March 2016. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. Tiered employer contribution rates were recommended and those applicable from the 1 April 2015 to 31 March 2021 were a lower limit of 5% and an upper limit of 14.5% of pensionable pay. Employers' pension cost contributions are charged to operating expenses as and when they become due. The expected value of the trust's employer's pension contributions for 2020/21 is £23.8m (£22.0m 2019/20)

During 2019/20 and 2020/21, NHS employers have been paying an employer contribution of 14.38% to the NHS pension scheme. However, from 1 April 2019, the employers' pension contribution changed to 20.68%. The difference of 6.3% has been funded and paid to the NHS BSA centrally by NHS England. The value of this additional pension payment included in in the value above is £7.2m

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.

Pension costs-NEST Pension Scheme
From the 1 October 2013 the Trust has participated in the Government's Auto Enrolment Pension scheme. It has auto enrolled those employees who are not eligible for the NHS Pensions scheme into an alternative defined contribution pension scheme run by National Employers Savings Trust (NEST).

The employer's contributions for all eligible staff is 3%. The Trust currently has, at the 31 March 2021, 135 employees enrolled into NEST and the employer's contributions for the current financial year have been £68k.

1.6 Property, Plant and Equipment

Recognition
Property, Plant and Equipment (PPE) is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and
- the item has a cost of at least £5,000, or

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, and are anticipated to have simultaneous 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, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent Expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
The Trust capitalises assets that individually have a cost of at least £5,000 or form a group of assets which individually have a cost of more than £250 and collectively have a cost of at least £5,000, where the assets are: functionally interdependent; have broadly simultaneous purchase dates; are anticipated to have simultaneous disposal dates and are under single managerial control.

Assets will also be capitalised if they form part of the initial set-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost. In accordance with IAS23, borrowing costs directly attributable to the financing of PPE are also capitalised up until all the activities necessary to prepare the asset for its intended use are complete.

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

Valuation
All property, plant and equipment assets are measured initially at cost, representing the cost 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. All assets are measured subsequently at current value.

The carrying value of fixtures and equipment are written off over the remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

Land and buildings are re-valued where a movement in current values is considered to be material. Current values are determined as follows:

- Land and non-specialised operational assets – Existing use value.
- Specialised assets – depreciated replacement cost applying the modern equivalent asset principle.

HM Treasury adopted a standard approach to depreciated replacement cost valuations on a modern equivalent asset where it would meet the location requirements of the service being provided; an alternative site can be valued.

In any event, professional valuations are carried out every five years, together with a three-year interim/desk top valuation. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Standards Manual.

The Trust has as at the 31 March 2021 undertaken a desktop valuation after taking advice from a RICS qualified valuer from District Valuer Services (DVS) on suitable indices to apply, to reflect changes in the building costs and local land price movements since the date of the last valuation. As a result, it estimated that there had been an

increase in the value of its assets by £1.7m which was reflected as an increase in non-current assets. The next full revaluation is due March 2024.

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

The DVS is the commercial arm of the Valuation Office Agency, which is an executive agency of HM Revenue & Customs (HMRC). It provides professional property advice across the public sector in England, Wales and Scotland.

Buildings are valued at depreciated replacement cost on a modern equivalent asset basis for buildings which qualify as a specialised operational property asset which is consistent with IAS 16, with regard to the suitable indices that reflect changes in the building costs.

Non-specialised operational property, including land, is assessed at existing use value whilst non-operational property, including surplus land is valued on the basis of market value. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Until 31 March 2008, plant, machinery, vehicles, furniture and fittings were carried at replacement cost, based on indexation and depreciation of historic cost. New assets are carried at depreciated historic cost, unless this is considered to be materially different from fair value due to significant volatility in asset values.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

Depreciation
Items of Property, Plant and Equipment are depreciated over their remaining 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' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, dwellings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset based on assessments by the Trust's professional valuers. Leasehold buildings are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the following estimated lives:

Asset Category	**Estimated life (in years)**
Buildings excluding dwellings	8 to 90
Dwellings	40
Plant and Machinery	5 to 20
Transport Equipment	7
Information Technology	2 to 8
Furniture and Fittings	5 to 10
Leased assets	Over the lease term

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 been previously recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent 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 DHSC GAM, impairments that arise from a clear consumption of economic benefit or 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 the 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 service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised as operating income to the extent that the asset is restored to its 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. Where impairment arises from a clear consumption of economic value, this is taken in full to operating expenses.

De-recognition
Assets intended for disposal, are reclassified as 'Held for sale' once all 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 then ceases to be charged and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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.

Donated and grant funded assets.
Government grants are grants from Government bodies other than income from CCG's or NHS Trusts for the provision of services. Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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

1.7 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 when it is probable that future economic benefits will flow to, or service potential will be provided, to the Trust where the cost of the asset can be measured reliably.

Internally Generated
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised and is recognised as an operating expense in the period that it is incurred.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

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

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 on a straight line basis, over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits over the following estimated lives:

Asset Category	**Estimated life in years**
Purchased computer software & Licences	2 to 10
Development	2 to 10
Internally generated IT	2 to 10

1.8 Inventories

Inventories comprise mainly of drugs and consumable medical products which are held at the lower of cost or net realisable value. The cost formula is determined by using the latest cost price from suppliers. Due to the high turnover of inventories and the low value held, the Trust considers this method to be an appropriate basis of measurement. Net realisable value is the estimated selling price less estimated costs to achieve a sale.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.9 Cash and cash equivalents

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

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

1.10 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, i.e., when receipt or delivery of the goods or services is made.

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

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

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

After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial assets.

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income. The trust holds financial assets measured at amortised cost and fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure. All financial liabilities held by the trust are measured at amortised cost. After initial recognition, these are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

Financial assets at amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.

The Trust has irrevocably elected to measure the following financial assets / financial liabilities at fair value through income and expenditure:

- Receivables

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income:

- Equity Investment in Induction Healthcare PLC – the decision was made due to the potential volatility in the market prices of shares and the subsequent impact this could have on planning and the Trust outturn position.

The Trust are currently in negotiations to secure a new strategic partnership that would allow the Trust to use anonymised patient data in order to support pharmaceutical research projects (ensuring compliance with processing under article 9(2) of the GDPR) to enable improvements in patient care. This partnership is due to commence in early 2021-22 and will result in a further equity investment of £2.5m which has also been elected to be measured at fair value through other comprehensive income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

1.11 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.

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 fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease, thereafter the asset is accounted for as an item of property, plant and equipment and the lease liability is de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating Leases
Other leases are regarded as operating leases and the rentals are charged to the operating expenses on a straight-line basis over the term of the lease. Lease incentives are recognised initially in other liabilities on the statement of financial position as a liability 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 if it is considered to be material and the classification for each is assessed separately.

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

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

1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount at the statement of financial position date, for which it is probable that there will be a future outflow of cash or other resources and a reliable estimate of the expenditure can be made. 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 rate. The rate for salary related provisions i.e., injury benefit provisions is minus 0.5% and long-term provisions is 1.99% in real terms is applied.

Clinical Negligence
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS resolution, which in return, settles all clinical negligence claims. Although the 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 the NHS Resolution on behalf of the trust is disclosed at note 17 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 the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Recognition
Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control. They are not recognised as assets but are disclosed in note 20 unless the probability of a transfer of economic benefit is remote.

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

1.14 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 original NHS Trust. 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 forecast cost of capital utilised by the Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:
https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

1.15 Value Added Tax

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

1.16 Corporation Tax

The Trust does not foresee that it will have any material commercial activities on which a corporation tax liability will arise under the guidance issued by HM Revenue and Customs.

1.17 Climate Change Levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.18 Foreign Exchange

The functional and presentational currencies of the Trust are sterling**.** A transaction which is denominated in a foreign currency is translated into sterling at the exchange rate ruling on the dates 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 retranslation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

1.19 Third Party Assets

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

1.20 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 accrual's basis.

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

1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 Early adoption of standards, amendments and interpretations

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

1.23 Accounting Standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. The trust currently has circa £3.3m of operating leases and it is not expected that this will have a material impact.
Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable.

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts
This standard establishes the principles for the recognition, measurement, presentation and disclosure of Insurance contracts within the scope of the Standard. The objective of IFRS 17 is to ensure that an entity provides relevant information that faithfully represents those contracts. This information gives a basis for users of financial statements to assess the effect that insurance contracts have on the entity's financial position, financial performance and cash flows. It is not expected that that this will have a material impact on the Trust. The effective date was due to be 2020/21 but due to the COVID-19 crisis adoption has been delayed by HM Treasury until 2022/23.

2. Operating Income

IFRS 8 requires the disclosure of results of significant operating segments, the Trust considers that it has only one operating segment, Healthcare.

2.1 Operating Income from Activities arising from Commissioner Requested Services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested services and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that the commissioners believe would need to be protected in the event of provider failure.

The Trust's commissioner requested services is the total income from activities excluding private patient income and non–protected clinical income. Non protected income relates to overseas patients, the NHS Injury Scheme and other Non-NHS bodies.

	2020/21 £000	2019/20 £000
Income from services designated (or grandfathered) as commissioner requested services	240,834	224,661
Income from services not designated as commissioner requested services	12,686	10,257
Total	**253,520**	**234,918**

2.2 Operating Income from patient Care Activities (By Nature)

	2020/21 £000	2019/20 £000
Income from activities		
Block contract / system envelope income *	218,893	163,040
High-cost drugs income from commissioners	18,662	18,610
Other NHS clinical income	3,279	43,011
Private patient income	285	507
Additional pension contribution central funding**	7,214	6,656
Other Non-NHS clinical income	5,187	3,094
Total income from activities	**253,520**	**234,918**

	2020/21 £000	2019/20 £000
Other operating income from contracts with customers:		
Research and development	978	902
Education and training	8,128	8,249
Non-patient care services to other bodies	1,338	1,930
Reimbursement and top up funding	26,465	24,838
Car parking	704	1,485
Staff Accommodation	1,195	1,101
Catering	516	733
Salary income	867	822
Other income	2,799	4,591
Other non-contract operating income		
Receipt of capital grants and donations	113	2,476
Contributions to expenditure - consumables (inventory) donated from DHSC group	3,921	0
Donated equipment from DHSC for COVID response (non-cash)	727	0
Total other operating income	**47,751**	**47,127**

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

**The employer contribution rate for NHS pensions increased from 14.38% to 20.68% (excluding administration charge) from 1 April 2019. For 2019/20 and 2020/21, NHS providers continue 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.

The Trust can confirm that there are no fees or charges raised under legislation, where the full cost exceeds £1 million, or the service is otherwise material in relation to the accounts.

2.3 Provision of goods and services for the purposes of health service

The Trust can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose. This is in accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

	2020/21 £000	2019/20 £000
Income from the provision of goods and services for the purposes of the health service	240,834	224,661
Income from the provision of goods and services for any other purpose	60,437	57,384
Total	**301,271**	**282,045**

2.4 Private patient income

The Health and Social Care Act from the 1st October 2012 repealed the statutory limitation on private patient income in section 44 of the National Health Services Act 2006. The Trust earned 0.1% of total patient care income from private patients in 2020/21 and 0.2% in 2019/20.

2.5 Operating Income from Patient Care Activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
CCGs and NHS England	251,493	230,576
Local authorities	108	1,747
Other NHS foundation trusts	795	770
NHS trusts	0	4
NHS other	38	147
Non-NHS: private patients	285	507
Non-NHS: overseas patients (chargeable to patient)	213	173
NHS injury scheme (was RTA)	445	991
Non-NHS: other	143	3
Total income from activities	**253,520**	**234,918**
Of which:		
Related to continuing operations	253,520	234,918

The responsibility for the commissioning of Healthcare services is from two main NHS Bodies, Clinical Commissioning Groups (CCG's) and NHS England. The major CCG for the Trust is Milton Keynes CCG which accounts for 73% of the Trust's clinical income.

NHS England commissions nationally for a number of specialist services which includes HIV, Neonatology and Specialist Cancers and screening. The Trust received £35.2m 2020/21 in respect of these services (£27.9m 2019/20). The Trust also received an additional £0.7m 2020/21 (£2m 2019/20) from the Cancer Drugs Fund.

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	884	881
Total	**884**	**881**

2.7 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	0	844
after one year, not later than five years	0	0
after five years	0	0
Total revenue allocated to remaining performance obligations	**0**	**844**

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.

2.8 Analysis of overseas visitors' income

	2020/21 £000	2019/20 £000
Income recognised this year	**213**	**173**
Cash payments received in-year	107	184
Amounts added to provision for impairment of receivables	96	104
Amounts written off in-year	**81**	**187**

3. Operating expenses

3.1 Operating expenses (by Type)

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	4,132	4,683
Purchase of healthcare from non-NHS and non-DHSC bodies	3,042	6,521
Staff and executive directors' costs	194,721	179,826
Remuneration of non-executive directors	142	139
Supplies and services - clinical (excluding drugs costs) *	18,914	17,781
Supplies and services - general	4,180	4,050
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,422	22,834
Inventories written down (net including drugs) **	104	0
Consultancy costs	44	58
Establishment	1,840	1,883
Premises	18,443	14,523
Transport (including patient travel)	657	640
Depreciation on property, plant and equipment	7,582	7,348
Amortisation of intangible assets	2,365	1,906
Net impairments	11	7,448
(decrease) in provision for impairment of receivables	(633)	(456)
Change in provisions discount rate(s)	42	100
Audit fees payable to the external auditor		
Audit services- statutory audit	108	84
Other auditor remuneration (external auditor only)	7	42
Internal audit costs	62	61
Clinical negligence	8,576	7,039
Legal fees	813	1,049
Insurance	158	115
Research and development	1,040	1,011
Education and training	5,755	5,220
Rentals under operating leases	1,059	398
Car parking & security	45	37
Hospitality	18	23
Losses, ex gratia & special payments	155	249
Other services	561	531
Other	635	(208)
Total	**297,000**	**284,935**
Of which:		
Related to continuing operations	297,000	284,935

*includes £3.5m utilisation of consumables donated from DHSC group bodies for COVID response.

** includes Inventories written down for consumables donated from DHSC group bodies for COVID response.

3.2 Operating lease

Operating lease includes rentals for premises, a variety of medical equipment as well as photocopiers and lease cars.

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	1,133	1,135
- later than one year and not later than five years;	1,643	1,515
- later than five years.	444	444
Total	**3,220**	**3,094**

4. Staff costs

4.1 Staff costs

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	156,651	138,536
Social security costs	15,985	14,803
Apprenticeship levy	742	694
Employer's contributions to NHS pensions	16,579	15,321
Pension cost - employer contributions paid by NHSE (6%)	7,214	6,656
Other employment benefits	13	0
Temporary staff	2,796	8,957
Total gross staff costs	**199,980**	**184,967**

These costs exclude those for Non-Executive Directors' remuneration and benefits in kind and include the additional 6% increase in employer's pension contribution which is being funded by NHS England on behalf of providers.

4.2 Retirements due to ill-health

During 2020/21 there were no early retirement from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). Therefore, there is no additional pension liability for ill-health retirement in 2020/21 (£13k in 2019/20).

The cost of the ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

4.3 Employee benefits

Employee benefits relate to payments made over and above salary costs. Employee benefits of £63k were paid in the year, these were in relation to temporary hotel accommodation, to enable staff to continue to work during the COVID pandemic. £13k of this benefit is recorded in staff costs as being the HMRC PAYE settlement agreement, where the Trust has agreed to pay the employee tax and National Insurance due on the benefit, and £50k is recorded in operating expenses, being the actual cost of the accommodation. There were no employee benefits in 2019/20.

4.4 Termination benefits

There were no termination benefits and no non-compulsory departures agreed in 2020/21 or 2019/20.

4.5 Salary and pension entitlements of Directors

The aggregate amounts payable to directors were:

	2020/21 £000	2019/20 £000
Salary	1,314	1,443
Taxable benefits	0	0
Employer's pension contributions	76	97
Total	**1,390**	**1,540**

Further details of directors' remuneration can be found in the remuneration report.

4.6 Highest paid Director analysis

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

The banded remuneration of the highest paid director in Milton Keynes University Hospital NHS Foundation Trust in the financial year 2020/21 was £210,000-£215,000 (2019/20 £205,000-£210,000). This was 6.2 times (2019/20 6.5 times) the median remuneration of the workforce which was £34,234 (2019/20 £32,123).

In 2020/21 and 2019/20 no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £8,473 to £213,696 (2019/20 from £12,000 to £207,500).

Total remuneration includes salary, non-consolidated performance related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The median remuneration has been calculated using the full time equivalent annualised salary costs taken from the March payroll data, excluding the highest paid director but including agency and bank costs.

The Trust's highest paid Director was the Chief Executive and the remuneration costs that have been used in the calculation are the banded, full time equivalent annualised total remuneration costs. The previous year's highest paid director was the Chief Executive.

5. Better Payment Practice Code

5.1 Better Payment Practice Code- measure of compliance

	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Total trade invoices paid in the year	58,956	156,250	67,647	146,115
Total trade invoices paid within 30 days	56,099	149,584	55,077	128,135
Percentage of total trade invoices paid within 30 days	95%	96%	81%	88%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. There were no payments made in year in respect of late payment of invoices under the Late Payment of Commercial Interest Act 1998 (2019/20 £0).

6. Audit Fees

The Trust incurred statutory audit fees totalling £108,000 including irrecoverable VAT, (£84,000 in 2019/20) and other auditor remuneration costs in 20/21 £7,200 (£41,541 in 19/20). Other auditor remuneration is detailed below.

6.1 Audit fees

	Trust	
	2020/21	**2019/20**
	£000	**£000**
Other auditor remuneration paid to the external auditor:		
All assurance services not falling within items above	7	42
Total	**7**	**42**

In addition to the amounts payable above, there is £12,000 payable for the audit of the Trust Subsidiary ADMK Ltd, this amount is not included in the Trust position as it is paid by ADMK Ltd.

6.2 Limitation on auditor's liability

There is a £0.5m limitation on auditor's liability for external audit work carried out for the financial years 2020/21 and 2019/20.

7. Finance income and expense

7.1 Finance income

	2020/21	**2019/20**
	£000	**£000**
Interest on bank accounts *	4	111
Total	**4**	**111**

* The change in the bank rate to 0.1% affected the rate of interest the National Loans Fund pays to Government Banking customers that have interest bearing accounts. HM Treasury applied the margin of 0.11% which means the National Loans Fund paid a new interest rate of 0.0% from March 2020.

7.2 Finance expenses

	2020/21	**2019/20**
	£000	**£000**
Interest expense:		
Loans from the Department of Health *	0	1,927
Finance leases	280	296
Total interest expense	**280**	**2,223**

* During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. All interest payments were frozen from 31st March 2020 and no interest was payable on the balance of the loans during the period.

7.3 Impairment of assets (PPE)

	2020/21	**2019/20**
	£000	**£000**
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	0	369
Changes in market price	11	7,079
Total net impairments charged to operating surplus / deficit	**11**	**7,448**
Impairments charged to the revaluation reserve	0	9,878
Total net impairments	**11**	**17,326**

In 2018/19 the Trust adopted a modern equivalent asset principle which reflected an alternative site valuation. In adopting the Modern Equivalent Asset – with alternative site approach, the valuation of land and buildings reflects the extent of estate required for the provision of the same service as already provided by the existing estate but not in the same form or location.

Following an assessment from the Trust's valuer, valuing the estate on an alternative site valuation basis led to a lower reported Current Value for accounting purposes. This arises from better configuration of the hospital estates (reducing circulation space) and a reduction in the land valuation.

8. Intangible Assets

8.1 Intangible assets – 2020/21

	Software & licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**11,740**	**11,048**	**1,891**	**3,827**	**28,506**
Additions	945	0	0	7,275	**8,220**
Reclassifications	124	0	0	(124)	**0**
Gross cost at 31 March 2021	**12,809**	**11,048**	**1,891**	**10,978**	**36,726**
Amortisation at 1 April 2020 - brought forward	**5,473**	**5,930**	**923**	**0**	**12,326**
Provided during the year	1,459	654	252	0	**2,365**
Amortisation at 31 March 2021	**6,932**	**6,584**	**1,175**	**0**	**14,691**
Net book value at 31 March 2021	**5,877**	**4,464**	**716**	**10,978**	**22,035**
Net book value at 1 April 2020	**6,267**	**5,118**	**968**	**3,827**	**16,180**

Note 8.2 Intangible assets - 2019/20

	Software & licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	**9,946**	**9,576**	**1,891**	**3,157**	**24,570**
Additions	1,382	909	0	1,645	**3,936**
Reclassifications	412	563	0	(975)	**0**
Gross cost at 31 March 2020	**11,740**	**11,048**	**1,891**	**3,827**	**28,506**
Amortisation at 1 April 2019 - brought forward	**4,303**	**5,447**	**670**	**0**	**10,420**
Provided during the year	1,170	483	253	0	**1,906**
Amortisation at 31 March 2020	**5,473**	**5,930**	**923**	**0**	**12,326**
Net book value at 31 March 2020	**6,267**	**5,118**	**968**	**3,827**	**16,180**
Net book value at 1 April 2019	**5,643**	**4,129**	**1,221**	**3,157**	**14,150**

9. Property, Plant and Equipment

Property, plant and equipment as at 31st March 2021 is broken down in the following elements:

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2020 - brought forward	**3,841**	**119,316**	**885**	**4,270**	**31,641**	**26**	**11,644**	**903**	**172,526**
Additions	0	3,404	0	21,732	3,754	0	3,651	82	**32,623**
Reclassifications	0	794	0	(3,134)	1,755	18	592	(25)	**0**
Revaluation	20	(2,881)	25	0	0	0	0	0	**(2,836)**
Disposals / de-recognition	0	(232)	0	(39)	(87)	0	0	0	**(358)**
Valuation/gross cost at 31 March 2021	**3,861**	**120,401**	**910**	**22,829**	**37,063**	**44**	**15,887**	**960**	**201,955**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**0**	**1**	**0**	**20,189**	**26**	**8,854**	**301**	**29,371**
Provided during the year	0	4,495	29	0	2,189	4	797	68	**7,582**
Impairments	0	11	0	0	0	0	0	0	**11**
Revaluation	0	(4,506)	(30)	0	0	0	0	0	**(4,536)**
Reclassifications	0	0	0	0	(16)	14	0	2	**0**
Accumulated depreciation at 31 March 2021	**0**	**0**	**0**	**0**	**22,362**	**44**	**9,651**	**371**	**32,428**
Net book value at 31 March 2021	**3,861**	**120,401**	**910**	**22,829**	**14,701**	**0**	**6,236**	**589**	**169,526**
Net book value at 31 March 2020	**3,841**	**119,316**	**884**	**4,270**	**11,452**	**0**	**2,790**	**602**	**143,155**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**3,841**	**124,454**	**855**	**5,973**	**29,361**	**169**	**11,059**	**457**	**176,169**
Additions	0	1,827	0	15,978	2,053	0	583	447	**20,888**
Impairments	0	(23,978)	30	0	0	0	0	0	**(23,948)**
Reclassifications	0	17,398	0	(17,589)	332	(143)	2	0	**0**
Disposals / de-recognition	0	(385)	0	(92)	(105)	0	0	(1)	**(583)**
Valuation/gross cost at 31 March 2020	**3,841**	**119,316**	**885**	**4,270**	**31,641**	**26**	**11,644**	**903**	**172,526**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**2,218**	**14**	**0**	**18,117**	**26**	**8,098**	**275**	**28,748**
Provided during the year	0	4,554	27	0	1,971	14	756	26	**7,348**
Impairments	0	(6,772)	(40)	0	190	0	0	0	**(6,622)**
Reclassifications	0	0	0	0	14	(14)	0	0	**0**
Disposals/ de-recognition	0	0	0	0	(103)	0	0	0	**(103)**
Accumulated depreciation at 31 March 2020	**0**	**0**	**1**	**0**	**20,189**	**26**	**8,854**	**301**	**29,371**
Net book value at 31 March 2020	**3,841**	**119,316**	**884**	**4,270**	**11,452**	**0**	**2,790**	**602**	**143,155**
Net book value at 1 April 2019	**3,841**	**122,236**	**841**	**5,973**	**11,244**	**143**	**2,961**	**182**	**147,420**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned	3,561	96,262	310	22,829	13,516	6,236	589	**143,302**
Finance leased	300	5,637	600	0	271	0	0	**6,808**
Government granted	0	12,669	0	0	0	0	0	**12,669**
Donated	0	5,833	0	0	914	0	0	**6,747**
Total at 31 March 2021	**3,861**	**120,401**	**910**	**27,329**	**14,701**	**6,236**	**589**	**169,526**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned	3,541	94,776	284	4,270	11,000	2,790	602	**117,263**
Finance leased	300	5,674	600	0	363	0	0	**6,937**
Government granted	0	12,723	0	0	0	0	0	**12,723**
Donated	0	6,143	0	0	89	0	0	**6,232**
Total at 31 March 2020	**3,841**	**119,316**	**884**	**4,270**	**11,452**	**2,790**	**602**	**143,155**

9.1 Analysis of Plant, Property and Equipment

The Trust does not have any government granted or donated assets which have any restrictions or conditions imposed on them.

The Trust can disclose that there have been no disposals in year of land and building assets used for the delivery of commissioner requested services (CRS). In addition, as at 31 March 2021, the Trust had no land and buildings valued at open market value.

9.2 Capital commitments

There is one capital commitment, (£9m) under PPE capital expenditure relating to the Pathway programme for 2021/22

10. Investments Carrying Amount

Associate entities are those over which the Trust has the power to exercise a significant influence, but not control over the operating and financial management policy decisions. This is generally demonstrated by the Trust holding in excess of 20% but no more than 50% of the voting rights.

With effect from August 2009 the Trust has an associate investment in Milton Keynes Urgent Care Services, a community interest company (CIC) and holds an equity investment of 40% voting rights. The sum of the investment was £40. The entity is incorporated in the UK and accounted for at cost.

The Trust has chosen not to reflect any surplus or deficit from the associate in the Trust accounts as the Trust deems the impact of its share to not be material. In the event of any impact becoming material, the Trust will review the position and reflect this as appropriate.

11. Inventories

	Drugs	Consumables	Energy	Total
	£000	£000	£000	£000
As at 1 April 2020	**1,219**	**2,115**	**60**	**3,394**
Additions	22,422	27,285	44	**49,751**
Write-down of inventories recognised as an expense	0	(104)	0	**(104)**
Inventories consumed (recognised in expenses)	(22,411)	(26,906)	(44)	**(49,361)**
As at 31st March 2021	**1,230**	**2,390**	**60**	**3,680**
As at 1 April 2019	**1,218**	**2,299**	**60**	**3,577**
Additions	22,836	20,283	13	**43,132**
Inventories consumed (recognised in expenses)	(22,835)	(20,467)	(13)	**(43,315)**
As at 31st March 2020	**1,219**	**2,115**	**60**	**3,394**

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £3.9m of items purchased by DHSC, these are included in the consumable additions disclosed above.

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

12. Trade and Other Receivables

	31 March 2021	31 March 2020
	£000	£000
Opening balances	**25,582**	**29,561**
Current		
Contract receivables	12,665	25,104
Allowance for impaired contract receivables / assets	(796)	(1,494)
Prepayments (non-PFI)	5,919	841
PDC dividend receivable	60	283
VAT receivable	1,978	848
Total current trade and other receivables	**19,826**	**25,582**
Non-current		
Contract receivables	316	763
Allowance for impaired contract receivables / assets	(71)	(335)
Clinician pension tax provision reimbursement funding from NHSE	353	301
Total non-current trade and other receivables	**598**	**729**
Of which receivables from NHS and DHSC group bodies:		
Current	7,274	18,731
Non-current	353	301

Changes were made to the financial regime of the NHS in 2020-21 in response to the COVID-19 pandemic. Block contract values for all services commissioned by NHS England and NHS Improvement and Clinical Commissioning Groups (CCG's) were established. The block payments were paid in advance of the relevant service period and as such, led to a reduction in contract receivables in 2020/21. Balances in prior year not outstanding or relevant in the position for 20/21 include PSF/FRF funding due £9m, COVID-19 additional income £1.9m, NHS WIP & NCA £1m and Sexual Health Service £1m.

NHS receivables are considered recoverable because the majority of trade is with CCG's, as commissioners for NHS patient care services. CCGs are funded by the Government to purchase NHS patient care services, therefore no credit scoring of them is considered to be necessary. The Trust has previously recognised an impairment for receivables which related to CCG income however, as a result of the changes to the financial regime, in response to the COVID pandemic, the Trust has released any provision held and has not recognised any further impairment related to CCG income in 2020/21. Similarly, other receivables with related parties are with other Government bodies, so no credit scoring is considered necessary.

Trade and Other Receivables included £0.8m for the value of partially completed patient episodes as of 31 March 2020, as a result of the changes to the financial regime in response to the COVID pandemic, to block contracts, no partially completed spells have been recognised in 2020/21.

At the Statement of Financial Position date there were no material concentrations of risk, the maximum exposure to credit risk being the carrying values of trade receivables.

12.1 Allowance for credit loss

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2020 - brought forward	1,829	0
New allowances arising	114	0
Changes in existing allowances	(747)	0
Utilisation of allowances (write offs)	(329)	0
Allowances as at 31 Mar 2021	**867**	**0**

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2019 - brought forward	2,580	0
New allowances arising	433	0
Changes in existing allowances	(889)	0
Utilisation of allowances (write offs)	(295)	0
Allowances as at 31 Mar 2020	**1,829**	**0**

The provision for impairment of receivables decreased in 2020/21. The main reduction was due to compensation recovery cases and NHS debtors.

13. Cash and cash equivalents

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

	2020/21	2019/20
	£000	£000
At 1 April	**16,286**	**6,175**
Net change in year	32,479	10,111
At 31 March	**48,765**	**16,286**
Broken down into:		
Cash at commercial banks and in hand	22	61
Cash with the Government Banking Service	48,743	16,225
Total cash and cash equivalents as in SoFP	**48,765**	**16,286**
Total cash and cash equivalents as in SoCF	**48,765**	**16,286**

14. Liabilities

14.1 Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	17,147	14,574
Capital payables	15,036	5,317
Accruals *	19,110	11,755
Social security costs	2,533	2,279
VAT payables	0	7
Other taxes payable	2,264	1,969
Other payables	2,394	3,046
Total current trade and other payables	**58,484**	**38,947**
Of which payables from NHS and DHSC group bodies:		
Current	12,566	4,297
Non-current	0	0

* This value includes £5.9m increase in untaken annual leave accrued. This is due to reduced capacity during the COVID pandemic, which resulted in staff being unable to take their full annual leave entitlement.

14.2 Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Opening balance	**2,272**	**1,706**
Current		
Deferred income: contract liabilities *	14,942	2,272
Total other current liabilities	**14,942**	**2,272**

* The deferred income balance includes £11.6m relating to elective activity recovery for 2021-22.

15. Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from the Department of Health	0	131,125
Obligations under finance leases	202	222
Total current borrowings	**202**	**131,347**
Non-current		
Obligations under finance leases	5,614	5,815
Total non-current borrowings	**5,614**	**5,815**

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 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

Outstanding interim loans totalling £130.9m interim loan principal as at 31 March 2020 in these financial statements have been converted to PDC in year.

15.1 Reconciliation of liabilities arising from financing activities.

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2020	**131,125**	**6,037**	**137,162**
Cash movements:			
Financing cash flows - payments and receipts of principal	(130,852)	(221)	**(131,073)**
Financing cash flows - payments of interest	(273)	(280)	**(553)**
Non-cash movements:			
Additions	0	280	**280**
Carrying value at 31 March 2021	**0**	**5,816**	**5,816**

16. Finance Lease Obligations

	Minimum Lease Payments		
	31 March 2021 Buildings	31 March 2021 Other	31 March 2021 Total
	£000	£000	£000
Gross lease liabilities	**9,070**	**353**	**9,423**
of which liabilities are due:			
- not later than one year;	313	155	468
- later than one year and not later than five years;	1,250	198	1,448
- later than five years.	7,507	0	7,507
	9,070	353	9,423
Finance charges allocated to future periods	(3,598)	(9)	(3,607)
Net lease liabilities	**5,472**	**344**	**5,816**
of which payable:			
- not later than one year;	53	149	202
- later than one year and not later than five years;	306	195	501
- later than five years.	5,113	0	5,113
	5,472	**344**	**5,816**

	Minimum Lease Payments		
	31 March 2020 Buildings	31 March 2020 Other	31 March 2020 Total
	£000	£000	£000

Gross lease liabilities	**9,382**	**542**	**9,924**
of which liabilities are due:			
- not later than one year;	313	189	502
- later than one year and not later than five years;	1,250	353	1,603
- later than five years.	7,819	0	7,819
	9,382	542	9,924
Finance charges allocated to future periods	(3,868)	(19)	(3,887)
Net lease liabilities	**5,514**	**523**	**6,037**
of which payable:			
- not later than one year;	43	179	222
- later than one year and not later than five years;	267	344	611
- later than five years.	5,204	0	5,204
	5,514	**523**	**6,037**

The finance lease items include the Trust's Accommodation Block, Beds, Multi-Function Devices (Printers) and car park equipment.

The accommodation block has no option to extend or purchase in the current lease agreement. The Trust entered the seven-year extension period of the beds lease in 2016/17, with no option to purchase under the current lease terms.
The Trust has the option to extend the lease for the Multi-Function Devices to the end of the useful economic life of the equipment, with no option to purchase under the current lease agreement.

The Trust entered into a four-year lease for the car park equipment, with two options to extend for a period of one year at each option. The Trust has exercised the option to extend at the first point and committed to a term of five years in total with the equipment passing to the Trust at the end of the contract.

17. Provisions

	Pensions Early departure costs	Pensions Injury benefits	Other* legal claims	Clinician pension tax	Other**	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	**45**	**869**	**624**	**301**	**1,192**	**3,031**
Change in the discount rate	(20)	40	0	0	22	**42**
Arising during the year	0	0	413	52	1,805	**2,270**
Utilised during the year	(7)	(34)	(12)	0	(120)	**(173)**
Reversed unused	0	0	(116)	0	(474)	**(590)**
At 31 March 2021	**18**	**875**	**909**	**353**	**2,825**	**4,580**
Expected timing of cash flows:						
- not later than one year;	3	34	909	0	1,908	**2,854**
- later than one year and not later than five years;	12	139	0	0	516	**667**
- later than five years.	3	702	0	353	1	**1,059**

Total	**18**	**875**	**909**	**353**	**2,425**	**4,580**

***** Other legal claims include contractual changes £0.8m

****** Other claims include contractual dilapidation, repairs and building removal costs £1.7m and clinician's pension tax reimbursement £0.3m

	Pensions Early departure costs	Pensions Injury benefits	Other* legal claims	Clinician pension tax	Other**	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**43**	**824**	**666**	**0**	**862**	**2,395**
Change in the discount rate	9	79	0	0	12	**100**
Arising during the year	0	0	577	301	813	**1,691**
Utilised during the year	(7)	(34)	(182)	0	0	**(223)**
Reversed unused	0	0	(437)	0	(495)	**(932)**
At 31 March 2020	**45**	**869**	**624**	**301**	**1,192**	**3,031**
Expected timing of cash flows:						
- not later than one year;	7	34	624	0	813	**1,478**
- later than one year and not later than five years;	29	137	0	0	379	**545**
- later than five years.	9	698	0	301	0	**1,008**
Total	**45**	**869**	**624**	**301**	**1,192**	**3,031**

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event and it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the obligation.

Pension provisions
The above provision for pension costs relate to:

- additional pension liabilities arising from early retirements whereby, unless due to ill-heath, these are not funded by the NHS Pension Scheme, as noted within note 1.5 the full amount of such liabilities is charged to the income and expenditure account at the time the Trust commits itself to the retirement and
- reimbursement of clinician's pension tax liability.

Legal provisions
The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 the Treasury's discount rate of 1.23% combined OBR CPI (Office of Budget Responsibility Consumer Price Index) inflation and discount rates.

NHS Resolution
NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, and all clinical negligence claims are recognised in the accounts of the NHSR, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is £158.8m (year ended 31 March 2020 £137.6m). No contingencies or provisions are in the accounts at 31 March 2021 in relation to these cases, even though the legal liability for them remains with the Trust.

Other schemes
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 the NHSR 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.

18. Revaluation Reserve

	Property, plant and equipment £000
Revaluation Reserve at 1 April 2020	**48,410**
Other reserve movements	1,700
Revaluation Reserve at 31 March 2021	**50,110**
Revaluation Reserve at 1 April 2019	58,288
Impairment losses property, plant and equipment	(9,878)
Revaluation Reserve at 31 March 2020	**48,410**

19. Post Balance Sheet events

There are no post balance sheet events.

20. Contingent Liabilities

The Trust has reviewed its liabilities and it does not consider that it has any material contingent liabilities for the forthcoming financial year. The provisions that the Trust has made for liabilities and charges are disclosed in note 17 including provisions held by the NHSLA as at 31 March 2021 in respect of clinical negligence liabilities of the NHS Foundation Trust.

21. Related Party Transactions

The Trust is a body corporate established by the Secretary of State for Health. Government departments and their agencies are considered by HM Treasury as being related parties. During the year, the Trust has had a significant number of material transactions with other NHS bodies and in the ordinary course of its business with other Government departments and other central and local Government bodies. Most of these transactions have been with HMRC in respect of deductions and payment of PAYE, NHS Pensions Agency, Milton Keynes Council in respect of payment of rates and Milton Keynes CCG which is the Trust's local commissioner of NHS services. There are additional related parties of NHSI, ADMK Ltd and the Milton Keynes Urgent Care Service, with which there have been no significant transactions in year.

The key management personnel of the Trust are all directors of the Trust. Their remuneration is disclosed in note 4.5. During the year none of the members of the key management personnel, or parties related to them, have undertaken any material transactions with the Trust.

21 Related parties

	2020/21			
	Payments to related party £000 exp	Receipts from related party £000 inc	Amts owed to related party £000 payable	Amts due from related party £000 receivable
Department of Health	0	0	0	0
NHS Bodies	2,798	5,831	2,083	293
Buckinghamshire Healthcare NHS Trust	1,531	59	707	34
NHS Milton Keynes CCG	0	181,640	10,144	197
NHS Bedfordshire CCG	24	18,228	24	2,000
NHS England	(4)	54,720	11,352	3,966
NHS Buckingham CCG	0	12,248	0	0
Bedfordshire Hospitals NHS Foundation Trust	412	420	972	242
Oxford University Hospital NHS FT	1,056	2,016	562	93
NHS Resolution	8,591	48	368	0
Central and North West London NHS Foundation Trust	461	1,139	80	215
Health Education England	0	2,655	241	174
Other WGA Bodies				
Other WGA Bodies	42	0	0	46
NHS Blood and Transplant (outside DH Group)	1,268	8	15	0
Local Authorities	21	107	0	0
HMRC	16,727	0	4,797	1,979
NHS Pensions	23,793	0	2,394	0
MK Charity	0	461	0	0
ADMK Ltd	428	74	26	0
Total	**57,148**	**279,654**	**33,765**	**9,239**

	2019/20			
	Payments to related party £000 exp	Receipts from related party £000 inc	Amts owed to related party £000 payable	Amts due from related party £000 receivable
Department of Health	0	0	0	0
NHS Bodies	2,642	3,956	864	1,650
Buckinghamshire Healthcare NHS Trust	1,925	79	671	54
NHS Milton Keynes CCG	27	158,836	1,584	1,314
NHS Bedfordshire CCG	0	15,222	45	305
NHS England	22	57,900	4,105	17,055
NHS Buckingham CCG	0	12,516	9	393
NHS Nene CCG	0	4,376	251	13
Bedford Hospital NHS Trust	124	326	186	94
Oxford University Hospital NHS FT	1,719	1,792	819	198
NHS Resolution	7,039	15	0	0
Central and North West London NHS Foundation Trust	611	985	125	309
Luton and Dunstable University Hospital NHS Foundation Trust	244	10	243	6
Health Education England	71	5,218	0	0
Other WGA Bodies				
Other WGA Bodies	34	70	17	84
NHS Blood and Transplant (outside DH Group)	1,203	0	8	16
Local Authorities	103	4,228	0	0
HMRC	15,526	0	4,248	848
NHS Pensions	21,977	0	2,242	0
MK Charity	0	323	0	0
ADMK Ltd	10,100	38	108	14
Total	**63,367**	**265,890**	**15,525**	**22,353**

22. Financial Instruments

	31 March 2021 £000	31 March 2020 £000
Cash	48,765	16,286
Total Capital	**48,765**	**16,286**
Total capital	48,765	16,286
Borrowings	5,816	137,162
Overall financing	**54,581**	**153,448**
Capital to overall financing ratio	**89%**	**11%**

Capital Risk Management

The Trust's capital management objectives are:

- to ensure the Trust's ability to continue as a going concern; and
- to provide an adequate return to reinvest in healthcare services by providing healthcare services commensurately with the level of risk of receiving income for those services provided.

The Trust monitors capital on the basis of the carrying amount of Public Dividend Capital less cash presented on the face of the balance sheet.

The Trust sets the amount of capital in proportion to its overall financing structure, i.e., equity and financial liabilities. The Trust manages the capital structure and makes adjustments to it in-light of changes in economic conditions and the risk characteristics of the underlying assets.

Interest Rate Risk

The Trust is not exposed to significant interest rate risk as the Borrowings are all at a fixed rate of interest.

Liquidity Risk

The Trust's net operating income is mainly incurred under legally binding contracts with the local CCGs, which are financed from resources voted annually by Parliament. The Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the liquidity risk.

22.1 Financial assets by category

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income: investment shares in Induction Healthcare Plc.

	Held at amortised cost £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2020			
Trade and other receivables excluding non-financial assets	12,467	0	**12,467**
Other investments / financial assets	0	432	**432**
Cash and cash equivalents	48,765	0	**48,765**

Total at 31 March 2021	**61,232**	**432**	**61,664**

	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	**£000**	**£000**
Carrying values of financial assets as at 31 March 2019			
Trade and other receivables excluding non-financial assets	24,239	0	**24,239**
Other investments / financial assets	0	175	**175**
Cash and cash equivalents	16,286	0	**16,286**
Total at 31 March 2020	**40,525**	**175**	**40,700**

22.2 Financial liabilities by category

	Held at amortised cost.	Held at amortised cost.
	2020/21 £000	**2019/20 £000**
Carrying values of financial liabilities as at 31 March		
Loans from the Department of Health and Social Care	0	131,125
Obligations under finance leases	5,816	6,037
Trade and other payables excluding non-financial liabilities	51,288	34,691
Provisions under contract	3,698	2,115
Total at 31 March	**60,802**	**173,968**

22.3 Maturity of Financial Liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021	31 March 2020
	£000	**£000**
In one year or less	54,585	167,753
In more than one year but not more than five years	1,964	1,982
In more than five years	7,860	8,120
Total	**64,409**	**177,855**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis in line with IFRS 7.

23 Third Party assets

The Trust held no third-party assets at the end of financial year 2020/21.

24. Losses and special payments

There were 127 cases at 31 March 2021 of losses and special payments totalling £240k approved during the year (201 cases to 31 March 2020 totalling £316k) These payments are the cash payments made in the year and are calculated on an accrual's basis. There were no compensation payments recovered during the year. Details of the payments are shown below.

	31 March 2021 Total number of cases	31 March 2021 Value £000	31 March 2020 Total number of cases	31 March 2020 Value £000
LOSSES:				
1. Losses of cash due to:				
b. overpayment of salaries etc.	40	10	44	23
2. Fruitless payments and constructive losses	0	0	0	0
3. Bad debts and claims abandoned in relation to:				
a. private patients	0	0	7	1
b. overseas visitors	31	81	56	187
c. other	26	49	48	1
4. Damage to buildings, property etc. (including stores losses) due to:				
b. stores losses	24	98	24	94
c. other	0	0	0	0
Total Losses	**121**	**238**	**179**	**306**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	0	0	0	0
6. Extra contractual to contractors	0	0	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	4	1	10	1
g. other	2	1	12	9
8. Special severance payments	0	0	0	0
9. Extra statutory and regulatory	0	0	0	0

Total Special Payments	**6**	**2**	**22**	**10**
Total Losses and Special Payments	**127**	**240**	**201**	**316**

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