NHS
Cambridge
University Hospitals
NHS Foundation Trust

Annual Report and Accounts
2019/20

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1. Chair's statement

There is no denying Covid-19 has had a huge impact on our hospitals this year.

The pandemic has required an extraordinary and agile response. One which has seen us work in close partnership with local communities, academia, industry and, most importantly, our patients and our staff.

There have been huge challenges to overcome. How to care for Covid and non-Covid patients, how to keep our staff safe, how to source personal protective equipment and how to continue to deliver the very highest levels of patient care.

But rather than knock our ambitions sideways, I have witnessed an unprecedented sense of solidarity across the Trust.

We are all tired, we are all worried about the impact of this devastating disease, but underneath there is an energy and a determination for the future that cannot be hidden.

And I think the reason for this is an unwavering belief, in the heart of every individual at the Trust, in the ability of Addenbrooke's and The Rosie to make a difference to people's lives.

We know we have strong foundations. Nestled in the heart of the Cambridge Biomedical Campus, CUH rubs shoulders with Royal Papworth Hospital NHS Foundation Trust, GSK, AstraZeneca, Abcam and the MRC Laboratory of Molecular Biology to name a few. Added to this is our unique and special partnership with the University of Cambridge which is recognised throughout the world as a centre of excellence for medical education and research.

Equally important is our role as part of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP), which I have the privilege of chairing. Increasingly we are working together as a health and care system to agree priorities and join up pathways of care so that our patients receive the right care in the right place at the right time.

In September 2019, we welcomed the news that CUH was the largest recipient of the Government's Health Infrastructure Plan. Thanks to £10 million in seed funding, we can now kick-start our plans to rebuild Addenbrooke's as a state-of-the-art environment, under-pinned by the world-leading research of Cambridge. Our ambitions include the building of a new £100m children's hospital, supported by our partners, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and the University of Cambridge. Our aim is to deliver a visionary new approach to healthcare for young people, treating the whole child, not just their illnesses or conditions, using all the talent available across the region.

Confidence in our ability to deliver has been underlined by recent visits from the Prime Minister Boris Johnson, Secretary of State for health and Social Care Matt Hancock and the new Labour Party leader Sir Keir Starmer. They recognise that Addenbrooke's works because of its location and the strong partnerships it has forged. And they were all especially interested in our work to advance patient care by exploring the power of the genome, carry out the latest ground breaking clinical research and utilise the latest computer technology.

When Covid-19 came along, rather than dampen our ambition, it provided us with a catalyst to accelerate our plans for the future.

For example, the NHS Long Term Plan is committed to reducing face-to-face appointments by up to a third over the next five years. From a patient perspective, delivering the right care in the right place at the right time saves money, time and effort on travel and means friends or relatives do not need to arrange for time off work to accompany patients. Working in partnership with GPs to improve referral processes by utilising telephone and video conferencing services, we have been able to continue with significant numbers of outpatient appointments during the Covid-19 outbreak. While we acknowledge the postponement of non-essential planned procedures has caused a significant backlog in patients waiting for appointments, the learning we have taken from the pandemic will enable us to deliver the best patient care in the future.

A focus on sustainability has also enabled us to achieve our financial plan for 2019/20. Our aim is maintain this position and continue to demonstrate the efficient use of resources.

Perhaps, most importantly, our desire to achieve one common goal – to improve people's quality of life through innovative and sustainable healthcare – has brought us closer together with our stakeholders, our local communities, our staff and our patients during this worrying time. This has been strongly evidenced by the support shown during the Clap for Carers and the Addenbrooke's Charitable Trust appeal, which topped £1 million within a few weeks of its launch.

All this has enabled us to really live our values of being Safe, Kind and Excellent. It has brought us all together in a way that makes us stronger, more effective and more resourceful.

Addenbrooke's and The Rosie are on the cusp of a revolution in healthcare. We are in the right place at the right time and never have I been more proud to work here.

Mike More
Chair
23 June 2020

2. Performance report

2.1 Overview

This section of the report provides a summary of the organisation, its purpose, the key risks to the achievement of its objectives and performance during the past year.

2.2 Statement from the Chief Executive

I write this in a world unrecognisable from a year ago. This statement would normally be about the events of the previous financial year, on which I touch in some of the latter paragraphs, but inevitably its focus is on our response to the Covid-19 pandemic since early 2020.

The first human case of Covid-19 was diagnosed in China in late December 2019. A month later it had arrived on the shores of the UK. There is no one whose life has not been drastically affected by Covid-19, and certainly things will never be quite the same again at CUH.

From mid-March 2020, we suspended normal operations at Addenbrooke's and The Rosie, and implemented new ways of working. This required activating our Emergency Planning, Resilience and Response processes, comprising a 24/7 critical incident management structure, reconfiguration of the hospital to provide intensive care bed-capacity in line with our own modelling of a worst case scenario, and segregation of the site into red, amber and green areas to ensure we could look after Covid and non-Covid patients separately.

This took a significant effort from CUH staff and our partners across the Cambridge Biomedical Campus (CBC) and the wider health and care system. I am so very proud of the way people have worked together in such an agile way; they have shown resilience as the ground moved beneath their feet, re-trained themselves, re-purposed and re-deployed, and delivered the very best care possible for our patients, while keeping our staff safe, in a challenging situation.

I am also immensely proud that our Campus has been at the heart of research to understand the fundamental biology of SARS-CoV-2 and find a cure for Covid-19. Every Covid patient admitted to CUH has been invited to take part in research, and thanks to our partners – not least the University of Cambridge which refocused all its efforts towards fighting Covid-19 – we have a greatly increased capacity for testing and preventing transmission, as well as a growing understanding of how the disease affects the body, and how we may be able to prevent it.

Covid-19 is likely to be with us for many months, if not years. We must find sustainable ways of delivering the full range of treatment and diagnostics required by a regional and national centre such as CUH, while being prepared for further Covid-19 outbreaks at any point. This will be no mean feat, and is the focus of our wholehearted attention at this time; but it does offer us the opportunity to rebuild our services in a different, better way. Overnight, some of our ways of working have drastically changed. Some of these changes – such as many outpatient appointments taking place remotely, the re-purposing of some areas of the

hospital, and the increasing ability to work from home – are welcome ones which we aim to build on for the future.

Excellent work is underway across all parts of the hospital and with our partners to develop our plan for the next 18 months. This will cover how we supply and use personal protective equipment, how we allocate beds for Covid and non-Covid patients, how we deal with emergency care and how to restart outpatient and diagnostic services. We are also addressing how to manage the movement of staff and patients in our hospitals to prevent transmission of the virus and maximise safety. Looking further ahead, we are exploring how to strengthen our work across the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) and CBC and build our innovation programme across both arenas. Our new hospitals programme is central to our future and we are pressing ahead with our plans for Cambridge Children's Hospital and the rebuilding of Addenbrooke's.

No one currently knows what the financial impact of Covid-19 will be. We do know that the Trust's financial results for 2019/20 were as planned, with a deficit for the financial year of £37.1m after deducting impairments of £3.2m (i.e. £33.9m before impairments). We had an ambitious cost improvement plan (CIP) of £30m for the year, which the Trust overachieved by delivering £30.6m of savings.

Earlier this year, the Secretary of State for Health and Social Care announced changes during 2020/21 to eradicate the majority of this historic debt and improve funding mechanisms for both revenue and capital going forward. By the end of 2020/21, we anticipate the Trust will be close to financial balance and will have less than £60m of loans remaining. This is clearly a better position in which to be, but it is imperative for creating a sustainable regional health care system of the future that we put every effort into working closely with Cambridgeshire and Peterborough health and care partners to ensure better use of health and care resources across the whole service – which will ultimately help CUH to deliver hospital-based care in a more clinically effective and efficient manner.

We must cement our recent experience of being a listening hospital. If this Covid-19 outbreak has taught us anything, it is that we can achieve a great deal if we bring together and listen to the wide range of exceptional voices on this campus. We now employ more than 11,000 staff at CUH; we are a multi-racial workforce embracing more than 100 nationalities, with a powerful shared mission to work together and save lives. Our 2019 National staff survey results showed a response rate of 55.5%, up from 51.5% in 2018 and above the national average of 47.6%. Our overall staff engagement score was 7.2 out of 10, again above the national average of 7.0. We were very pleased to see many areas of continued improvement in staff experience, but we know that more work is needed particularly around issues of equality, diversity and inclusion. As a Trust we have responded to this latest staff feedback by refreshing and ranking our five trust wide priorities, with equality, diversity and inclusion being our number one priority.

We must also listen to our patients, members and stakeholders: the Trust welcomes patient feedback and aims to make the complaints process accessible and responsive. The information from complaints investigations is used to make improvements to treatment and patients' experience of care. For example, feedback from our children's group Active, and the Patient Experience Group led by our Chief Nurse, are going to be essential to us as we develop our 18-month

plan and our capital building projects, and we will be seeking to communicate with our membership in new ways, to open up additional channels of meaningful engagement .

In our efforts to always improve our performance, we were looking forward to welcoming the Care Quality Commission into CUH in early 2020 for their latest round of inspections. Unfortunately, this coincided with the start of the Covid-19 outbreak, and the CQC has to postpone its visit. Regardless of this, we continue to strive for excellence across the entire Trust, and we do this now at a time when real change is not only possible, but inevitable.

I look forward to the year ahead, with some trepidation, but mainly with great expectations, knowing what we are capable of when we all work together.

Roland Sinker
Chief Executive
23 June 2020

2.3 Purpose and history

Cambridge University Hospitals NHS Foundation Trust (CUH), including both Addenbrooke's and the Rosie Hospitals, was one of the first NHS foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003, and came into being in July 2004.

Our constitution defines our principal purpose as 'the provision of goods and services for the purposes of the health service in England'.

The Trust has its foundation in Addenbrooke's Hospital, which opened in October 1766 in Trumpington Street, Cambridge, as one of the first provincial teaching hospitals in the country. By the 1950s, the hospital was experiencing difficulty accommodating the expansion generated by the introduction of the NHS, and moved to the site on Hills Road. It was officially opened by Her Majesty Queen Elizabeth II in 1962.

Today, CUH has over 1,000 beds and 11,000 members of staff. We are one of the largest and best known acute hospital trusts in the country. The 'local' hospital for our community, delivering care through Addenbrooke's and the Rosie, CUH is also a leading regional and national centre for specialist treatment; a government-designated comprehensive biomedical research centre; a partner in one of six academic health science centres in the UK – Cambridge University Health Partners (CUHP); and a university teaching hospital with a worldwide reputation.

Our CUH Together Strategy has been developed with staff, patients and partners. Patients are central to everything we do and we want to ensure that CUH is an exciting and supportive place to work. Our vision is to improve people's quality of life through innovative and sustainable healthcare. We will deliver our vision in a way that is consistent with our values of *Together* – Safe | Kind | Excellent, and

the associated behaviours that define how we care for our patients and work with our colleagues and partners.
Our strategy has four key priorities:

- Improving patient journeys
- Working with our communities
- Strengthening the organisation
- Contributing nationally and internationally

We are grateful for the efforts of everyone within the Trust, and in the wider community, who raise funds to help us provide improved services for our patients. The Addenbrooke's Charitable Trust (ACT) plays a key role in the life of our hospitals, working with us to ensure that charitable donations are put to the very best use in funding, for example, new high-tech equipment, specialist staff, vital research and facilities and activities focused on patient and staff wellbeing. Over the past year, ACT has run a number of specific fundraising campaigns including for the Children's Emergency Ambulance Service and for cancer, major trauma and transplant services. ACT is also a vital partner in the programme to build a new Children's Hospital for the East of England.

2.4 Key risks

Key risks are identified by the Board of Directors through the Board Assurance Framework (BAF). At the end of 2019/20, the five most significant risks to achieving the organisation's strategic objectives as identified by the Board are outlined in table one.

Table 1: Board Assurance Framework (BAF)

The top five 'risks' identified in the 2019/20 BAF as reviewed by the Board of Directors on 11 March 2020 were as follows:

Risk ref.	Current risk score	Risk description	Lead Executive	Board monitoring committee
002	20	The Trust does not sustain timely and effective emergency and elective patient flow through its hospitals which impacts on the responsiveness of services including waiting times, safety and patient experience.	Chief Operating Officer	Performance and Quality
007	20	A failure to address estate backlog maintenance and statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety	Director of Capital, Estates & Facilities Mgt	Performance and Quality

		and continuity of clinical service delivery.		
008	20	A failure to address fire safety statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety and continuity of clinical service delivery.	Director of Capital, Estates & Facilities Mgt	Board of Directors
009	16	Despite having an estates strategy and master plan aligned with the Trust's organisational and clinical strategy, the Trust takes sub-optimal short-term decisions on estates investment and is not able to plan appropriately for long-term investment in its estate and infrastructure due to capital constraints.	Director of Capital, Estates & Facilities Mgt	Board of Directors
011	15	The Trust does not agree a medium-term financial plan to achieve financial sustainability for the Trust and the Cambridgeshire and Peterborough health and care system which impacts on the ability to invest for the future and provide high quality services for patients.	Chief Finance Officer	Performance

The BAF is used by the Board of Directors and its sub-committees to track progress in seeking assurance that appropriate controls are in place and actions are being taken to mitigate the key risks to the achievement of the Trust's strategic objectives. Further details of how the Board gains assurance that there are effective arrangements in place for internal control and risk management to safeguard public investment, the Trust's assets, patient safety and service quality are included in the Annual Governance Statement (AGS).

Each risk on the BAF is assigned to a lead Executive Director who reviews the risk on a monthly basis. The BAF is discussed on a monthly basis by the Risk Oversight Committee, which is chaired by the Chief Executive, and is received by the Board of Directors four times a year. In addition, each Board sub-committee reviews those risks assigned to it at each of its meetings to ensure that it has appropriate assurance on the effectiveness of the controls in place and progress on actions to address any gaps in control and/or assurance.

The processes outlined above and in the AGS ensure that the BAF is a living document, representing the risks of greatest concern to the Board of Directors.

2.5 Going concern statement

The Trust has considered the situation with regard to 'going concern' and after making enquiries, the directors have a reasonable expectation that CUH will have access to adequate resources to continue in operational existence for the foreseeable future.

2.6 Performance management approach

The Trust's approach to performance management is based on our operational plan with clear priorities, objectives and metrics. A process is in place to ensure staff are clear about the priorities and that these are linked to individual objectives. Arrangements are in place for reporting to our commissioners and regulators, and there is a clear and simple quality message to our patients and the wider public through our quality account.

Performance is monitored by the Board of Directors through a monthly Integrated Performance Report, with detailed scrutiny and assurance sought by the Performance Committee of the Board. There is a focus across a broad range of metrics covering quality, operational performance, workforce and finance. Clinical divisions review performance through their divisional boards and associated governance arrangements and monthly performance review meetings are held between the executive team and each clinical division, with issues escalated as required to the Management Executive.

2.7 Financial Performance

The Trust's financial results for 2019/20 were as planned, with a deficit for the financial year of £37.1m after deducting impairments of £3.2m (i.e. £33.9m before impairments). The Trust is currently rated within segment 3 of NHS Improvement's Single Oversight Framework, which is unchanged from 2018/19. The plan included an ambitious cost improvement plan (CIP) of £30m, which the Trust overachieved by delivering £30.6m of savings. £21.6m (71%) of these savings have a recurrent benefit, with £9m (29%) being delivered non-recurrently.

The Trust's underlying deficit continues to be the result of a number of challenges, both local to the organisation and reflected nationally. However, the significant improvement in headline deficit from 2018/19 is largely the result of the receipt of Provider Sustainability Fund income in 2019/20 due to the Trust's successful achievement of its Control Total agreed with NHS England and Improvement (NHSE/I).

Whilst the Board continues to take its financial responsibilities very seriously and has been deeply concerned about the ongoing underlying deficit position which has resulted in a cumulative revenue deficit of £282.7m and loans from the Secretary of State totalling £408.3m, the Secretary of State has announced changes during 2020/21 which will eradicate the majority of this historic debt and improve funding mechanisms for both revenue and capital going forward. By the end of 2020/21 we anticipate that the Trust will be close to financial balance and will have less than £60m of loans remaining from the Secretary of State. In the meantime, we will continue to work very closely with Cambridgeshire and Peterborough health and care partners to ensure that there is better use of health

and care resources across the whole service – which will ultimately help CUH to deliver hospital-based care in a more clinically effective and efficient manner. Over the past 12 months, we have worked hard with our partners across Cambridgeshire and Peterborough to reach a collective understanding of the causes of the system financial deficit and to assess the potential for reducing the deficit over time. Discussions were progressing well with NHSE/I and we were hopeful of coming to an agreed plan over the medium term to return to financial balance. Events have overtaken us with the arrival of the COVID-19 crisis and Control Totals have been suspended for 2020/21, but we will continue to work with national and regional partners to agree a fair funding mechanism for the medium term, which should result in us being able to agree a sustainable medium-term financial plan for 2021/22 and beyond.

The benefits of the work to date are clearly visible in the successful delivery of our CIP programme, which has been achieved at the same time as protecting quality and safety standards and achieving a Care Quality Commission assessment of "good". It is also worth reflecting that this is the fourth consecutive year that the Trust has successfully achieved its financial plan and CIP target.

2.8 Environmental matters, social, community and human rights issues

The activities and policies of CUH in the areas of social, environmental, community and human rights are outlined in Chapter 3, specifically within the equality, diversity and inclusion report and sustainability and climate change report.

2.9 Emergency Planning, Resilience and Response

The Trust is classified as a Category 1 responder under the Civil Contingencies Act 2004. Under this legislation the roles and responsibilities are clearly outlined to ensure that the Trust has arrangements in place to respond appropriately to incidents or events impacting on the health of the community and minimise any further disruption.

The Trust has a Major Incident Plan which sets out the process by which the organisation will respond to, manage and recover from an incident. This plan is sponsored by the Chief Operating Officer who has the role of the Accountable Emergency Officer for the Trust. The Major Incident Plan is owned by the Trust's Resilience Manager who has the responsibility for ensuring it is reviewed in line with organisational policy.

The Trust has completed the annual self-assessment against the NHS England EPRR core standards in conjunction with a peer review conducted by Cambridgeshire and Peterborough CCG. The Trust was declared as 'substantially compliant' against the core standards in October 2019. The tasks allocated to the action plan were successfully completed in February 2020 and, as such, the Trust was able to report its 'full compliance' against the core standards.

An additional lead resilience role was approved for the team and had been successfully filled. A suitable candidate had been appointed but they were unable to start immediately due to the current COVID-19 incident; the candidate has subsequently withdrawn and therefore this post is now vacant. Advertising for this post has recommenced but there will be a likely gap for at least three months.

The Trust continues to participate in emergency planning exercises and training and is an active member of the Local Resilience Forum working groups. There is closer working with Royal Papworth Hospital since its relocation to the Cambridge Biomedical Campus.

As part of the Trust's EU Exit planning and preparedness, a review of divisional business continuity plans was conducted. A number of table-top exercises were undertaken both locally, with representation from clinical divisions and corporate teams, and regionally to work through a series of scenarios and to test planning assumptions.

The Trust declared a Major Incident in March 2020 in response to the COVID-19 incident being declared a level 4 national emergency and instigated an incident management team and appropriate governance arrangements. The size and remit of the Trust's response is unprecedented. The Trust is maintaining its statutory functions and operating appropriate command and control arrangements in line with the national incident declaration at level 4. CUH's strategic objectives for managing the outbreak are to maximise survivorship for patients with and without COVID-19, and to keep staff safe. A sustainability taskforce has been established, led by the Chief Operating Officer and senior clinicians. The aim is to implement a clinical and operating model that can be sustained for the next 18 months, throughout the peaks and troughs of the outbreak. Alongside this, learning and lessons learned are being captured and fed into the recovery phase of the incident and will feed into next year's plan.

Emergency Planning priorities for 2020 include:

- Supporting the incident response and recovery for the COVID-19 pandemic
- Supporting any contingency work required for EU Exit
- Continuing to review and update Business Continuity Plans and Business Impact Analyses
- Ensuring that the Trusts' EPRR policies and procedures are current and fit for purpose
- Continuing to prepare and deliver a range of exercises across the Trust and with multi-agency partners

2.10 Freedom to Speak Up

In line with the recommendations of the Freedom to Speak Up Review undertaken by Sir Robert Francis, the Trust appointed a Freedom to Speak Up Guardian in December 2016. The Guardian is supported by a network of local listeners across the organisation.

The Speaking Up service offers support to all employees and workers to raise concerns in a confidential environment. In parallel, the Guardian works with staff across the organisation to promote and improve the speaking up and listening culture so that raising concerns becomes part of our normal business.

In the financial year 2019/20, 93 people raised concerns directly with the Speaking Up service. Across the concern themes, 29% related to behaviour and relationships, 26% to Trust policy and procedure, 22% to management support, 16% were patient-related and 6% were about capacity/workload/training. The

staff groups accounting for the greatest proportions of concerns raised are nursing and midwifery and administrative and clerical staff. While the number of concerns raised is broadly comparable with the national average, the Trust is lower than average on concerns about behaviour/relationships and patient-related concerns raised through this route. Trends continue to be monitored through twice-yearly reporting to the Board of Directors.

The 2019 staff survey showed a further improvement in the two key questions relating to raising concerns and the Trust's local survey (July-September 2019) reported that 90% of staff feel secure to raise concerns with line management. Work continues to spread awareness and support improvements to raise these engagement scores further.

The Trust is using the National Guardian's Office guidance on best practice and consistent approaches and NHS Improvement's guide for boards as a self-review tool to evaluate our strategy and further improve our speaking up culture.

2.11 Significant events after the balance sheet date

COVID-19 has had a significant impact on the operations of the Trust since the March 2020. The financial implications of COVID-19 will primarily impact on the 2020/21 financial statements.

3. Accountability report

3.1 Board of Directors

The Board of Directors comprises full-time Executive and part-time Non-Executive Directors, the latter selected for their knowledge, areas of relevant expertise and experience. All directors meet the Fit and Proper Persons Requirements.

The role of the Board of Directors is to provide effective and proactive leadership of the NHS foundation trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided; and to ensure that the Trust is well-governed in all aspects of its activities.

The section below demonstrate the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors bring to the foundation trust.

The Board of Directors met 19 times during the year under review, 6 times in public and 13 times in confidential session.

3.2 Board and committee effectiveness

The performance of the Board of Directors is reviewed collectively as part of a board evaluation process; and individually, with each board director undertaking performance appraisal with either the Chief Executive for Executive Directors or the Chair for the Chief Executive and Non-Executive Directors. The Chair is appraised by the Senior Independent Director in consultation with the Lead Governor. Board committees undertake an annual review of their effectiveness against their terms of reference and work programmes and report to the Board of Directors on this.

3.3 Trust Chair

Dr Michael More, CBE – Chair

Mike became Chair of CUH on 11 April 2017. In December 2019 Mike was re-appointed for a further term of three years starting in April 2020. In 2018, he assumed the accountable officer role for integrated care system partners in Cambridgeshire and Peterborough, who between them serve a population of 1 million people with a health and social care spend of £1.5 billion. The integrated care system and the hospital trust are heavily focussed on innovation and improvement, linking with universities and industry to deliver this.

He joined the CUH board of directors in September 2013 bringing extensive experience from health, police, transport as well as local government. He was chief executive for Westminster City Council until the end of 2013. Mike began his career at the National Audit Office in 1981.

He was senior auditor at Cambridgeshire County Council in 1986 moving on to a number of increasingly high-level positions at the council including head of finance. Mike was appointed as the director of resource management of Suffolk

County Council in 1999, and progressed to the position of chief executive in 2002 joining Westminster City Council as chief executive in April 2008.

Mike's non-executive roles have included non-executive director on the Joint Venture Board for the University Campus Suffolk, plus positions as chair for the Prince's Trust for Suffolk and the East of England Regional Chief Executives' Group. He was also chair of the Central London Resilience Panel which includes all agencies including health and managed emergency planning.

Mike also held a representative role on the Olympic Games Transport Board, overseeing the overall transport consequences of hosting the Games in London. He is a Group Board member of L&Q Housing Association, one of the larger Housing Associations in the country.

Mike holds a PhD from the University of Hull.

3.4 Non-Executive Directors

Daniel Abrams – Non-Executive Director

Daniel is a non executive director of Genome Research Ltd (Wellcome Sanger Institute) where he is also the Audit Committee Chair, and of BioCity Group ltd, a national biotech and medtech incubator, where he is also Audit committee Chair. Daniel has previously held executive director positions including as Chief Financial Officer at Volex plc, Fiberweb plc, CDT inc and Xenova plc and senior executive roles at PepsiCo Inc and Diageo plc.

He is also a former non executive director of the Biotech Industry Association and Panel member of the FRRP in the FRC.

Daniel has an MA (Hons) Law from Cambridge University and is a qualified chartered accountant, FCA, and barrister-at -law.

Adrian Chamberlain – Non-Executive Director

Adrian began his career working with Bank of America before joining Boston Consulting Group after receiving and MBA from London Business School. In 1986 he joined British Telecom plc as a Business Strategy Manager before becoming Marketing and Commercial Director for Sears Sports and Leisurewear. Subsequently he undertook a number of senior roles with Cable and Wireless plc including Chief Executive of the Consumer Markets Division (now Virgin Media), Managing Director of the Consumer and Multimedia Division in Australia and Group Director of Strategy and Corporate Development. He then became Chief Executive Officer of Global Services for Europe and Asia and a member of the Cable and Wireless Board. In 2003 he was appointed Main Board Director and CEO Europe of Bovis Lend Lease Corporation, a leading construction, property development and property management company. Between 2006 and 2015 he was CEO of private equity backed MessageLabs and Achilles, high tech companies specialising in Software as a Service cyber security and supply chain management.

He currently chairs eConsult, a company specialising in cloud based medical diagnostics, in addition he is Non-Executive Director and Chair of the Remunerations Committee for Alfa Financial Software Holdings plc and Volex plc.

Dr Annette Doherty, OBE – Non-Executive Director

Annette has 32 years of international experience working within the pharmaceutical sector, leading Research and Development groups worldwide, including at Pfizer and GlaxoSmithKline (GSK). She is currently Senior Vice President, Global Head of Product Development and Clinical Supply at GSK.

She has published more than 100 scientific manuscripts and written 19 reviews in the research areas in which she has worked. She is co-inventor of over 30 patents. In 2007 she received an honorary degree of Doctorate of Science from the University of Greenwich for her scientific leadership in research and contributions to education and industry/academic partnerships. She chaired the Association of British Pharmaceutical Industry (ABPI) R&D group from 2005-2009 and served on the ABPI Board. She was a Member of the Technology Strategy Advisory Board and an industry participant in a House of Lords session on Genomic Medicine. She has been a member of the Medical Research Council (2008-2012), the Council of the Royal Society of Chemistry (2011-2015) and the Medicines Manufacturing Industry Partnership (2017-2019). She has served as a member of the Cambridge University Chemistry Strategic Advisory Panel from 2013-2019 and was a Member of the Cambridge Biomedical Research Centre Scientific Advisory Board in 2019. She is currently a member of the UK Nucleic Acid Therapy Accelerator Scientific Advisory Group.

In 2009, Annette was awarded the OBE in recognition of her services to the pharmaceutical sector.

Dr Michael Knapton – Non-Executive Director

Mike holds an MA in physiology from the University of Cambridge, a bachelor of medicine & bachelor of surgery (MB BChir) and is a fellow of the Royal College of General Practitioners. Mike's career began at Cambridge University Hospitals, volunteering at the Old Addenbrookes site in 1977, as a clinical student in 1980 and a junior doctor at Cambridge University Hospitals from 1982 to 1986, moving into local general practice as GP principal in 1987 at the surgery in Harston. He has also worked at Addenbrooke's as GP tutor, as well as a spell as cardiology assistant from 1997 to 2003. He joined Cambridge City Primary Care Group 1999 as Professional Executive Committee chairman and by 2005 was appointed medical director of Cambridge and South Cambridgeshire Primary Care Trust. He was associate medical director of the British Heart Foundation from 2006 until 2017. Mike's additional roles include treasurer roles for Cambridge Medical Society, and past Chairman of the East Anglian Faculty of the Royal College of General Practitioners. He is also a trustee for Addenbrooke's Charitable Trust.

Professor Patrick Maxwell – Non-Executive Director

Patrick is the Head of the University of Cambridge, School of Clinical Medicine – CUH is the major teaching hospital for the University. He is also the Regius Professor of Physic – one of the oldest professorships at the University, founded by Henry VIII in 1540 and appointed by the Queen. Patrick holds a Wellcome Trust Senior Investigator award for his research on oxygen sensing. At CUH

Patrick has a special interest in quality, patient safety, audit and public engagement.

Patrick undertook postgraduate clinical and research training in nephrology and general medicine at Guy's Hospital and in Oxford. He was appointed as University Lecturer and then Reader at the University of Oxford. In 2002 he was appointed Professor of Nephrology at Imperial College, followed by the Chair of Medicine at University College London in 2008, prior to moving to his role in Cambridge in 2012.

Patrick is a member of the Board of Cambridge University Health Partners (CUHP) – a partnership between the University and the NHS.

Patrick was elected a fellow of the Academy of Medical Sciences in 2005 and was elected to its Council in 2018. He was appointed a trustee of the Medical Schools Council in 2018 and is a member of its Executive Committee.

Doris Olulode – Non-Executive Director (from 1 November 2019)

Doris has extensive global human resources experience gained in a career at Ford Motor Company at both the operational and strategic level, across a range of disciplines. Latterly she was Ford's HR Director for Europe, the Middle East and Africa. Doris also led the African Ancestry Network at Ford and was named by Autocar as one of the top 100 most influential women in the Auto industry.

Doris is currently a freelance HR consultant. She holds the position of Non-Executive Director for the Diocese of Chelmsford Multi Academy Trust, Royal Free London NHS Foundation Trust, Royal National Orthopaedic Hospital and the Chartered Institute of Legal Executives. She is also a Lay Member to HM Courts and Tribunals Service.

Professor Sharon Peacock, CBE – Non-Executive Director

As of 5 March 2020, Sharon Peacock is on a temporary leave of absence from the Board of Directors. Further details regarding responsibilities and experience of Sharon were included in the 2018/19 Annual Report and Accounts.

Shirley Pointer – Non-Executive Director and Senior Independent Director

Shirley Pointer joined the Trust as a non-executive director on 1 December 2015.

Shirley has worked in both the public and private sectors and is a highly respected, experienced leader and senior executive with extensive experience in the areas of people, organisational capability and change.

Shirley joined CUH from the Department of Health where she was the HR Director. She has previously held senior leadership roles in the Department for Communities and Local Government, the Department for Innovation, Universities and Skills and the Department for Trade and Industry, as well as working a CQC Special Adviser in the areas of leadership and governance.

Prior to joining the Civil Service Shirley spent 20 years in the private sector, primarily in financial services and has non-executive experience gained in the charity sector.

Shirley is currently a Non-Executive Director for a medium sized Housing Association and she also works as an independent consultant in the development and delivery of people strategies to enable organisational change.

Her passion is to create successful organisations through authentic leadership underpinned by robust governance and management practices.

3.5 Executive Directors

Roland Sinker – Chief Executive

Areas of responsibility include: *accounting officer, overall responsibility for management of the Trust, ensuring its obligations and targets are met within a framework of prudent and effective systems of internal control*

Roland started as Chief Executive in November 2015. Previously he was the Acting Chief Executive at King's College Hospital NHS Foundation Trust, and spent 2009 to 2015 as their Chief Operating Officer.

Coming from a legal and management consultancy background, Roland served as Strategy Director at King's between 2005 and 2008.

Nicola Ayton – Director of Strategy and Major Projects

Areas of responsibility include: *establishing and agreeing strategic choices, business planning, and leading the Trust in co-creating and delivering the Cambridgeshire and Peterborough STP to improve health and care for our local population*

Nicola joined Cambridge University Hospitals as Director of Strategy and Major Projects in March 2018. Nicola moved to the role of Chief Operating Officer in April 2020.

Previously she held the position of Deputy Director for the National System Transformation Group at NHS England, as well as Head of Strategy and Delivery for the New Care Models Programme. Before joining NHS England in 2015, Nicola worked as a civil servant in Central Government where she held a number of senior policy roles including health spending at HM Treasury. Prior to that, she worked at the Department for Education focusing on social work and school funding reform having started her career at Deloitte.

Dr Ewen Cameron – Director of Improvement and Transformation

Areas of responsibility include: *continuous improvement within the organisation as well as cost improvement, eHospital, information governance and innovation*

Ewen started as Director of Improvement and Transformation in February 2018. Having originally trained in Cambridge, he returned to the Trust as a Consultant Gastroenterologist with an interest in Endoscopy in 2007. He was the Clinical Lead for Endoscopy and the Clinical Director of the Cambridge Bowel Cancer Screening Centre from 2007 until 2013 when he was appointed Divisional Director for Medicine. He was subsequently the Divisional Director for Division C from 2014 to 2018. He continues to practice as a Gastroenterologist.

Sam Higginson – Chief Operating Officer until 20 October 2019

Sam left the Trust on 20 October 2019. Further details regarding his responsibilities and experience were included in the 2018/19 Annual Report and Accounts.

Paul Scott – Chief Finance Officer

Areas of responsibility include: *financial strategy, financial planning, financial management, estates and facilities, commissioning and contracting and statutory accounts.*

Paul started as Chief Finance Officer in October 2017. Previously he held the position of Executive Director of Finance, Strategy and Performance at Ipswich Hospital NHS Trust, covering Finance, Strategy, Partnerships and Commercial Contracts and IT. Before joining Ipswich in 2013, Paul spent three years as Executive Director of Finance at the East of England Ambulance Service. He has also worked in a range of finance roles across the East of England, including at Mid-Essex Hospitals Trust, Barts and The London NHS Trust and local PCTs.

Dr Ashley Shaw – Medical Director

Areas of responsibility include: *professional medical governance; medical revalidation clinical outcomes; infection prevention and control; research and development; medicines management; clinical networks; GP liaison; undergraduate education; post-graduate education*

Ashley took up the post of Medical Director for CUH in November 2017. He joined the Trust as a Consultant Radiologist with an interest in cancer imaging in 2004 and became Divisional Director for Investigative Sciences in 2012, subsequently for Division B from 2014. Ashley continues to practice as a consultant radiologist.

Lorraine Szeremeta – Chief Nurse

Areas of responsibility include: *nursing and midwifery strategy and standards, executive lead for quality and safety and patient experience, safeguarding children and vulnerable adults, professional lead for allied health professionals, and executive lead for psychological medicine services*

Lorraine joined Cambridge University Hospitals as Chief Nurse in July 2018, coming to the organisation from University College London Hospitals, where she had worked as Deputy Chief Nurse for the surgery and cancer board for 5 years. During her time in London she also worked on a part time seconded basis on the pan London Capital Nurse programme, leading on retention workstreams. Lorraine

has held a number of senior management and nursing roles throughout her career in a number of different organisations, and has a keen interest in staff development and organisational culture. She is co chair of the Shelford Group's Safer Nursing Care Tool Steering Group and a member of the NHSI Safe Staffing Faculty Steering Group. She is a visiting professor for London South Bank University and a Florence Nightingale Scholar.

Ian Walker – Director of Corporate Affairs

Areas of responsibility include: *corporate governance, public engagement, legal services, communications, foundation trust membership and raising concerns.*

Ian joined the Trust in May 2017, having previously worked at Barts Health NHS Trust for 14 years as Director of Corporate Affairs and Trust Secretary. Prior to that, Ian worked at Her Majesty's Treasury where he undertook a wide range of roles, including on health policy and funding.

David Wherrett – Director of Workforce

Areas of responsibility: *human resources (including medical staffing); organisational development and design, health and safety, recruitment, employee relations, occupational health, pensions and voluntary services*

David started as the Director of Workforce in April 2014.

David has worked in human resources for over 20 years in various organisations. He has spent the majority of his recent career in the NHS, working primarily in hospitals. His focus is to ensure that CUH supports its staff to deliver excellent care for patients and carers.

3.6 Register of interests

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an on-going basis.

The register is available online at https://cuh.mydeclarations.co.uk/. The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs.

3.7 Appointment of Chair and Non-Executive Directors

The Council of Governors has the responsibility for appointing the Chair and the other Non-Executive Directors (except in the case of the Regius Professor of Physic) in accordance with the Constitution and in line with relevant legislation.

Candidates are nominated by the Council of Governors' Nomination and Remuneration Committee. This Committee comprises two public, two patient, one staff and one partnership governors. It is chaired by the Chair of the Trust for Non-Executive Director appointments only, and by a governor (currently Patient Governor Julia Loudon, who is also the Lead Governor) for all its other functions including the appointment of the Trust Chair.

Non-Executive Directors are normally appointed for a term of three years. Following this term, and subject to satisfactory performance appraisal, a Non-Executive Director is eligible for consideration by the Council of Governors for re-appointment up to a maximum cumulative total of nine years' service.

When undertaking its nomination responsibilities, the Committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate.

The removal of a Non-Executive Director requires the approval of three quarters of members of the Council of Governors. Details of the criteria for disqualification from holding the office of a director can be found in the Constitution.

Disclosures of the remuneration paid to the Chair and Non-Executive Directors (and also to the Chief Executive and Executive Directors) are given in the remuneration report at section 3.22.

3.8 Non-Executive Directors' expenses

CUH is committed to reimbursing expenses incurred on Trust business to the Chair and Non-Executive Directors at rates set by the Council of Governors. A copy of the policy is available from the Director of Corporate Affairs.

3.9 Attendance at Board meetings in 2019/20

Meeting dates

2019: 3 April, 10 April, 8 May, 14 May, 12 June, 10 July, 11 September, 10 October, 13 November and 11 December.

2020: 15 January, 12 February and 11 March.

There were two meetings of the Board of Directors on the dates listed above in May (8 May), July, September, November, January and March.

Table 2: Attendance at Board meetings in 2019/20

Name	Title	Attendance
Dr Michael More	Trust Chair	18/19
Daniel Abrams	Non-Executive Director	18/19
Nicola Ayton	Director of Strategy and Major Projects	16/19
Dr Ewen Cameron	Director of Improvement and Transformation	19/19
Adrian Chamberlain	Non-Executive Director	15/19
Dr Annette Doherty	Non-Executive Director	14/19
Sam Higginson	Chief Operating Officer (until 20 October 2019)	10/11

Dr Michael Knapton	Non-Executive Director	18/19
Professor Patrick Maxwell	Non-Executive Director	16/19
Doris Olulode	Non-Executive Director (from 1 November 2019)	5/8
Professor Sharon Peacock	Non-Executive Director	11/19
Shirley Pointer	Non-Executive Director	14/19
Paul Scott	Chief Finance Officer	17/19
Dr Ashley Shaw	Medical Director	16/19
Roland Sinker	Chief Executive	17/19
Lorraine Szeremeta	Chief Nurse	17/19
Ian Walker	Director of Corporate Affairs	19/19
David Wherrett	Director of Workforce	18/19

3.10 Committees of the Board of Directors

The Board of Directors is required to establish and maintain an Audit Committee and Remuneration Committee. Further details about the Audit Committee and Remuneration Committee are contained in sections 3.11 (Audit Committee) and 3.22 (Remuneration Committee).

The Board of Directors has also established the following committees of the Board:

- Performance Committee
- Quality Committee
- Workforce and Education Committee

The membership of the committees is determined by the Chair of the Trust in consultation with the Board of Directors. Any changes to the membership of committees are reported to the next meeting of the Board of Directors.

Table 3: Committee membership as of 31 March 2020

Committee	Membership
Audit Committee	NEDs: Daniel Abrams (Chair), Professor Patrick Maxwell (Sharon Peacock was a member until beginning her temporary leave of absence on 5 March 2020)
Remuneration Committee	All Non-Executive Directors. Chaired by Shirley Pointer.
Quality Committee	NEDs: Dr Michael Knapton (Interim Chair), Adrian Chamberlain, and Doris Olulode. (Sharon Peacock was a member and Committee Chair until beginning her temporary leave of absence on 5 March 2020)

Performance Committee	NEDs: Adrian Chamberlain (Chair), Daniel Abrams, Shirley Pointer Executive Directors: Chief Finance Office, Chief Operating Officer and Medical Director
Workforce and Education Committee	NEDs: Shirley Pointer (Chair), Dr Michael Knapton, Professor Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director

Table 4: Attendance of committee members at Board Committee meetings 2019/20

Audit Committee

Name	Title	Attendance
Daniel Abrams	Committee Chair	4/4
Dr Michael Knapton	Non-Executive Director	1/1
Professor Patrick Maxwell	Non-Executive Director	2/4
Professor Sharon Peacock	Non-Executive Director	2/4

Dr Michael Knapton attended the February 2020 meeting as a substitute member of the committee.

Performance Committee

Name	Title	Attendance
Adrian Chamberlain	Committee Chair	10/11
Daniel Abrams	Non-Executive Director	10/11
Sam Higginson	Chief Operating Officer	5/6
Shirley Pointer	Non-Executive Director	10/11
Paul Scott	Chief Finance Officer	10/11
Dr Ashley Shaw	Medical Director	9/11

Quality Committee

Name	Title	Attendance
Professor Sharon Peacock	Committee Chair	5/6
Adrian Chamberlain	Non-Executive Director	4/6
Dr Michael Knapton	Non-Executive Director	6/6
Doris Olulode	Non-Executive Director	1/1
Dr Ashley Shaw	Medical Director	4/6
Lorraine Szeremeta	Chief Nurse	4/6

Remuneration and Nomination Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	3/3

Daniel Abrams	Non-Executive Director	3/3
Adrian Chamberlain	Non-Executive Director	3/3
Dr Annette Doherty	Non-Executive Director	3/3
Dr Michael Knapton	Non-Executive Director	2/3
Professor Patrick Maxwell	Non-Executive Director	2/3
Dr Michael More	Trust Chair	3/3
Doris Olulode	Non-Executive Director	0/2
Professor Sharon Peacock	Non-Executive Director	2/3

Workforce and Education Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	4/4
Dr Michael Knapton	Non-Executive Director	3/4
Professor Patrick Maxwell	Non-Executive Director	2/4
Dr Ashley Shaw	Medical Director	3/4
Lorraine Szeremeta	Chief Nurse	2/4
David Wherrett	Director of Workforce	3/4

Other Directors and Senior Managers attend the committees as required.

3.11 Audit Committee

Membership of this committee is made up of Non-Executive Directors and was chaired by Daniel Abrams for the whole of the reporting period.

The committee's primary role is to oversee the governance and assurance process and the effectiveness of risk management systems and the control environment, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, and also the adequacy of the Trust's internal audit arrangements.

The committee's terms of reference are available on the Trust website.

Meeting dates

The Audit Committee met as follows:

- 2019: 21 May, 24 July and 3 October
- 2020: 7 February

A summary of attendance at Audit Committee is included in table 4 in section 3.10.

Significant issues

The Audit Committee met on 17 June 2020 to consider the financial statements for the period for the period 2019/20. The Audit Committee reviewed the financial statements and identified no significant issues with the statements.

External auditors

During 2015/16, following a tender process, the Council of Governors appointed Mazars Limited as external auditors for three years from 1 April 2016. The contract was subsequently extended for a further period of two years until 31 March 2021. Mazars Limited reports to the Council of Governors through the Audit Committee. Mazars' accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS Foundation Trusts as issued by NHS Improvement. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

The external audit process is subject to annual review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The Audit Committee meets with the auditors (Internal and External) without any Trust Executive Directors present prior to each meeting to improve its knowledge of their contribution.

Non-audit work may be performed by the external auditors where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

Audit Fees

The statutory audit fee, including quality account and whole of government accounts and others is included in note 3 to the accounts.

Internal auditors

During 2016/17, following a tender process, KPMG were appointed as the internal auditors for the Trust with effect from 1 April 2017.

The internal auditors are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit Committee on the audit activity undertaken.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. Further details are provided in the Annual Governance Statement.

3.12 Remuneration and Nomination Committee of the Board of Directors

The work of the Remuneration and Nomination Committee is described in section 3.22.

There is also a Governors' Nomination and Remuneration Committee which identifies and nominates Non-Executive Directors as described in section 3.4.

3.13 Cost statement

CUH has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector information guidance during 2018/19.

3.14 Better payment practice code

The Trust's performance against the better payment practice code in 2018/19 and 2019/20 was as follows:

Better payment practice code	Actual 31/03/2020 Number	Actual 31/03/2020 £'000
Non NHS		
Total bills paid in the year	135,247	454,525
Total bills paid within target	31,570	126,525
Percentage of bills paid within target	**23.3%**	**27.8%**
NHS		
Total bills paid in the year	4,238	64,859
Total bills paid within target	256	13,164
Percentage of bills paid within target	**6.0%**	**20.3%**
Total		
Total bills paid in the year	**139,485**	**519,384**
Total bills paid within target	**31,826**	**139,689**
Percentage of bills paid within target	**22.8%**	**26.9%**

Better payment practice code	Actual 31/03/2019 Number	Actual 31/03/2019 £'000
Non NHS		
Total bills paid in the year	120,120	411,328
Total bills paid within target	29,025	105,102
Percentage of bills paid within target	**24.2%**	**25.6%**
NHS		
Total bills paid in the year	3,605	49,283

Total bills paid within target	160	8,701
Percentage of bills paid within target	**4.4%**	**17.7%**
Total		
Total bills paid in the year	**123,725**	**460,611**
Total bills paid within target	**29,185**	**113,803**
Percentage of bills paid within target	**23.6%**	**24.7%**

3.15 Quality strategy

With input from the Council of Governors, the Board of Directors agreed a five year quality strategy (the Quality Plan) in 2018 which aims to ensure every patient receives safe care, provided to the highest clinical standards, while ensuring a positive patient experience.

The new plan is aligned to the Trust's overarching strategy has been key; with a clear focus on ensuring improvement work enhances patient care across all domains of quality while supporting improved performance.

The Quality Plan (2018-2023) builds on the work already undertaken over the past five years, outlining plans to increase in capability and capacity for improvement.

The Quality Plan outlines how successes will be shared and learned from, in addition to reinforcing the framework for improvement, with a focus on supportive leadership, which will enable our workforce to drive improvement.

3.16 Income statement

CUH has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

3.17 Statement regarding disclosure to auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors to be aware of any relevant audit information and to establish that the auditors are aware of that information.

3.18 Patient care

Improvements in patient/carer information

The Trust Reader Panel is a voluntary group whose members read and evaluate new patient information leaflets and procedure specific consent forms.

Working from home, panel members review leaflets from a lay perspective to ensure that regardless of a patient's background the leaflet is clear, understandable and helpful to patients. The members provide recommendations to improve the readability of the leaflets.

During 2019/20, the Reader Panel reviewed 110 documents.

Compliance of in-date patient information leaflets and procedure specific consent forms is reported monthly to each division's governance forums and escalated to the Patient Experience Group where appropriate.

The Accessible Information Standard

The Accessible Information Standard sets out the requirements for NHS organisations to identify, record, flag, share and meet individuals' information and communication support needs. Over the year, a steering group worked on assessing the extent and effectiveness of the systems in place to enable the Standard to be met, and to determine the areas of focus for further work. Staff training is in place across the Trust, together with systems to record, flag and share information and communication needs. Work continues to achieve consistent provision of correspondence in a format that meets the patient's needs.

Information on complaints handling

The Trust welcomes patient feedback and aims to make the complaints process accessible and responsive. The information from complaints investigations is used to make improvements to treatment and patients' experience of care.

In 2019/20 CUH received 660 complaints, a 7% decrease on the previous year's total of 710. This is in contrast to the previous year on year increase of 17%, and is due to significantly lower numbers of complaints being received in December 2019 and March 2020 (the latter likely to have been affected by the COVID-19 pandemic). The number of complaints received is higher than the total for 2017/18 (608).

The overall rate of complaints is 0.06% of activity compared with 0.07% in 2018/19 ('activity' here means patient episodes, e.g. an inpatient stay or outpatient attendance).

Of the total number of complaints received in 2019/20, investigated and closed at the date of reporting (604 as of 26/05/20), 14.6% were fully upheld, 45.3% were partially upheld and 40.1% were not upheld after investigation. Where complaints are not upheld – where it is considered that there were no shortfalls in the care provided – an explanation is provided and apology for the patient's negative experience.

The complaints regulations require NHS organisations to acknowledge complaints within three working days. In 2019/20, we achieved this in 95% of cases.

Under the current legislation, NHS organisations have six months to resolve a complaint: this allows for flexibility and agreement with the complainant as to an appropriate timescale for investigating and responding. CUH aims to provide a

response in as timely a manner as possible, and works to internal standards of responding to 50% of complaints within the timeframe set after initial receipt and assessment of the complaint, and responding to 80% of complaints within the initial timeframe *or* within an extended timeframe agreed with the complainant.

Complaints are graded from 1 to 5 according to complexity/severity. Cases graded 1, 2 or 3 in the grading framework should be investigated and responded to within 30 working days (or fewer); cases graded 4 - response within 45 working days, cases graded 5 - response within 60 working days.

During investigation, factors can arise which mean that cases take longer to investigate and the time to respond exceeds the initial set timeframe. Factors affecting timeliness of responding are availability of Trust staff to investigate complaints, resource issues within the complaints team and unforeseen additional information being required as a result of initial investigations. In these cases the complaints team communicate with complainants in order to negotiate an extended set timeframe for response.

Of the total number of complaints received in 2019/20, investigated and closed at the date of reporting, we responded to 33.9% of complaints within the initial set timeframe. We agreed and met an extension to the responding timeframe in a further 50.7% of cases, meaning that we responded to 84.6% of complaints either within the initial set timeframe or by the later date agreed, above our internal target.

Complaints are recorded on a secure database and the information is categorised to help us identify themes and trends. We record the area where the issue occurred (division, directorate, specialty, ward/clinic), the staff group (e.g. consultant, physiotherapist, nurse) and the subject of the complaint (e.g. communication, cancelled appointment, delayed discharge), as well as the outcome of the investigation, the lessons learned and action taken, and whether the complaint was upheld. This information is available to staff across the Trust and presented to the Patient Experience Group bi-monthly.

We categorise complaints by their main subject (e.g. 'clinical treatment', 'communications'), together with sub-subjects within that category (e.g. delay or failure in treatment or procedure, post-treatment complications, communication with patient). The most common main subject of all complaints received is consistently clinical treatment. This category encompasses aspects of a patient's medical or nursing care at the Trust. Within this category, delay or failure to diagnose, delay or failure in treatment, and post-treatment complications were the three most frequently identified sub-subjects.

Emphasis is placed on identifying lessons learned and actions taken where shortfalls in care are identified. Over the past year, examples of actions implemented as a result of patient complaints include: clinical skills training for nursing staff members; training for day surgery unit staff on the needs of breast feeding mothers; additional checking of blood pressure monitoring equipment; and the inclusion of patient falls risk discussions in daily ward staff meetings.

The Parliamentary and Health Service Ombudsman (PHSO) undertakes the second stage in the complaints procedure. Complainants may take their case to the PHSO if they consider that attempts at local resolution have failed, and the PHSO will review the case and decide whether to re-investigate. Six cases were accepted

for investigation by the PHSO in 2019/20, compared with three in 2018/19. Two PHSO investigations concluded over the year with a decision to partly uphold the complaint and the Trust implemented action plans to remedy the shortfalls identified by the PHSO. One case was not upheld. The PHSO suspended their casework in mid-March 2020 due to Covid-19, and three cases remain under investigation until such time as their work restarts.

In July 2019 the Trust agreed to be a pilot site for a PHSO Early Dispute Resolution (EDR) process. It was anticipated that the Trust would experience faster case handling times for complaints with the PHSO, and increased complainant satisfaction. The Trust would also be given the opportunity to provide feedback and have the opportunity to inform the process design decisions. EDR involves engagement with a facilitative resolution process in order to discuss and negotiate options to resolve complaints, in place of a full PHSO investigation. Over the year, the PHSO and the Trust have worked collaboratively on three cases. In one case resolution was achieved, with the Trust agreeing to provide financial recompense for the provision of incorrect information about risks associated with Deep Vein Thrombosis. Two further complainants have agreed to EDR conference meetings, but these have been paused due to the Covid-19.

In addition to complaints, the Trust receives and responds to a larger volume of feedback through the Patient Advice and Liaison Service (PALS), encompassing enquiries, comments, concerns, requests for advice and compliments. All cases are recorded on our database apart from straightforward queries such as wayfinding and car parking information. 3980 cases were managed and recorded on the database compared with 3337 in 2018/19, an increase of 19%.

Problems with communication and delayed or cancelled/rescheduled appointments are most commonly identified via PALS feedback.

525 compliments were received by the PALS team in 2019/20, (45% increase from 360 in 2018/19), but this is just a small proportion of the greater number of compliments and expressions of gratitude received directly by ward and clinic staff.

The PALS team aim to resolve 80% of cases within ten working days, and this target was met in 67% of cases in 2019/20.

3.19 Stakeholder engagement

ACTIVE (Children and Young People's Board at CUH)

Active is thriving with children and young person (CYP) engagement, as evidenced by its 39 members (aged 8-18 years) who come from the local community to voice their opinions and work on projects. On average, fifteen young people attend each group meeting and work to progress projects with Children's services staff and partners keen to co-produce with CYP. The group is planned and steered by a team of young people and a CUH co-production leader.

The focus of the group this year was to raise the profile of the group to the wider community and celebrate the achievements of projects. In April, in collaboration with Addenbrooke's Art (AA) we opened our art exhibition near the ATC. For six weeks, a series of images made by CYP of the group and the community entertained and educated staff and patients alike. As a legacy to this temporary

exhibition, AA installed an original Active artwork called 'Hello, my name is….' near paediatric recovery.

In June, CYP the public engaged with the public directly at the CUH recruitment day in the Deakin Centre. They successfully attracted new young members from the community aiming for careers in health. Active also engaged with the public and health care professionals at the NIHR biomedical campus open evening in CRUK in the autumn.

Within the trust, CYP updated the Council of Governors in December and also the Patient Experience working group, ensuring that not only the public but also leadership understand Active's contribution to the Trust. In March, Active was shortlisted for the Patient Experience Network National Awards for engaging and championing the public, with winners yet to be confirmed.

In terms of progressing CYP ideas for improving the care of children around the Trust, Active has been working with staff to improve the D2 garden space. A large focus for the group has been improving care of the bed bound child, focusing on what they see and their patient experience at the bedside. The work to improve transition to adult services continues and leaflets to aid this process have been reviewed and are designed to help teams progress children with chronic conditions on their patient journey to adult care.

Staff regularly consult with the group for assessing improvements in their clinical environments. CYP opinions were sought for the new Emergency Paediatric waiting area and in the Patient Led Assessment of Clinical Environments this year focused on the waiting area looked in the Child Development centre. For the review of written information, CYP have been involved with the leaflet review with a wide range of topics including tissue sampling, and common procedures including undergoing an x-ray, barium meal and a dexa scan. CYP voices have also worked on research design with the NIHR for a study with young people and eating disorders.

Patient experience

The Patient Experience Group, chaired by the Chief Nurse, monitors activities relating to learning from and improving patient experience. The group meets bi-monthly and has governor representation to ensure that the views of members and the public are heard.

Information reviewed by the Group includes complaints, concerns and compliments, the 'Friends and Family Test' survey results, local and national patient survey results, focus group activity, '15 steps' patient experience visits to wards and clinics, patient participation groups and other sources of feedback such as that received by Healthwatch. At each meeting, there is a presentation from one Trust Division highlighting developments, initiatives and good practice relating to patient experience. Reports are also received from operational groups focussed on improving patient experience, including Discharge Assurance, Accessible Information Standard and Dementia. Patient Experience insights are also reviewed at specialty clinical governance meetings, divisional governance meetings and cross-divisional groups such as the Outpatient Governance Board.

Over the year, the volume of complaints received decreased by 7%. This is in contrast to the previous year on year increase of 17%, and is due to significantly

lower numbers of complaints being received in December 2019 and March 2020 (the latter likely to have been affected by the COVID-19 outbreak). Themes identified in complaints, and concerns raised through the Patient Advice and Liaison Service, include shortcomings in communications and issues with appointments. For each case where shortfalls in care are identified, lessons learned and actions taken are identified and taken forward. A new project to monitor the implementation of lessons learned and actions taken from complaints was initiated over the year.

Results of the Friends and Family Test surveys show that the Trust continues to be rated very positively by patients, with most recommend scores showing a small improvement or remaining consistent compared to the previous year. Recommend scores are as follows: inpatient 95.1%, Emergency Department 90.9%, Outpatients 95.3%, Maternity 94.6%.

Response rates to the Friends and Family Test surveys are good across the Trust, and improved significantly in outpatients and day case surgery with the introduction of SMS text messaging survey methodology. Patients in all service areas rate respect for their privacy and dignity highly as well as feeling safe – inpatients scored these areas at 97%.

National survey results for inpatients, cancer, children and young people, maternity and emergency care were available over the year, and action plans are in progress. A local survey was run in outpatients.

Six focus groups supported by the patient experience team have been held during the year, where recent patients/carers are invited to a give their opinions on key issues relating to specific departments or care pathways. Governors are invited to attend to hear the views first hand.

43 '15 steps' visits were made to wards and clinics: verbal feedback is given at the time of the visit to senior staff. Most of the observations made are positive, especially regarding staff being welcoming and cleanliness of the ward and clinic environments. Areas for improvement identified over the year include tidiness and the need for minor refurbishments.

Patient participation groups are active in oncology, maternity and paediatrics, and a group in outpatients was formed over the year. Examples of projects undertaken by these groups include a presentation on 'My Ideal Nurse' from children working with student nurses, working with staff on the refurbishment of the Oncology Outpatients area, and championing direct communication with patients about their consultations - the 'Please Write To me' campaign. .

Work continued to support unpaid 'family' carers, with use of the carers' passport now embedded in the Trust. Carers Champions have been identified, and training delayed by COVID-19 will take place over the coming year. Funding was secured for refreshments for carers who accompany patients unexpectedly admitted to hospital, and for a Carers' resource handbook. The Outpatients Department was assessed by the local carers' support organisation, Caring Together, and received a Carer Friendly award.

In the last year a number of changes have been made to accelerate the use of MyChart the patient portal and enable more patients to use it. Over the year, 27,468 patients activated accounts to access MyChart, resulting in a total of

32,361 patients able to access their record with CUH on line. The results of a patient survey, co-produced with patients, are being used to improve how clinical teams work with patients and the developments we are making to further enhance MyChart at CUH.

Cambridge University Health Partners (CUHP) and Academic Health Science Centre

Cambridge University Health Partners (CUHP) is one of six Academic Health Science Centres in England whose mission is to improve patient healthcare by bringing together the NHS, industry and academia.

The partners are Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and the University of Cambridge.

By inspiring and organising collaboration, CUHP aims to ensure that patients reap the benefits of the world class research, clinical services and industry based in Cambridge and the surrounding area.

For more information on CUHP please see www.cuhp.org.uk.

Consultation with local authorities covering the membership area

The Trust works with a range of local authorities across the region including as a member of Cambridgeshire and Peterborough STP and the Cambridgeshire Health and Well-Being Board.

Education and training

CUH is a teaching hospital for medical undergraduates and postgraduates, nurses and students in other clinical professions. Patient-centred teaching is one of our core activities and is central to our vision. We are the teaching hospital for the University of Cambridge through the School of Clinical Medicine and the Postgraduate Medical Centre which provide the infrastructure and support to facilitate the education, training and continuing development of postgraduate professionals in hospital medicine, general practice and dentistry.

Research and development

CUH works strategically in partnership with other NHS organisations, universities, research councils, research charities and industry to provide an outstanding infrastructure that builds research capacity and supports excellence in clinical research that will benefit patients.

3.20 Trust membership

The membership

The membership of CUH is split into three constituencies: patient, public and staff.

Public Membership

Any person who is sixteen years of age or over and who lives within our membership area is eligible for public membership.

Table 5: The membership area

Braintree District Council	Bumpstead electoral ward
Cambridge City Council	All wards
East Cambridgeshire District Council	All wards
East Hertfordshire District Council	Buntingford; Braughing and Mundens and Cottered electoral wards
North Hertfordshire District Council	Ermine; Royston Palace; Royston Meridian and Royston Heath electoral wards
South Cambridgeshire District Council	All wards
Uttlesford District Council	Ashdon; Clavering; Debden and Wimbish; Littlebury, Chesterford and Wenden Lofts; Newport; Saffron Walden Audley; Saffron Walden Castle; Saffron Walden Shire; The Sampfords; Takeley and Thaxted and the Eastons electoral wards
West Suffolk Council	Clare, Hundon and Kedlington; Exning All Haverhill Wards (West, North, East, South, Central and South East); Newmarket East; Newmarket North; Newmarket West and Withersfield electoral wards

Patient membership

Any individual who has been a patient at any of the Trust's hospitals from 5 July 1948, or who has been a carer of a patient who meets that criterion, is eligible for patient membership, regardless of where they live, as long as they are aged sixteen years or over.

Staff membership

All staff at CUH with contracts of employment at least twelve months, or contracts with no fixed term, are automatically members unless they choose to opt out. Registered volunteers are also automatically members of the staff constituency. The Trust greatly values the contribution employees of other companies on campus make to the organisation and for this reason staff membership includes

on application all employees of companies based on the campus who provide services to CUH.

Membership numbers

At 31 March 2020 there were 19,555 members (2019: 19,813); patients 4,122 (2019: 4,253); public 4,877 (2019: 4,956) and staff 10,556 (2019: 10,604).

Membership strategy

The current membership strategy was approved by the Council of Governors in September 2016. The revision sets out our vision for a representative, active and engaged membership, grouped around five key areas:

1. Maintaining and continuing to build a representative membership of our constituencies
2. Ensuring members are informed and that their views are valued and listened to
3. Increasing the proportion of total membership who wish to be more actively involved and promote more effective, more modern and more timely communication with members
4. Ensuring a high level of interest/participation and attracting high quality candidates for the annual governor elections
5. Aligning engagement activities with other local health bodies and campus partners to have a constituent-centred approach

3.21 Council of Governors

The Council of Governors is composed of 19 elected governors (eight patient, seven public and four staff) and ten partnership governors. The council is chaired by the Trust chair.

Dr Julia Loudon is the Lead Governor, and was elected from 1 July 2016 for a two year term. In March 2018 Julia Loudon was re-elected for a further term of two years from 1 July 2018 to 30 June 2020.

David Dean is the Deputy Lead Governor, and was elected from 1 December 2017 for a two-year term. David Dean was re-elected for a further term of two years from 1 December 2019 to 30 November 2021.

Patient governors

Table 6

The table below shows patient governors, representing and elected by the patient members of Cambridge University Hospitals NHS Foundation Trust.

Miss Ruth Greene	Re-elected in 2019 for a second three-year term.
Dr Jeremy Griggs	Elected for a one year term in 2019.
Dr Julia Loudon	Re-elected in 2018 for a second three-year term.
Mr Harry Richardson	Elected in 2016 for a first three-year term. Did not stand for re-election in 2019, and retired from the Council of Governors in June 2019.
Dr Colin Roberts	Elected in 2018 for a first three-year term.
Dr Howard Sherriff	Elected in 2019 for a first three-year term.
Dr Neil Stutchbury	Elected in 2017 for a first three-year term.
Mrs Adele White	Elected in 2018 for a first three-year term.
Mr Simon Whitworth	Elected for a one year term in 2019.

Public governors

Table 7

The table below shows public governors, representing and elected by the public members of Cambridge University Hospitals NHS Foundation Trust.

Dr Jane Biddle	Elected in 2017 for a first three-year term.
Mrs Dawn Chapman OBE	Re-elected in 2018 for a second three-year term.
Mr David Dean	Elected in 2017 for a first three-year term.

Mr Roberto Gherseni	Elected in 2018 for a two-year term. Resigned in March 2020. The vacancy arising from the resignation will be filled at the next scheduled election to the Council of Governors.
Mr Graham Green	Elected in 2019 for a two-year term.
Ms Melisa Lee	Elected in 2019 for a first three-year term.
Mrs Wendy Menon	Re-elected in 2016 for a third three-year term. Wendy was not eligible to stand for re-election so retired from the Council of Governors in June 2019.
Ms Anna Miller	Elected in 2018 for a first three-year term.

Staff governors

Table 8
The table below shows staff governors, representing and elected by the staff members of Cambridge University Hospitals NHS Foundation Trust.

Mr Bill Davidson	Elected in 2019 for a first three-year term.
Dr Deepa Krishnakumar	Elected in 2018 for a first three-year term.
Mrs Hannah Jackson	Elected in 2018 for a first three-year term.
Dr Patricia Set	Elected in 2017 for a first three-year term.
Mr Andi Thornton	Elected in 2017 for a first two-year term. Did not stand for re-election in 2019, and retired from the Council of Governors in June 2019.

Governor elections 2019 and 2020

In 2019, three patient governors, two public governors and one staff governor were elected by members of the foundation trust. These elections were 'first past the post' and Electoral Reform Services acted as returning officer and independent scrutineer.

Due to the COVID-19 pandemic, on 26 March 2020 the Board of Directors following consultation with the Council of Governors suspended the scheduled 2020 governor elections for a period of up to 12 months. The Board of Directors also authorised the extension of the terms of office for elected Governors whose terms of office were due to expire 30 June 2020 until the rescheduled elections occur.

Table 9
Governor Election Turnout by constituency 2018 and 2019

Constituency	2018	2019
Patient Constituency	25.1%	25.7%
Public Constituency	21.7%	22.9%
Staff Constituency	27.0%	21.9%

Partnership governors

Table 10

Partnership governors, representing and appointed by external organisations to the Council of Governors are shown in the table below.

Anglia Ruskin University	Professor Ruth Taylor	Appointed in July 2014 for a first three-year term and re-appointed in 2017. Ruth resigned in June 2019.
Anglia Ruskin University	Dr Annette Thomas-Gregory	Appointed in June 2019 for a first three-year term.
Cambridge Biomedical Campus Research Organisations	Mr Simon Chaplin	Appointed by Wellcome Trust to represent research organisations on the biomedical campus site in November 2018 for a three-year term to replace John Wells
Cambridge City Council	Cllr Nicky Massey	Appointed by Cambridge City Council in June 2018.
Cambridgeshire and Peterborough Clinical Commissioning Group	Ms Jessica Bawden	Appointed in June 2017 for a first three-year term.
Cambridgeshire and Peterborough NHS Foundation Trust	Mr Stephen Legood	Appointed in February 2015 for three years to represent Cambridgeshire and Peterborough NHS Foundation Trust. Reappointed in 2018
Cambridgeshire County Council	Cllr Mark Howell	Appointed by Cambridgeshire County Council in June 2017 for the life of the Council (May 2021).
Cambridgeshire County Council (Public Health)	Dr Laurence Gibson	Appointed by Cambridgeshire County Council in May 2019. Resigned in March 2020. The role is currently vacant.
Royal Papworth Hospital NHS Foundation Trust	Ms Josie Rudman	Appointed as partnership governor in

		October 2017 for a first three year term to represent Royal Papworth Hospital NHS Foundation Trust.
University of Cambridge	Professor Peter St George-Hyslop	Appointed as partnership governor in July 2018 for a first three year term to represent University of Cambridge.
University of Cambridge	Professor Fiona Karet	Appointed as partnership governor in June 2017 for a first three year term to represent University of Cambridge. Resigned from the Council of Governors in June 2019.
University of Cambridge	Professor John Clarkson	Appointed as partnership governor in September 2019 for a first three year term to represent University of Cambridge.

Register of governors' interests

At the time of their appointment, all Governors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an on-going basis.

The register is available online at https://cuh.mydeclarations.co.uk/ .The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs.

Governor expenses

Governors participating in events such as council meetings whose expenses are not paid by another organisation are entitled to claim reasonable expenses. Expenses are reimbursed at rates agreed by the Council of Governors, which has adopted HMRC approved amounts. Expenses to be reimbursed include:

Travel by car, motor cycle or bicycle; public transport on a like for like basis on provision of a receipt; receipted costs for caring arrangements at previously agreed rates of up to £10 per hour; expenses for a companion required to enable the individual to participate and costs for interpretation. Governor expenses are reported in the remuneration report, 3.22. The full policy is available from the Director of Corporate Affairs, address as above.

Table 11 : Attendance at Council of Governors' meetings 2019/20

Name	Title	Attendance
Dr Michael More	Trust Chair	7/7
Ms Jessica Bawden	Partnership Governor	6/7
Dr Jane Biddle	Public Governor	5/7
Mr Simon Chaplin	Partnership Governor	2/7
Mrs Dawn Chapman	Public Governor	7/7
Prof John Clarkson	Partnership Governor	5/5
Mr Bill Davidson	Staff Governor	5/5
Mr David Dean	Public Governor	5/7
Mr Roberto Gherseni	Public Governor	0/6
Dr Laurence Gibson	Partnership Governor	2/6
Mr Graham Green	Public Governor	7/7
Ms Ruth Greene	Patient Governor	6/7
Dr Jeremy Griggs	Patient Governor	5/7
Cllr Mark Howell	Partnership Governor	7/7
Mrs Hannah Jackson	Staff Governor	5/7
Dr Deepa Krishnakumar	Staff Governor	5/7
Ms Melissa Lee	Public Governor	5/5
Mr Stephen Legood	Partnership Governor	0/7
Dr Julia Loudon	Patient Governor	7/7
Cllr Nicky Massey	Partnership Governor	2/7
Mrs Wendy Menon	Public Governor	2/2
Ms Anna Miller	Public Governor	5/7
Mr Harry Richardson	Patient Governor	2/2
Dr Colin Roberts	Patient Governor	5/7
Ms Josie Rudman	Partnership Governor	2/7
Dr Patricia Set	Staff Governor	2/7
Dr Howard Sherriff	Patient Governor	5/5
Professor Peter St George Hyslop	Partnership Governor	3/7
Dr Neil Stutchbury	Patient Governor	7/7
Dr Annette Thomas-Gregory	Partnership Governor	7/7
Mr Andi Thornton	Staff Governor	0/2
Mrs Adele White	Patient Governor	7/7
Mr Simon Whitworth	Patient Governor	3/7

There were seven meetings of the Council of Governors during 2019/20, three public, three confidential and one teleconference meeting. The Chief Executive, Non-Executive Directors and Executive Directors also attended.

Governor activities

All governors and directors are invited to attend the two Governor/Director Working Groups on Scrutiny and Performance and Communications and Engagement which meet quarterly. The groups continue to ensure that the views of members, patients and the wider local community are brought directly to the directors, and also to ensure that governors are up-to-date on key issues of concern and interest.

Governor access to papers is via a secure portal. Governors are provided regularly with, Trust news, wider NHS news, relevant national policy initiatives and press coverage information.

As part of the code of conduct, all governors on appointment/election are expected to sign up to the fact that they have read and will abide by our policy for governor communication with members and the public. The emphasis is, as always, on encouraging interaction, listening and capturing views, speaking on behalf of members and thereby being able to influence opinions and decisions before feeding-back to members and the public.

To aid this two-way communication process, governors attend community groups in the local area on request to speak on issues of interest or concern. They 'host' focus groups led by the patient experience team which gives them an opportunity to hear patient views on certain key issues. Many governors and members use PLACE visits (Patient-Led Assessments of the Care Environment) to talk personally to patients/visitors and inspect the care surroundings. Similarly, the 'Fifteen Steps' initiative is used to enable governors to be involved first-hand in the patients' experience of first entering a ward area. The governors and the membership office have dedicated mailboxes to allow members/public to contact governors directly. Governors also continue to host the 'Medicine for Members' lecture series.

The Annual Public Meeting took place in September 2019 and carried the theme of "Digital health". The first part of the evening was devoted to the presentation of the annual report and accounts; and provided attendees with a review of 2018/19 with an update on current and future developments. The second part of the evening was dedicated to a wide ranging discussion on digital health.

Representative of Governors attended the annual NHS Providers' conference in order to network with governors from other trusts and to share good practice.

The Lead Governor attends and reports to all Board meetings. Governors meet informally with Non-Executive Directors on a quarterly basis to discuss Trust issues, priorities and developments as they arise. They also attend Board Sub committees in an observer capacity. These interactions assist them in fulfilling their duty to hold the non-executive directors to account. Governors are also actively involved in the development of the annual plan and the Trust's Quality Account.

3.22 Remuneration report

Annual statement on remuneration

In 2019/20, the Board of Directors' Remuneration and Nomination Committee maintained its overview of Executive Directors' salaries, following the principles established for Executive and senior salaries in 2015/16 (from the external review commissioned in that year).

Senior managers' remuneration policy

CUH is aware of public attention given to the levels of remuneration of senior managers within the NHS. CUH has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

To determine Board of Director level salaries, the Remuneration and Nomination Committee may use one or more of the following:

- Benchmarking data surveyed confidentially among CUH's peer group.
- NHS Employers' annual salary survey of NHS Chief Executives and Executive Directors.
- IDS NHS Boardroom pay report and other benchmark information.
- NHS and other relevant advertised jobs databases.
- The prevailing market position, including the ability to recruit and retain individuals.

Any amendments to salary are decided by the Remuneration and Nomination Committee on the basis of the size and complexity of the job portfolio. Annual salary is inclusive of other payments such as bonus, overtime, long hours, on-call, standby, etc. Additional payments do not feature in Executive Directors' remuneration. The Trust has no plans to introduce performance related pay. The salaries of the Medical Director and the Director of Improvement and Transformation are in accordance with the terms and conditions of service of the consultant contract 2003 plus a responsibility allowance determined by the Committee payable for the duration of office.

Chief Executive and Executive Director performance is measured against objectives set at the beginning of the financial year and agreed by the Remuneration and Nomination Committee.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the 'Agenda for Change: NHS terms and conditions of service' handbook (section 16); or, for those above the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Pay awards agreed nationally for other staff groups working at CUH, including staff on Agenda for Change contracts and medical and dental staff, are determined by the Department of Health and Social Care/NHS Pay Review Body, which looks at salaries and pay conditions across the NHS.

Duration of contracts, notice periods and termination payments

Table 12: Executive Director contractual terms

Executive Director	Date in post	Unexpired term	Notice
Chief Executive	16.11.15	Permanent	Six months
Chief Finance Officer	02.10.17	Permanent	Six months
Chief Nurse	23.07.18	Permanent	Six months
Director of Corporate Affairs	15.05.17	Permanent	Six months

Director of Improvement and Transformation	01.02.18	Permanent	Six months
Director of Strategy and Major Projects	26.03.18	Permanent	Six months
Director of Workforce	01.04.14	Permanent	Six months
Medical Director	01.11.17	4 years	Six months

Remuneration and Nomination Committee of the Board of Directors

Membership of the committee comprises Non-Executive Directors and the Chair with the Chief Executive in attendance. The Director of Workforce and Director of Corporate Affairs also attend meetings of the committee where appropriate.

The Committee met three times during 2019/20. The Committee was chaired by Shirley Pointer, Non-Executive Director and Senior Independent Director. A summary of attendance at the committee is included in table 4 in section 3.10.

The role of the Committee is to:

- To act under the delegated authority of the Board of Directors to approve and oversee the arrangements for the appointment, termination and remuneration of the Chief Executive and all Executive Directors. In addition, the Committee will be responsible for agreeing the remuneration for any other posts with remuneration outside the Agenda for Change pay framework.

Statement of directors' remuneration - Subject to Audit

The Trust's Remuneration and Nomination Committee oversees pay arrangements for posts whose salary is not determined through national term and conditions. This includes but is not limited to the Executive Directors of the Trust (both voting and non-voting executive Board members). The Committee is mindful of discharging its obligations in respect of salaries above £150,000. This salary is updated as set out in the guidance from NHSI, updated in March 2018. It considers each new post and the process to be followed on an individual basis. The Governors' Nomination and Remuneration Committee establishes remuneration for the Trust Chair and Non-Executive Directors.

Fair pay multiple - Subject to Audit

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Executive Director in Cambridge University Hospitals NHS Foundation Trust in the financial year 2019/20 was £265,000 to £270,000. This was 8.68 times (year ended 31 March 2019, 8.87 times) the median remuneration of the workforce, which was £30,812 (year ended 31 March 2019, £29,608).

Table 13: Statement of remuneration 2019/20 - Subject to Audit

Name of senior manager	2019/20 Salary & fees (in bands of £5k) £000s (Band of £5k)	2019/20 All taxable benefits (total to the nearest £100) £s (nearest £100)	2019/20 Annual performance related bonuses £000s (Band of £5k)	2019/20 Long-term performance related bonuses £000s (Band of £5k)	2019/20 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2019/20 Other (total to the nearest £5k) £s to nearest £5k	2019/20 Total (bands of £5k) £000s (Band of £5k)
Nicola Ayton, Director of Strategy and Major Projects	150-155	-	-	-	55-57.5	-	205-210
Ewen Cameron, Director of Improvement and Transformation*	50-55	-	-	-	195-197.5	150-155	400-405
Sam Higginson, Chief Operating Officer until 20 October 2019	90-95	-	-	-	107.5-110	-	200-205
Paul Scott, Chief Finance Officer	175-180	-	-	-	-	-	175-180
Ashley Shaw, Medical Director*	75-80	-	-	-	285-287.5	170-175	535-540
Roland Sinker, Chief Executive	265-270	11,000	-	-	100-102.5	-	380-385

Name of senior manager	2019/20 Salary & fees (in bands of £5k) £000s (Band of £5k)	2019/20 All taxable benefits (total to the nearest £100) £s (nearest £100)	2019/20 Annual performance related bonuses £000s (Band of £5k)	2019/20 Long-term performance related bonuses £000s (Band of £5k)	2019/20 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2019/20 Other (total to the nearest £5k) £s to nearest £5k	2019/20 Total (bands of £5k) £000s (Band of £5k)
Lorraine Szeremeta, Chief Nurse	155-160	-	-	-	135-137.5	-	290-295
Ian Walker, Director of Corporate Affairs	135-140	-	-	-	50-52.5	-	185-190
David Wherrett, Director or Workforce	125-130	-	-	-	(47.5-50)	-	75-80
Daniel Abrams, NED	15-20	-	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Annette Doherty, NED	0	1,600	-	-	-	-	0-5
Michael More, Chair	55-60	-	-	-	-	-	55-60
Michael Knapton, NED	10-15	-	-	-	-	-	10-15
Patrick Maxwell, NED**	10-15	-	-	-	-	-	10-15
Sharon Peacock, NED	10-15	-	-	-	-	-	10-15

Name of senior manager	2019/20 Salary & fees (in bands of £5k) £000s (Band of £5k)	2019/20 All taxable benefits (total to the nearest £100) £s (nearest £100)	2019/20 Annual performance related bonuses £000s (Band of £5k)	2019/20 Long-term performance related bonuses £000s (Band of £5k)	2019/20 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2019/20 Other (total to the nearest £5k) £s to nearest £5k	2019/20 Total (bands of £5k) £000s (Band of £5k)
Shirley Pointer, NED	10-15	1,000	-	-	-	-	15-20
Doris Olulode, NED	5-10	-	-	-	-	-	5-10

*Other remuneration for two Directors relates to their pay in respect of clinical duties.

** Professor Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2019/20 to the University of Cambridge in recognition of his time spent undertaking duties as a Non-Executive Director.

Table 14: Statement of remuneration 2018/19 - Subject to Audit

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
Nicola Ayton, Director of Strategy and Major Projects	140-145	-	-	-	55-57.5	-	195-200
Ewen Cameron, Director of Improvement and Transformation*	50-55	-	-	-	12.5-15	150-155	220-225
Sam Higginson, Chief Operating Officer	170-175	-	-	-	275-277.5	-	450-455
Ann-Marie Ingle, Chief Nurse until 22 July 2019	60-65	-	-	-	17.5-20	-	80-85
Paul Scott, Chief Finance Officer	170-175	-	-	-	-	-	170-175
Ashley Shaw, Medical Director*	70-75	-	-	-	(47.5-50)	170-175	190-195

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
Roland Sinker, Chief Executive	265-270	3,200	-	-	87.5-90	-	355-360
Lorraine Szeremeta, Chief Nurse from 23 July 2019	100-105	-	-	-	232.5-235	-	335-340
Ian Walker, Director of Corporate Affairs	130-135	-	-	-	115-117.5	-	245-250
David Wherrett, Director of Workforce	135-140	-	-	-	(42.5-45)	-	90-95
Daniel Abrams, NED	15-20	1,300	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Annette Doherty, NED	0	1,000	-	-	-	-	0-5
Michael More, Chair	55-60	-	-	-	-	-	55-60
Michael Knapton, NED	10-15	-	-	-	-	-	10-15

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
Patrick Maxwell, NED**	10-15	-	-	-	-	-	10-15
Sharon Peacock, NED	10-15	-	-	-	-	-	10-15
Shirley Pointer, NED	10-15	1,600	-	-	-	-	15-20

*Other remuneration for two Directors relates to their pay in respect of clinical duties.

** Professor Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2018/19 to the University of Cambridge in recognition of his time spent undertaking duties as a Non-Executive Director.

Statement of directors' and governors' expenses

Directors and governors are reimbursed for expenses incurred on Trust business in accordance with agreed Trust policies. Where applicable, these are subject to income tax and national insurance in accordance with HMRC legislation and guidance.

Table 15: Governors' expenses

Name	Mileage (Car/Cycle)	Rail/bus Travel	Taxis	Hotel Accom.	Meals/Subsistence and parking	Conference fees	Other	Total 2019/20	Total 2018/19
Jessica Bawden	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£25.00	£25.00	£0.00
Jane Biddle	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Simon Chaplin	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Dawn Chapman	£259.20	£0.00	£0.00	£0.00	£3.00	£0.00	£0.00	£262.20	£313.45
John Clarkson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£23.00	£0.00	N/A
Bill Davidson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
David Dean	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Roberto Gherseni	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Laurence Gibson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Graham Green	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Ruth Greene	£79.20	£0.00	£79.10	£0.00	£107.80	£0.00	£0.00	£266.10	£0.00
Jeremy Griggs	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£25.00	£25.00	N/A
Mark Howell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Hannah Jackson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Fred Jacobsberg	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Fiona Karet	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Deepa Krishnakumar	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Melissa Lee	£4.50	£0.00	£0.00	£0.00	£6.00	£0.00	£220.00	£230.50	N/A
Stephen Legood	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Andrew Lever	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Julia Loudon	£818.55	£32.90	£0.00	£0.00	£125.00	£0.00	£0.00	£976.45	£1,457.00
Jan Lupton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£235.30
Nicola Massey	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Wendy Menon	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Anna Miller	£130.50	£0.00	£0.00	£0.00	£163.30	£0.00	£0.00	£293.80	£86.30

Laura Minter	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£490.05
Fraz Mir	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Harry Richardson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Colin Roberts	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Josie Rudman	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Patricia Set	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Howard Sherriff	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Patrick Smith	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Peter St George-Hyslop	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Chris Stanley	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Neil Stutchbury	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£25.00
Ruth Taylor	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Thomas-Gregory	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Andi Thornton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
John Wells	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Adele White	£229.50	£0.00	£0.00	£0.00	£14.60	£0.00	£0.00	£244.10	£467.30
Simon Whitworth	£113.40	£0.00	£0.00	£0.00	£19.00	£0.00	£25.00	£157.40	N/A
Lorne Williamson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Totals	**£1,634.85**	**£32.90**	**£79.10**	**£0.00**	**£438.70**	**£0.00**	**£318.00**	**£2,480.55**	**£3,074.40**

Table 16: Directors' expenses

	2019/2020										2018/2019
	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels	Meals and Parking	Air Travel	Conference fees	Other	Total	Total
Daniel Abrams	£543.20	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£543.20	£1,275.89
Nicola Ayton	N/A	£0.00	£250.30	£12.60	£0.00	£0.00	£0.00	£0.00	£0.00	£262.90	£436.22
Ewen Cameron	N/A	£0.00	£188.15	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£269.75
Adrian Chamberlain	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Doherty	£1163.20	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1163.20	£1,360.60
Sam Higginson	N/A	£0.00	£171.30	£22.00	£0.00	£0.00	£0.00	£0.00	£0.00	£193.30	£415.30
Ann-Marie Ingle	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£375.60
Michael Knapton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Patrick Maxwell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael More	£0.00	£164.30	£0.00	£32.74	£0.00	£0.00	£0.00	£0.00	£0.00	£197.04	£356.18
Sharon Peacock	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Shirley Pointer	£997.02	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£997.02	£1,582.00
Doris Olulode	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Paul Scott	N/A	£519.83	£805.45	£0.00	£397.50	£22.00	£0.00	£0.00	£0.00	£1744.78	£1,155.70
Ashley Shaw	N/A	£178.49	£473.90	£0.00	£0.00	£18.00	£0.00	£0.00	£0.00	£670.39	£725.50
Roland Sinker	N/A	£0.00	£391.10	£223.61	£0.00	£41.44	£0.00	£0.00	£0.00	£656.15	£332.30
Lorraine Szeremeta	N/A	£0.00	£469.30	£0.00	£0.00	£5.70	£0.00	£0.00	£0.00	£475.00	£1,332.26
Ian Walker	N/A	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Wherrett	N/A	£8.90	£588.40	£13.40	£0.00	£11.95	£0.00	£0.00	£0.00	£622.65	£447.53

Notes

1. Non-Executive Directors may claim for home based to Trust travel costs and if claimed are taxable benefits. Non-home base to Trust travel costs are not classed as taxable benefits.
2. Executive Directors may not claim for home to Trust travel costs.

Table 17: Pension benefit 2019/20

Name and title	Real increase / (decrease) in pension at pension age (bands of £2,500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2019 £000	Real increase / (decrease) in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2020 £000	Employer's contribution to stakeholder pension £000
Nicola Ayton Director of Strategy and Major Projects	2.5-5	0	10-15	0	73	25	100	0
Dr Ewen Cameron Director of Improvement and Transformation	7.5-10	17.5-20	45-50	100-105	612	170	797	0
Sam Higginson Chief Operating Officer unitil 20 October 2019	5-7.5	0	30-35	0	340	(191)	157	0
Paul Scott Chief Finance Officer	0	0	0	0	0	0	0	0
Dr Ashley Shaw Medical Director	12.5-15	32.5-35	45-50	120-125	587	234	835	0
Roland Sinker Chief Executive	5-7.5	0	50-55	0	557	74	645	0
Lorraine Szeremeta Chief Nurse	5-7.5	7.5-10	50-55	115-120	717	112	846	0
Ian Walker	2.5-5	(0-2.5)	25-30	45-50	398	40	448	0

Director of Corporate Affairs								
David Wherrett Director of Workforce	(0-2.5)	(12.5-15)	50-55	115-120	1040	(35)	1030	0

*The 2018-19 comparative figures for Sam Higginson have been restated due to corrections made on the opening data as provided by the NHS Pension Agency.

2018/19

Name and title	**Real increase / (decrease) in pension at pension age (bands of £2,500) £000**	**Real increase / (decrease) 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 1 April 2018 £000**	**Real increase / (decrease) in cash equivalent transfer value £000**	**Cash equivalent transfer value at 31 March 2019 £000**	**Employer's contribution to stakeholder pension £000**
Nicola Ayton Director of Strategy and Major Projects	2.5-5	0	5-10	0	39	32	73	0
Dr Ewen Cameron Director of Improvement and Transformation	0-2.5	(2.5-5)	35-40	75-80	521	76	612	0
Sam Higginson Chief Operating Officer	12.5-15	0	25-30	0	256	216	340	0
Paul Scott Chief Finance Officer	0	0	0	0	0	0	0	0

Dr Ashley Shaw Medical Director	(0-2.5)	(5-7.5)	30-35	85-90	529	58	587	0
Roland Sinker Chief Executive	2.5-5	0	40-45	0	421	124	557	0
Ann-Marie Ingle Chief Nurse until 22 July 2018	0-2.5	(2.5-5)	45-50	115-120	823	97	945	0
Lorraine Szeremeta Chief Nurse from 23 July 2018	10-12.5	22.5-25	40-45	100-105	463	240	717	0
Ian Walker Director of Corporate Affairs	5-7.5	2.5-5	20-25	40-45	275	115	398	0
David Wherrett Director of Workforce	(0-2.5)	(10-12.5)	50-55	125-130	951	61	1040	0

The disclosure for Ashley Shaw has been restated due to his re-joining to the pension scheme in July 2019

These pension disclosures relate to directors who were members of the NHS Pension Scheme during the financial year. The figures represent estimates by the NHS Pensions Agency of the theoretical value of each director's pension "fund" at the start and end of the financial year. The difference between these two values is taken to represent the director's pension benefits for the year. Any benefits earned in this way remain in the pension scheme until the director retires in accordance with the rules of the NHS Pension Scheme. These rules are the same for both directors and staff.

Roland Sinker
Chief Executive
23 June 2020

3.23 Staff report

Staff numbers

As of 31 March 2020 the Trust had 17 directors (eleven male and six female) and 11,050 employees (2,931 male and 8,119 female).

Table 18: Staff numbers

Average number of employees (WTE basis)	2019/20 Total Number	2019/20 Permanent Number	2019/20 Other Number	2018/19 Total Number	2018/19 Permanent Number	2018/19 Other Number
Medical and dental	1,428	598	830	1383	566	817
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,440	2,158	282	2,343	2,096	247
Healthcare assistants and other support staff	1,969	1,614	355	1,901	1,487	414
Nursing, midwifery and health visiting staff	3,556	3,198	358	3,393	2,963	430
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	830	735	95	771	685	86
Healthcare science staff	550	518	32	541	503	38
Social care staff	0	0	0	0	0	0
Agency and contract staff	0	0	0	0	0	0
Bank staff	0	0	0	0	0	0

Average number of employees (WTE basis)	2019/20 Total Number	2019/20 Permanent Number	2019/20 Other Number	2018/19 Total Number	2018/19 Permanent Number	2018/19 Other Number
Other	4	0.0	4	0	0	0
Total average numbers	**10,777**	**8,821**	**1,956**	**10,332**	**8,300**	**2,032**

Recruitment and retention

To support our recruitment and retention strategy the following is in place:

- Work/life balance schemes to offer opportunities for part time hours and flexible working along with comprehensive childcare facilities (two on-site nurseries and access to a local discounted holiday play scheme)
- 'Advantage' salary sacrifice scheme offering a wide range of options for staff to make tax and NI savings.
- Annual leave purchase scheme
- Eldercare/family support schemes
- NHS pension scheme
- A range of on-site facilities – leisure and social centre (Frank Lee Centre)
- Comprehensive range of staff engagement surveys and many joint working initiatives with staff and trade unions
- Occupational health service including Health Assured counselling service and a range of health and well-being initiatives
- Onsite shopping and eating services
- Range of leadership and employee development opportunities along with continuous professional development
- Relocation assistance to provide financial support for nurses who move home to work at CUH
- Employee referral scheme which offers a monetary incentive for employees to refer potential nursing candidates who are successfully employed by CUH
- Exit questionnaire in which leavers are contacted and given the opportunity to feed back so that we can improve our employees' experience at work
- Deposit loan scheme of up to £3,000 of all staff Bands 1 – 6 to cover the first month's rent and deposit for a new property, open to both starters and existing staff

Our role as a local employer

CUH is an important local employer and is constantly seeking ways to develop its role and to work with the local community to develop pathways into employment for disadvantaged groups. We offer a range of schemes: work experience, traineeships, voluntary worker schemes, apprenticeships and work with the long-term unemployed including the Prince's Trust. We continue to provide a comprehensive apprenticeship scheme and are committed to maintaining this.

Information about staff sickness

The information in the table below is compiled on a calendar year basis according to national requirements.

Table 19: Staff sickness

	2019/20	2018/19
Total days lost	81,872	69,281
Total staff years	10,004	9,440
Average working days lost per WTE	8.2	7.3

Equality and diversity

The Trust uses the NHS equality delivery system (EDS2) as a tool to use as evidence of compliance with the public sector equality duty (PSED) to engage with the public and staff and agree equality objectives. The Trust's EDS equality improvement plan 2018/19 was based on feedback from an EDS equality and engagement rating event and focussed on these areas:

- Better health outcomes for all
- Improve transition care between services for both admission and discharge of those patients with special complex needs
- Improvement of data collection in referral information to highlight special needs of patients by protected characteristic to ensure reasonable adjustments can be made
- Fully embed the Accessible Information Standard since implementation in 2016
- Improved patient access and experience
- Improve equality monitoring collection of patients' complaints and patient survey data recorded by protected characteristic to identify areas to improve the patients' experience
- Accessible premises and services
- Empowered, engaged and well-supported staff
- Fair recruitment and selection processes lead to a more representative workforce at all levels in the organisation
- Training and development opportunities are taken up and positively evaluated by all staff
- When at work staff are free from abuse, harassment bullying and violence from any source
- Staff report positive experiences of their membership of the workforce
- Workforce Race Equality Standard implementation
- Inclusive leadership at all levels of the organisation
- Board and senior leaders routinely demonstrate their commitment to promoting equality within and beyond the organisation
- Middle managers and line managers support staff to work in culturally competent ways within a work environment free from discrimination

Our patient profile and workforce equality monitoring reports are published on our public website equality and diversity pages.

https://www.cuh.nhs.uk/about-us/our-responsibilities/equality-and-diversity/workforce-equality-monitoring-information

Our fifth Workforce Race Equality Standard reporting template and action plan, which is coproduced with BAME staff and directors was approved by the Board in September 2019 and is published on the Trust public website.

Our third Gender Pay Gap report with narrative and action plan was approved by the Management Executive and published on our website on 29 March 2020.

The Trust is not only committed to fulfilling its legislative requirements but to go beyond what is legally required and to be an exemplar of best practice.

Further information on equality and diversity issues are included in section 3.28.

Disabled employees

In September 2019 the Trust published our first NHS Workforce disability equality standard (WDES) set of metrics and WDES action plan, which was co-created with disabled staff as a result of a disabled staff engagement event in June 2019, which was facilitated by Purple Space. The WDES action plan is approved by the Trust Board and published on the Trust's website. The WDES implementation group will be set up in 2020 to provide governance and oversee the WDES action plan progress.

The Trust is a 'Disability Confident employer and is a signatory of the 'Mindful Employer Charter' for 'Employers who are Positive about Mental Health'. The Trust's Equality Diversity and Inclusion in employment policy is applied and in addition, all workforce policies include an equality and diversity statement which sets out the Trust position and intent.

'Cambridge University Hospitals NHS Foundation Trust is committed to a policy of equal opportunities in employment. The aim of this procedure is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This procedure concerns all aspects of employment for existing staff and potential employees.'

Consulting staff and representatives on matters of concern and the performance of the organisation

The Trust works in partnership with staff side representatives through a number of mechanisms on matters of concern to staff and the performance of the organisation. In addition the Trust follows a communication strategy to update and consult employees with relevant information. The following points provide examples of some of the actions taken by the Trust to keep the employees updated and provide opportunities for staff to raise their views and concerns:

- CUH Daily is a daily email update that is sent to all employees regarding topical issues, events and any other information that the employees need to be aware of.
- 8:27 is a weekly Tuesday meeting which provides an opportunity for staff to hear the latest developments within the Trust and speak with the chief executive and senior management team about progress on key issues. It is an open invitation to all staff to participate in the forum.
- A new monthly Core Brief cascade briefing system was introduced during the year.
- Management Staff Forum is the formal body for Trust-wide consultation which meets approximately every six weeks. The Forum includes the Trust recognised senior management and staff representatives who come from the unions. These two groups come together in the Forum to foster good employee relationships which then in turn benefit patient services.
- Weekly media update which is a summary of articles mentioning Cambridge University Hospitals in the media.
- Connect the Trust's internal intranet site has a communication hub where information is held that has been communicated across the Trust via internal communications channels.
- Employees can also share their views in Share Your Views online forum which provides a platform for them to raise any concerns or views.

Health and safety

2019/20 marked the final year of the Trust's four year health and safety strategy – 'Safe people, places and processes' (2016). Significant improvements have been made over the last four years in relation to the management of health and safety at the Trust. The Year 1 saw the service focus on re-laying the foundations for the management of health and safety at CUH. Year 2 saw the service take a more systematic and proactive approach to improving health and safety with the launch of its health and safety risk assessment programme. Year 3 focused on providing evidence-based assurance on the management of health and safety with the development of CUH's H&S assurance model, risk profiling and extensive audit programme. During 19/20, year 4, the service acted on what it had learnt from its assurance processes to achieve continual improvement in H&S management and performance.

Looking ahead, The Trust will remain firm in a strong commitment to provide safe services and safe arrangements for all staff by establishing and maintaining a robust H&S management system in line with the H&S policy. This includes striving for continual improvement in safety performance, always aiming to increase staff engagement and promote the safe behaviours expected from staff and others.

Occupational health and wellbeing

Occupational Health and Wellbeing is the Trust's in-house service, providing a full range of services to CUH staff, Royal Papworth Hospital NHS Foundation Trust, West Suffolk Hospital NHS Foundation Trust as well as other organisations in the local area. The service works closely with local public health and wellbeing

services to provide staff with access to a range of support and guidance on workplace health protection.

We work collaboratively seeking opportunities to as effective and efficient as we can be. We actively contribute to supporting a culture of workforce health and contribute to regional and national guidance and developments in this area. We are committed to consistently deliver on our vision of being a specialist clinical, trusted and responsive service.

The service continues to meet the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation quality standards.

We have again this year achieved the staff flu vaccination target with 75.8% of CUH frontline staff receiving their vaccination.

Counter fraud

CUH has taken all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and has a named individual nominated to provide the lead local counter fraud specialist function, who is an accredited counter fraud specialist. When that specialist is absent, arrangements have been made to ensure that specialist assistance is available.

Under the NHS Standard Contract for 2019-2020, all organisations providing NHS services (providers) must put in place and maintain appropriate anti-crime arrangements. CUH fully complies with this requirement.

Standards of business conduct and the Bribery Act

The Bribery Act 2010 has been in force since July 2011. This act creates the offences of offering, promising or giving a bribe, requesting, agreeing to receive or accepting a bribe, bribing a foreign public official and the corporate offence of failing to prevent bribery. We have a clear policy, which includes our zero-tolerance approach to bribery. Our stance is equally strong and clear in relation to those associated with or contracting with the Trust, and we avoid doing business with any individuals and organisations who fail to demonstrate their commitment to operate fairly, openly and honestly. Doing business transparently and preventing bribery is important in safeguarding the proper use of public money and resources, and a clear stance also provides patients, other customers, potential contractors and business partners as well as our governors and members with confidence that we will act in a transparent and fair way. This in turn protects our trusted position within our community and our reputation as a leading national and international centre for specialist treatment, education and research.

CUH has in place a number of procedures for the prevention of bribery, including a clear raising concerns policy and procedure, and a local counter-fraud specialist. In addition, we keep a publicly-available register of interests for directors, governors and staff as well as a hospitality register. All staff have a role to play, but individuals with specific responsibility for implementing bribery-prevention procedures include the Board of Directors, the Deputy Trust Secretary, and our managers, both clinical and non-clinical.

We work closely with colleagues both within and outside the NHS to support a concerted effort to promote fair, honest and open operations and to prevent bribery, for the ultimate benefit of the patients and public we serve.

Staff survey

Staff engagement at CUH remains an important part of our work; continually placing great importance on ensuring that all staff have a great work experience and are enabled to be the best and provide the best possible care for our patients.

The 2019 National staff survey results for CUH show continued areas of improvement across many areas of staff experience. There was a response rate of 55.5% up from 51.5% in 2018 and above the national average of 47.6%. Our overall staff engagement score was 7.2 out of 10, again above national average of 7.0.

Of the ten Shelford Group Trusts we have seen our comparative position remain at third.

All eleven themes (detailed below) scored above or the same as the national average. CUH significantly improved in three of those themes from the previous year.

We are proud that our Staff recommendation score of CUH as a place to work continued to increase 71.6% and that we are one of the best performing acute trusts for staff recommending a friend or relative for treatment at 84.5%. This result reflects the commitment of our staff to deliver excellent patient care.

Staff survey response rates

	2015	2016	2017	2018	2019
CUH	37%	45%	49%	52%	56%
Average Acute Trusts	40%	42%	44%	44%	48%
Best Acute Trust	79%	76%	73%	72%	72%
Worst Acute Trust	25%	31%	29%	33%	30%

Equality, diversity & inclusion

	2015	2016	2017	2018	2019
CUH	9.1	9.0	8.9	8.9	9.0
Average Acute Trusts	9.2	9.2	9.1	9.1	9.0
Best Acute Trust	9.5	9.4	9.4	9.6	9.4
Worst Acute Trust	8.3	8.2	8.1	8.1	8.3

Health & wellbeing

	2015	2016	2017	2018	2019
CUH	6.1	6.5	6.4	6.3	6.2
Average Acute Trusts	6.0	6.1	6.0	5.9	5.9
Best Acute Trust	6.8	6.8	6.6	6.7	6.7
Worst Acute Trust	5.3	5.3	5.4	5.2	5.3

Immediate managers

	2015	2016	2017	2018	2019
CUH	6.7	6.8	6.8	6.9	7.0
Average Acute Trusts	6.6	6.7	6.7	6.7	6.8
Best Acute Trust	7.1	7.2	7.2	7.3	7.4
Worst Acute Trust	6.1	6.2	6.3	6.2	6.0

Morale

	2018	2019
CUH	6.2	6.2
Average Acute Trusts	6.0	6.1
Best Acute Trust	6.7	6.7
Worst Acute Trust	5.4	5.5

Quality of appraisals

	2015	2016	2017	2018	2019
CUH	5.3	5.6	5.6	5.8	5.9
Average Acute Trusts	5.1	5.3	5.3	5.4	5.6
Best Acute Trust	6.1	6.3	6.4	6.5	6.6
Worst Acute Trust	4.2	4.4	4.7	4.6	4.8

Quality of care

	2015	2016	2017	2018	2019
CUH	7.5	7.7	7.6	7.6	7.6
Average Acute Trusts	7.5	7.6	7.4	7.4	7.5
Best Acute Trust	8.1	8.2	7.9	8.1	8.1
Worst Acute Trust	6.9	7.0	7.0	7.0	6.7

Safe environment - Bullying & harassment

	2015	2016	2017	2018	2019
CUH	8.0	8.2	8.1	8.1	8.0
Average Acute Trusts	7.9	8.0	8.0	7.9	7.9
Best Acute Trust	8.4	8.5	8.4	8.5	8.5
Worst Acute Trust	7.0	7.1	7.2	7.1	7.3

Safe environment - Violence

	2015	2016	2017	2018	2019
CUH	9.5	9.5	9.5	9.5	9.5
Average Acute Trusts	9.4	9.4	9.4	9.4	9.4
Best Acute Trust	9.6	9.7	9.6	9.6	9.6
Worst Acute Trust	9.1	9.2	9.1	9.2	9.2

Safety culture

	2015	2016	2017	2018	2019
CUH	6.5	6.9	6.8	6.9	7.0
Average Acute Trusts	6.5	6.6	6.6	6.7	6.7

Best Acute Trust	7.1	7.0	7.1	7.2	7.2
Worst Acute Trust	5.9	6.0	5.9	6.0	5.7

Staff engagement

	2015	2016	2017	2018	2019
CUH	7.1	7.2	7.1	7.2	7.2
Average Acute Trusts	7.0	7.0	7.0	7.0	7.0
Best Acute Trust	7.6	7.4	7.4	7.6	7.5
Worst Acute Trust	6.4	6.5	6.4	6.4	6.1

Team Working

	2015	2016	2017	2018	2019
CUH	6.4	6.7	6.5	6.7	6.7
Average Acute Trusts	6.5	6.5	6.5	6.5	6.6
Best Acute Trust	6.9	7.0	7.0	7.1	7.2
Worst Acute Trust	6.1	6.1	6.0	5.9	5.9

Future priorities and targets 2020/21

From an organisational perspective, we have responded to this latest staff feedback by refreshing and ranking our five trust wide priorities, with Equality, Diversity and Inclusion; being our number one priority. Alongside the Trust response, Clinical Divisions and Corporate departments have critically reviewed their own results and shared the learning, involving others in identifying objectives and improvements.

Monitoring arrangements

The progress of the action plans associated with these priorities will continue to be monitored through the Trust's Workforce and Education Committee meetings which reports to the Board of Directors. Performance will be monitored upon receipt of national staff survey 2020 and local staff engagement results to demonstrate levels of improvement.

Analysis of staff costs - Subject to Audit

Table 20

2019/20

Employee expenses	**Year ended 31 March 2020 Total £000**	**Year ended 31 March 2020 Permanent**	**Year ended 31 March 2020 Other £000**
Salaries and wages	433,289	429,447	3,842
Social security costs	43,138	43,138	-
Apprenticeship Levy	2,072	2,072	-
Pension cost – defined contribution plans employers contributions to NHS pensions	48,774	48,774	-
Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	21,341	21,341	-
Temporary staff – agency/contract staff	4,597	-	4,597
Total gross staff costs	**553,211**	**544,772**	**8,439**

Included within:			
Staff and executive directors costs	523,221	544,772	8,439
Redundancy	4	4	-
Early Retirements	0	0	-
Special Payments	35	35	-
Total employee benefits	523,221	544,772	8,439

2018/19

Employee expenses	**Year ended 31 March 2019 Total £000**	**Year ended 31 March 2019 Permanent**	**Year ended 31 March 2019 Other £000**
Salaries and wages	363,771	359,000	4,771
Social security costs	39,993	39,993	-
Apprenticeship Levy	1,910	1,910	-
Pension cost – defined contribution plans employers contributions to NHS pensions	45,377	45,377	-
Temporary staff – external bank	38,689	-	38,689
Temporary staff – agency/contract staff	8,072	-	8,072
Total gross staff costs	**497,812**	**446,280**	**51,532**
Included within:			
Staff and executive directors costs	497,560	446,280	51,532
Redundancy	38	38	-
Early Retirements	171	171	-
Special Payments	43	43	-
Total employee benefits	**497,812**	**446,280**	**51,532**

Expenditure on consultancy

Information regarding expenditure on consultancy can be found in the annual accounts.

Relevant Union Officials

Table 21 - What was the total number of your employees who were relevant union officials during the relevant period?

What was the total number of your employees who were relevant union officials during the relevant period? Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
43	40.75

Table 22 - Percentage of time spent on facility time: How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	24 (including medical reps)
1-50%	19
51-99%	0
100%	0

Table 23 - Percentage of pay bill spent on facility time: the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Total cost of facility time	£34,422.15
Total pay bill	£552,899,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.00622%

Table 24 - Paid trade union activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated	3.34%

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

Off-payroll engagements

Table 25: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months.

Number of existing engagements as of 31 March 2020	0
Of which :	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 26: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	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 27: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

Exit packages - Subject to Audit

Exit packages are accounted for in full in the year of departure.

Table 28 : Exit packages

Reporting of other compensation schemes - exit packages 2019/20 Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages
<£10,000	1	4	0	0	1	4	0	0
£10,001 - £25,000	0	0	2	35	2	35	2	35
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	1	4	2	35	3	39	2	35

Reporting of other compensation schemes - exit packages 2018/19 Exit package cost band (including any special payment element)	**Number of compulsory redundancies Number**	**Cost of compulsory redundancies £000s**	**Number of other departures agreed Number**	**Cost of other departures agreed £000s**	**Total number of exit packages Number**	**Total cost of exit packages £000s**	**Number of departures where special payments have been made Number**	**Cost of special payment element included in exit packages**
<£10,000	2	12	12	43	14	55	0	0
£10,001 - £25,000	2	26	0	0	2	26	0	0
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	4	38	12	43	16	81	0	0

Exit packages: other (non-compulsory) departure payments - 2019/20	2019/20 Payments agreed Number	2019/20 Total value of agreements £000	2018/19 Payments agreed Number	2018/19 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice			12	43
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval*i	2	35		
Total	2	35	12	43

of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

3.24 Code of governance

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 reviewed in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust has reviewed our compliance with the 'NHS Foundation Trust code of governance'. As a result of this review, we consider that CUH complies with the main and supporting principles of the code of governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B1.1. The Board of Directors has determined that all of the NEDs are independent in character and judgement. This includes the appointed representative of University of Cambridge, Professor Patrick Maxwell, the Regius Professor of Physic, notwithstanding the Trust's relationship during this reporting period with the University of Cambridge, School of Clinical Medicine and with Cambridge University Health Partners (CUHP).

In relation to the more detailed provisions of the code of governance, CUH is compliant with the provisions with the following exceptions:

B.1.3 The Chief Nurse holds a position of partnership governor at Royal Papworth Hospital NHS Foundation Trust and the Director of Nursing from Royal Papworth Hospital NHS Foundation Trust is a partnership governor on the CUH Council of Governors. During the reporting period the Director of People and Business Development of Cambridgeshire and Peterborough NHS Foundation Trust was a partnership governor on the CUH council of governors.

3.25 NHS Improvement's Single Oversight Framework

NHS Improvement's Single 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.

Finance and use of resources rating	
Capital service cover rating	4
Liquidity rating	4
I&E margin rating	4
I&E margin: distance from financial plan	1
Agency rating	1

Overall rating unrounded	2.80
Risk ratings after overrides	3

3.26 Well Led

The Trust commissioned an external review against NHS Improvement's Well-Led Framework which reported in late 2016.

The recommendations of the Well-Led Review were implemented during 2016/17 and 2017/18, with updates provided to the Board of Directors.

In line with a recommendation of the Well-Led Review, work was undertaken during 2017/18 to develop a formal Accountability Framework for the organisation which was endorsed by the Board of Directors in May 2018.

In the most recent Care Quality Commission inspection published in February 2019, the Trust was rated as 'Outstanding' in the 'Well-led' domain.

3.27 Statement of the Chief Executive's responsibilities as the Accounting Officer of Cambridge University Hospitals NHS Foundation Trust

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

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

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

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

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

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 to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Signed

Roland Sinker
Chief Executive
23 June 2020

3.27 Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control integrates a number of individual controls as described in other sections of this statement, and other key policies and procedures such as the Standing Orders, identification of matters reserved to the Board, Standing Financial Instructions and Scheme of Delegation used to govern the Trust's activities, together with checks and balances provided by Board oversight, and internal and external audit reviews.

Capacity to handle risk

The Board of Directors sets the policy framework and provides leadership for the management of risk within the Trust. The Chief Nurse is the Executive Director lead for risk management.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with key controls and assurances and any gaps in those controls and assurances.

Operational responsibility for risk management sits within the clinical divisions and corporate directorates. Each clinical division and corporate directorate is required to have processes in place by which risks are identified, evaluated and managed at a local level, and escalated as required in accordance with the Trust's policy framework.

The principles of risk management are included as part of the mandatory corporate induction programme and guidance and training are provided to staff through the annual refresher programme, risk management training, Trust-wide policies and procedures and feedback from audits, inspections and incidents.

The Trust also learns from good practice through a range of mechanisms including those detailed above together with clinical supervision and reflective practice, individual and peer reviews, after action reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice.

The risk and control framework

The Risk Management Strategy and Policy sets out the approach to managing risk within the organisation. The latest version of the Strategy and Policy was approved by the Board of Directors in September 2019. It defines the roles, responsibilities and reporting lines in relation to risk management as well as the overall governance structure underpinning this at both Board and divisional/directorate level. It details the Trust's approach to identification, assessment, management, monitoring and escalation of risk and a statement of the Board's risk appetite.

As noted above, the BAF sets out the principal risks to the achievement of the Trust's strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF describes controls in place to manage each of the risks and explains how the Board is assured that those controls are in place and operating effectively. The BAF also identifies any gaps in control or assurance and the actions being taken to address these within specified timeframes.

The Risk Oversight Committee meets monthly. It is chaired by the Chief Executive and membership includes all members of the Management Executive. The Risk Oversight Committee reviews the BAF and the Corporate Risk Register (CRR), which includes risks escalated from clinical divisions and corporate directorates. The BAF and the CRR are received by the Board of Directors four times a year, detailing movements in risk and mitigating actions being taken with the aim of reducing the risk towards its target level. In addition, entries on the BAF and CRR are received and considered at each meeting of the relevant Board assurance committees to which they are assigned.

At an operational level, responsibility rests with each Divisional Director, supported by the Associate Director of Operations and Head of Nursing, for clinical divisions; and with each Executive Director for the corporate directorates. Divisional 'red-rated' risks are reviewed at divisional Performance Meetings with members of the Executive Team.

The above meetings and associated processes are intended to facilitate a seamless risk management system from Board to ward.

The Board of Directors has previously agreed the principles regarding the level of risk which the Trust is prepared to seek, accept or tolerate in pursuit of its agreed objectives. These principles are focused on quality, finance and value for money, innovation, commercial opportunities, compliance and regulatory framework,

reputation and workforce. The Board of Directors has reviewed the principles and the organisational risk appetite during the financial year.

The 2019/20 internal audit report on the BAF and risk management provides an overall assessment of 'Significant assurance'. The recommendations of the report have been accepted by the Executive Team and will be actioned during 2020/21.

As at 31 March 2020, the Trust identified through the BAF the most significant risks to the achievement of its strategic objectives as being:

- The Trust does not sustain timely and effective emergency and elective patient flow through its hospitals which impacts on the responsiveness of services including waiting times, safety and patient experience.

- A failure to address estate backlog maintenance and statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety and continuity of clinical service delivery.

- A failure to address fire safety statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety and continuity of clinical service delivery.

- Despite having an estates strategy and masterplan aligned with the Trust's organisational and clinical strategy, the Trust takes sub-optimal short-term decisions on estates investment and is not able to plan appropriately for long-term investment in its estate and infrastructure due to capital constraints.

- The Trust does not agree a medium-term financial plan to achieve financial sustainability for the Trust and the Cambridgeshire and Peterborough health and care system which impacts on the ability to invest for the future and provide high quality services for patients.

The Trust has identified the controls in place to manage these risks and the sources of assurance that the controls are effective. It has also identified any gaps in control or assurance and the associated actions being taken to address these gaps. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk, where this is within the Trust's ability to do so.

Some temporary changes to the Trust's governance structure and risk and control framework were introduced in mid-March 2020 in response to the COVID-19 pandemic. These changes were agreed by the Board of Directors and clearly documented. The Board of Directors, Board assurance committees, the Management Executive and the Risk Oversight Committee continued to meet during this period.

One of the specific principles of the Trust's strategy for managing the response to the COVID-19 pandemic was "*To ensure there are appropriate governance and risk management arrangements to (i) enable the Trust to adapt quickly to the emerging*

situation and run its core functions safely; and (ii) provide a clear account of its decision making for future scrutiny".

Quality governance

The Board of Directors has a collective responsibility for providing high quality care to the Trust's patients and has put in place a quality governance framework to ensure that quality is an integral part of the Trust's activities. The quality governance framework is kept under regular review, having due regard to the Well-Led Framework and best practice from other organisations. The Care Quality Commission (CQC) undertook a Well-Led review of the Trust in November 2018 and rated the Well-Led domain as 'Outstanding'.

The Quality Committee, in conjunction with the Performance Committee, provides assurance to the Board on the quality of patient care and compliance with national and local standards, with reference to the monthly Integrated Performance Report and other relevant reports and data. It reviews the Trust's clinical audit programme, compliance with the requirements of the Care Quality Commission, and Trust preparedness for regulatory inspections.

The Committee also oversees the implementation of the Trust's Quality Plan and its ongoing development. This includes a focus on clinical quality improvement to ensure that the Trust learns, shares and takes appropriate action in respect of safety reporting, and prospective and proactive patient safety risk detection; information and experience from outside the Trust; external reviews of Trust activity; and the results of clinical audit. It also oversees the development of and agrees priorities for the Trust's annual Quality Account.

Never Events and clinical and non-clinical incidents which are significant enough to be classified as Serious Incidents are identified by the Director of Clinical Quality and are reported immediately to the Executive Directors and to the Trust's lead commissioner. The incidents are detailed in the monthly Integrated Performance Report and in the Patient Safety report received by the Quality Committee. Incident information is reviewed at monthly divisional Quality meetings. All incidents are subject to a Root Cause Analysis and learning is shared with the divisions and through the organisation. Themes are identified in the Integrated Report. The Quality Committee receives a bi-monthly report on serious incidents as part of the Patient Safety report including themes and actions taken.

Information governance

The Trust has in place an Information Governance policy which sets out the Trust's commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded. The policy establishes a robust information governance framework which includes up to date policies, procedures and accountabilities. Managers within the Trust are responsible for ensuring that the policy and its supporting standards and guidelines are built into divisional and directorate processes and that there is ongoing compliance.

The Trust complies with the requirements of the NHS Digital Data Security and Protection Toolkit for the management and control of risks to information. The current level (2018/19) of compliance with the Toolkit is 'standards met'. Due to

the COVID-19 pandemic, the finalisation of the toolkit submission for 2019/20 has been deferred to September 2020.

The Director of Improvement and Transformation is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors. Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance policy and management framework. The Information Security and Governance Programme Board is chaired by the Chief Information Officer and reports to the Board of Directors through the Quality Committee.

Risks to foundation trust governance

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. During the year the Board has reviewed progress against the Trust's strategic programmes on a regular basis. The Trust's core governance documents establish the roles and responsibilities of directors and other Trust officers.

The Audit Committee is the Board committee with primary responsibility for overseeing the Trust's governance and assurance processes and, in particular, for independently reviewing the effectiveness of the system of internal control and risk management, and ensuring that all significant risks are properly considered and communicated to the Board.

The Performance Committee, the Quality Committee and the Workforce and Education Committee provide independent and objective oversight and assurance to the Board of Directors on the Trust's performance in relation to operational standards, quality, finance and workforce.

As set out in the Trust's Accountability Framework, the clinical divisions are held to account and escalate issues as required through monthly Performance Review meetings with the Executive Team. Each division provides a balanced scorecard of performance information which is included in the monthly Integrated Performance Report.

Involvement of stakeholders in risk

The Trust endorses three principles which underpin the quality framework:

- Quality is at the heart of all that the Trust does.
- There is an open and transparent culture to facilitate a learning organisation.
- The organisation will work collaboratively with stakeholders to ensure the quality and safety of services and demonstrate commitment to continual improvement.

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

The Trust informs and engages with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters and to engage with them on the development of the Trust's Quality Account.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through the work of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP).

The Trust engages with public stakeholders and the local Healthwatch in discussions including consideration of risks which impact on them. Governors are involved in discussions about risks which impact on patients and members through regular meetings including of the Council of Governors and Governor-Director Working Groups. They are also involved in the development of the Trust's strategy and operational plans.

CQC registration

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust was inspected by the CQC in November 2018 and the inspection report was published in February 2019. The CQC inspected four core services and undertook a Trust-wide Well-Led review, together with a Use of Resources assessment by NHS Improvement. The Trust continued to be rated as 'Good' overall for Quality, with both the Caring and Well-Led domains being rated as 'Outstanding'. The Trust was rated as 'Requires Improvement' for the Responsive domain and for Use of Resources. An action plan is in place to address the 'Should Dos' identified in the CQC inspection.

The Trust was scheduled for a CQC inspection, including a Well-Led review, in late 2019/20 and early 2020/21. However, this was postponed due to the COVID-19 pandemic.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period

Other compliance issues

The Workforce and Education Committee received an analysis of compliance with the Developing Workforce Safeguards in October 2019. An action plan to address areas where further work is required in relation to the safeguards is in the process of being implemented.

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

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 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

The Trust's Operational Plan for 2019/20 was approved by the Board of Directors following review by the Council of Governors. The Plan was submitted to and accepted by NHS Improvement. For 2020/21 the Trust is no longer required to produce and submit a provider level operational plan. Instead a system level submission is required, supported by a Trust Forward Plan. Both submissions were postponed due to the COVID-19 pandemic.

Delivery of the Operational Plan was monitored by the Management Executive. Progress against cost improvement programmes was monitored through a robust programme management office process reporting to the Improvement Steering Group and the Management Executive. The Performance Committee sought assurance on behalf of the Board of Directors on the delivery of the Operational Plan.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee. Non-financial audits relating to quality are considered by the Quality Committee.

The process to ensure that resources are used economically, efficiently and effectively across clinical services include divisional Performance Reviews meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Information Governance

During 2019/20 the Trust recorded five incidents relating to information governance, including data loss or confidentiality breach, which were classified as a reportable Information Governance Incidents. These cases have been reported to the Information Commissioner's Office and have been fully investigated.

Data quality and governance

The assessment of performance data, including quality metrics, is an integral part of the Trust's performance management system. The Trust produces a monthly Integrated Performance Report which includes operational, quality, workforce and financial data and had been subject to significant review during 2019/20 to incorporate systematic use of the statistical process control methodology to support effective data interpretation. In addition to ongoing internal review and audit of data quality, in accordance with the Trust's Data Governance policy, data quality is

subject to periodic audit by the Trust's internal auditors. A Data Quality audit undertaken by the Trust's internal auditors during 2019/20 covering three key performance indicators (including the 62-day cancer waiting time standard) provided an overall significant assurance assessment.

Review of effectiveness

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

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the Quality Committee, the Performance Committee, the Workforce and Education Committee and the Internal Auditors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by the work through the year of the Board of Directors and of Board committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by the Audit Committee, and the action plans resulting to address areas for improvement.

The Head of Internal Audit opinion has concluded that significant assurance could be provided that the organisation has an adequate and effective framework for risk management, governance and internal control.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Other external assurance is provided by CQC insight reports, the outcomes of the clinical audit programme and the results of reviews and inspections by external organisations.

The Audit Committee has reviewed the overall framework for internal control, and has recommended this statement to the Board of Directors.

Significant internal control issues

The Board of Directors has identified the following significant internal control issues for the Trust:

- Insufficient capacity to sustain timely and effective patient flow through the Trust's hospitals has again impacted during the year on the Trust's ability to deliver key operational performance targets in relation to both emergency and elective care. The Trust has continued to take actions internally to improve patient flow, as well as working with partners to reduce delayed transfers of care and identify the

scope to provide additional physical capacity both on-site and elsewhere within the local health economy.

- Insufficient capital funding and decant capacity has again impacted during the year on progress in addressing estates backlog maintenance and statutory compliance priorities (including in relation to fire safety and infection control). The Trust has taken a risk-based approach to prioritising investment within the capital resources available, has taken the decision to proceed with critical investment 'at risk' ahead of receipt of capital funding, and has continued to escalate and work closely with its regulators on these issues.

- In the final weeks of the 2019/20 financial year, the Trust faced the significant challenge of responding, alongside the rest of the health and care system, to the initial phase of the COVID-19 pandemic. An incident management command structure was put in place in line with national guidance and taskforces were established to address key issues including staff safety and well-being, cohorting and configuration, critical care, personal protective equipment, supply chain and testing. A significant amount of non-COVID clinical activity was postponed and the Trust's ability to meet other objectives was inevitably affected. While there was impact during March 2020, the most significant impact has been felt in the early months of 2020/21. Further information will be included in next year's Annual Governance Statement.

Conclusion

My review has established that Cambridge University Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

Roland Sinker
Chief Executive
23 June 2020

3.28 Equality, diversity and inclusion report

Overview

The Trust is committed to tackling inequality of opportunity and eliminating discrimination both within the workforce and in the provision of services. The Trust has a legal responsibility under the Equality Act 2010 to:

- Eliminate discrimination, harassment and victimisation

- Advance equality of opportunity
- Foster good relations between persons who share a relevant characteristic and those who do not. The nine protected characteristics being age, disability, ethnicity, gender, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion or belief and sexual orientation.

- Publish information to demonstrate compliance with the general duty at least annually
- Prepare and publish equality objectives every 4 years.

The Trust takes due regard for equality by undertaking equality impact assessments/ equality analysis when reviewing policies or when planning changes to services as part of organisational change processes to ensure our functions and services are not discriminatory. This report sets out the Trust's annual progress report and actions to promote workforce and service equality, diversity and inclusion.

NHS equality delivery system (EDS2)

The EDS has been developed by the NHS England Equality and Diversity Council to improve equality and diversity practice in the NHS as a tool to embed equality and diversity practice to meet the public sector equality duty.

The EDS contains 18 outcomes grouped under four goals, which are equality objectives for the Trust:

1. Better health outcomes for all
2. Improved patient access and experience
3. Workforce – the NHS as a fair employer
4. Inclusive leadership at all levels.

The Trust's fifth equality objective is to improve patient data at referral to enable adjustments accordingly and measure equity of access, experience and outcomes.

The Trust uses the NHS Equality Delivery System (EDS2) as a tool to drive equality improvements, to engage patients, staff and the community to review service and employment equality performance and to identify future priorities and actions for the Trust's equality objectives. The Trust's directors each have responsibilities for equality and diversity. The Trust's EDS equality improvement plan 2018/19 was based on feedback from an EDS equality engagement and rating event.

The EDS improvement plan includes implementation and embedding of the Accessible Information Standard, the Workforce Race Equality Standard action plan and Workforce Disability Equality Standard. The Trust's EDS rating reporting template and annual equality objectives are published on the Trust website.

Workforce Race Equality Standard

Since July 2015 all NHS trusts are required to publish their Workforce Race Equality Standard metrics as part of the new NHS contract. The 5th WRES reporting template and action plan was revised and approved by the Board in September 2018 and is published on the Trust public website. THE WRES implementation group chaired by Associate Director for OD and Leadership development meets bimonthly and oversees implementation of the WRES action plan to ensure traction and includes members of the BAME staff network. The WRES report and action plan are standing items for the Workforce and Education committee, the Equality, Diversity and Dignity Steering committee and updates are provided to the Board and Management Staff Forum.

In 2019/20 key activities on the WRES action plan have included:

- WRES indicators including WRES staff survey metrics have been shared with divisional management teams and BAME network representatives. Divisional engagement has taken place to share and support the WRES action plan, and to promote the BAME network.
- All acting up posts and secondment opportunities must be advertised centrally and no contracts will be processed by recruitment unless this has been undertaken.
- Diverse interview panels have been introduced for all posts band 8a and above/equivalent. The Chair of the BAME network has recruited diverse panel members to assist appointing officers to ensure diversity on panels
- Executive mentoring scheme of BME staff has continued.
- The RCN cultural ambassador programme was launched in 2019. Eleven BME staff at bands 6 and above have been trained as Cultural Ambassadors and involved on the investigatory panel at disciplinary investigations for all potential investigations involving BME staff from informal stage since September 2019. Our Cultural ambassadors have acted as mentors to
- Reverse mentoring scheme was introduced in January 2020. Prof Stacy Johnson, MBE from University of Nottingham trained 16 staff to be reverse mentors for the executive and non-executive directors.
- The Trust CEO is the senior responsible officer for the WRES and is the BAME network board champion and meets with the BAME network.
- The BAME staff network chair and EDI lead have organised a number of events including: a Black history month talk “The Story of Windrush” with guest speaker Arthur Torrington, MBE the Windrush Foundation in October 2019. The network’ also held a “Race for Equality” inclusion conference in November for all staff with guest speakers including Jennifer Izekor from Above Difference facilitating Introduction to Cultural Intelligence workshop and staff sharing the WRES action plan initiatives

Workforce disability equality standard (WDES)

In September 2019 the Trust published our first NHS Workforce disability equality standard (WDES) set of metrics and WDES action plan that was co-created with disabled staff as a result of a disabled staff engagement event in June facilitated by Purple Space. The WDES action plan approved by the board is published on the rust’s public website. The WDES implementation group has been set up to provide

governance and oversee WDES action plan progress and about to meet for inaugural meeting at the time of COVID-19 restrictions.

Leadership and management of equality, diversity and inclusion

The Chief Nurse is the executive director responsible for service equality and the Director of Workforce is the executive director responsible for workforce equality. A number of working groups drive equality activity in the Trust. These include groups focussed on staff and patient services:

- Equality, Diversity and Dignity Steering Committee chaired by the Chief Nurse provides governance and assurance for equality diversity and inclusion.

EDI staff networks include:

- Equality and diversity staff group
- BAME staff networks,
- LGBT+ network,
- The Purple Network- for disabled staff and staff with health conditions
- It's Not Just You group" (staff group for mental wellbeing and resilience)
- CUH Time to change" (group of mental health first aiders campaigns against mental health stigma and organises events and talks),
- CUH Women's staff network,

  Service equality groups include
- Learning disability and autism working group,
- Dementia strategy group,
- Accessible Information Standard Implementation Task and Finish group,
- Carers Strategy group.

Equality monitoring

As required by the public sector equality duty, the Trust's workforce equality monitoring information is published on the CUH public website.

This includes:

- the profile of our staff by age band, disability, race, religion, sex, sexual orientation and marital status
- ethnic profile of our staff compared to the local population
- recruitment data by age band, disability, race, religion, sex, sexual orientation and marital status (those applying, shortlisted and appointed)
- staff in post by pay band by age, disability, race, sex and sexual orientation

- the number attending training courses by age band, disability, race and sex
- the number of leavers by age band, disability, race and sex
- employee relation cases (disciplinary, capability, performance and sickness bullying and harassment) cases by age band, disability, race and sex

Our patient profile is published on the Trust website equality and diversity pages.

Key equality and diversity activities for service equality and workplace in 2019/20

Training and awareness

A range of training and awareness activity has taken place in 2019/20 including:

- "Understanding Unconscious bias" e-learning package from Skill-boosters has been in place since September 2016 and is mandatory for all line managers, supervisors and all staff within the workforce directorate. It is also a pre-course learning requirement for all staff undertaking recruitment and selection training. This is in addition to the e-Learning module on equality and diversity and inclusion as part of biannual e-Learning refresher training.

  A suite of equality diversity and inclusion e-learning packages from Skill-boosters can now be accessed by all our staff.
- Be Disability Confident workshops face to face training for training for staff continue involving disabled people sharing their experiences
- "Demystifying Equality, Diversity and Inclusion" - half day workshops for managers facilitated by external facilitator Jagtar Singh, OBE – 10 half day sessions held for all divisional/corporate senior teams and others to attend
- The Kite Trust was commissioned to facilitate LGBT+ awareness training in 2019/20 and provided a training session for the Board.
- Dementia awareness training programme
- Mental health first aid training for staff continues to be provided
- Events were held for NHS equality and human rights week in May 2019 including a workshop with guest speaker Cherron Inko-Tariah on the Power of staff networks
- Disabled Staff and BAME staff stories have been shared at Board meetings

Service equality

Key activities in 2019/20 to improve service equality have included:

- Three Patient service equality workstreams set up by Chief Nurse
  - Patient data project -including implementation of sexual orientation monitoring standard to improve patient data on EPIC
  - Traveller community working group led by Divisional Nurse working with Gypsy traveller liaison team

  - Trans service users policy -has been developed by Deputy Chief Nurse in conjunction with the LGBT+ staff network and Encompass network
- Embedding the national Accessible Information Standard.
- Launch of the NHS Rainbow Badge in May 2019 to promote LGBT inclusion for patients and the public; so far 2000 have signed up to the NHS rainbow badge since it launched
- Oncology service improvement lead has been engaging with local Encompass network to ensure services are LGBT+ inclusive
- Introduction of the Safe Places Scheme. CUH is now registered with this national scheme for a place of safety for people with learning disabilities

Workforce equality

The Trust is signed up to the following standards

- "Disability Confident" Committed Employer
- 'Mindful Employer' charter signatory for employers who are positive about mental health
- Time to Change organisational employer pledge to end mental health stigma and discrimination
- The Trust is a member of Purple Space, networking organisation to support disabled staff networks

Key workforce equality activity in 2019/20 other than the work streams reported earlier includes:

- CUH took part in the nine month NHS Employers Diversity and Inclusion Partner Programme for the third year running in 2019/20 and participated in: benchmarking activities; research with the University of York into LGBT+ staff networks; we took part in national consultation Government testing Race equality audit metrics;
- LGBT+ staff network members and EDI lead took part in the inaugural Cambridge Pride event June 2019
- 10 October 2019 - The Time to Change group organised an Open Mind Night cabaret evening to mark World Mental Health day raising money for MIND and a lunchtime Walk and Talk with PAT dogs to mark Time to Talk Day in February.
- The Purple Network our disabled staff network was launched on 3 December to mark International Day for Persons of Disabilities with our Purple Light Up evening event when we lit the hospital chimney purple
- A bespoke version of the Diversity Inclusion calendar was produced for CUH for publication with images of Trust events for publication on the Intranet and on the public website.

3.29 Sustainability and climate change report

Introduction

This report describes the commitment, approach, and performance of Cambridge University Hospitals NHS Foundation Trust (CUH) in its ongoing response to the

environmental sustainability agenda during 2019/20 - specifically including the challenge of tackling climate change. The report is divided into two sections:

Section 1: provides the frame for understanding the Trust's actions for tackling environmental sustainability and climate change in 2019/20 – a process of continuous development and improvement in line with the Board adopted Sustainable Development Management Plan 2013-2020;

Section 2: details performance and achievements during 2019/20 and provides a brief look forward to the delivery priorities for the coming year.

Section 1 - Commitment

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart, efficient and ecologically responsible use of natural resources and contributing to building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that we consider the social and environmental impacts of our activities ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

The Trust acknowledges this responsibility to our patients, staff, visitors and local communities by working hard to minimise the 'footprint' of our local and global environmental impacts.

Context – what we consume and how we consume it

Sustainability asks us to question our way of doing things -to check that we can carry on without making things difficult for ourselves or others today, or anytime in the future.

In more concrete terms, sustainability asks us to constantly review what we consume and how we consume it in order to ensure that, in delivering our services, the Trust is taking steps to:

- reduce greenhouse gas emissions by half in the next ten years, and almost entirely in the next 30 years, in order to keep the probability of the dangerous impacts of climate change within safe limits;
- control the pollution of the air, land and water so that it does not endanger health;
- carefully manage our draw on natural resources so that they do not become irreversibly damaged or depleted.

Context 2020 – the next ten years are critical

Despite national commitments to change, deliberate action in each of the above three areas is falling well short of what is required to halt the environmental crisis unfolding around us. The European Environment Agency's (EEA) latest 'State of

the Environment' briefing (May 2020) states that "Europe will not achieve its 2030 goals without urgent action during the next 10 years to address the alarming rate of biodiversity loss, increasing impacts of climate change and the overconsumption of natural resources" and confirms that these challenges are of unprecedented scale and urgency.

The things we need and want are not produced and consumed in a vacuum. The transition to sustainable consumption at scale means looking beyond our single point of use. The big sustainability solutions lie in the links with our supply and disposal chains. The majority of environmental impact rests with the carbon, pollution and resource-loss connections wrapped up in the life cycles of what we consume. Between extracting and refining raw materials, manufacturing them into the products we need, then distributing and using them to finally disposing of what we no longer want, lie the big joined-up but difficult solutions. Solutions we must deliver and enact over the next 10 years. Reaching for the quick-wins and 'low-hanging fruit' remains important but is no longer sufficient to steer us away from a climate emergency and ecological breakdown.

Making the connections

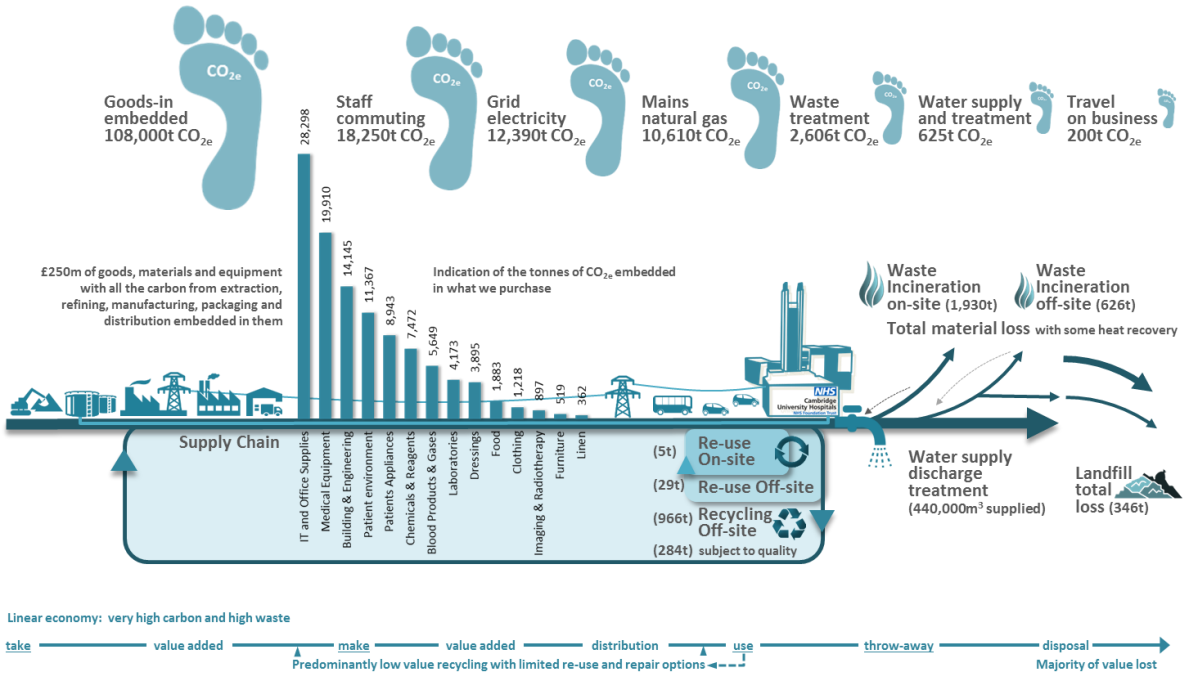
For many years the Trust has worked hard to reduce its on-site consumption of utilities, goods and materials. These demand-side measures, combined with sustainable waste management practices, have been effective in cutting running costs and also some aspects of the organisation's 'ecological footprint'. These latter benefits are very hard to quantify and so work largely under the assumption that if less is consumed there will be less environmental damage. Without firm metrics, however, we cannot set targets or assess progress. For intense consumers such as CUH, there are only two workable measures that (subject to some averaging and generalisation) allow us to start making the essential supply-use-disposal connections that can achieve the deeper and lasting transformation so urgently required to sustain our natural environment.

The first is carbon emissions (greenhouse gases expressed as carbon dioxide equivalent, or CO_{2e} for short). Almost everything we consume has a CO_{2e} conversion factor, with many related to the means of consumption. Some are more accurate than others: for example a kilowatt hour (kWh) of mains electricity is responsible for 0.256 kg CO_{2e}, one mile in an average car is estimated to produce 0.279 kg CO_{2e} and every pound (£) spent on patient appliances is deemed responsible for 1.54kg CO_{2e}. For most organisations this 'carbon footprint' is how it can most reasonably understand and measure its environmental impact. It is often taken as a useful proxy for several aspects of the wider environmental agenda as there are correlations with air pollution and habitat loss.

The second is volume of waste produced by type (with as many types as possible – CUH currently separates its waste into 27 streams). Understanding what we look to throw away and then the steps we take to segregate it into streams that mean it can be repaired, re-used or recycled is the other very measurable indicator of the Trust's endeavour to reduce its environmental impact. How well we are able to develop this also draws attention to the constraints that existing supply and disposal infrastructure apply to our plans to maximise the value and minimise the damage of everything that would otherwise create pollution and/or be totally wasted.

Both of the above measures are put into the context of CUH's consumption for 2019/20 in Figure 1.

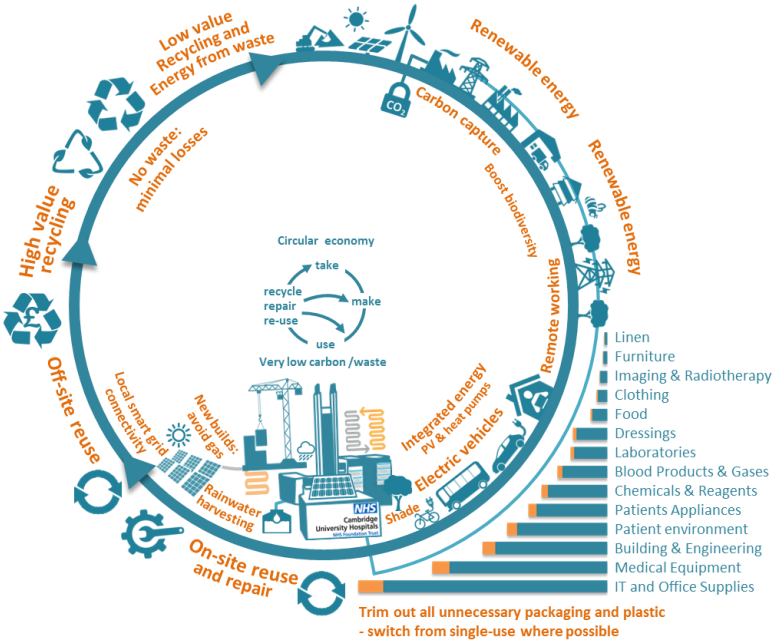
Figure 1: CUH carbon footprint and material throughput 2019/20



Framing a very low carbon – very low waste future

When the current take-make-use-throwaway 'linear' approach to the business of consumption is drawn out, it becomes clear that escalating carbon emissions, waste and pollution are almost inevitable. With the global carbon emissions from what we consume stubbornly refusing to drop, with over 90% of the 100 billion tonnes of global resource inputs being literally wasted, it is very apparent that linear business-as-usual needs to urgently change with both commitment and pace. The sustainable alternative reflects natural ecology: nothing is wasted and everything (energy, water, goods and materials) is renewable within a human timeframe. This is referred to as a 'circular economy' and is illustrated in Figure 2 as a frame to CUH's future consumption.

Figure 2: CUH carbon footprint and material throughput 2030



For the wheel to turn there are three principles that the Trust endeavours to take forward in its decision making:

Apply a life-cycle assessment: to assess the environmental impacts associated with the key life-cycle stages of a product, process or service - covering use of raw materials (including water), use of energy and the release of waste substances.

Connecting budgets: linking today's spend on goods, equipment and capital projects with tomorrow's operational revenue budgets. This allows for savings or additional spends in the future (operating, maintenance and remedial costs) to be accounted for in present day decision-making (invest to save).

Devolved responsibility: decisions on what to purchase, how to consume it and where to dispose of it afterwards stretch across all aspects of the Trust's activity. To be effective, the decisions need to incorporate local circumstances and local service needs. Local teams that take real steps to align their physical infrastructure, organisational processes and behavioural responses to low carbon and low waste working practices will be doing the most to reduce their environmental impacts. Sustainability is for everyone.

Policies

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Trust's Board adopted the CUH SDMP in 2013 and covers the period up to 2020. A new plan is currently under development – this will come forward under the new *Greener NHS* guidance for these documents as a *Green Plan*.

This core plan is supported and augmented by a range of more subject-specific policies and procedures. These include a comprehensive Travel Plan that appropriately embraces the wider Cambridge Biomedical Campus. This has been fully reviewed, refreshed, updated and consulted-on and was formally approved by the CBC Landowners Executive in November.

Other key documents include the Trust's Environmentally Sustainable Design and Construction Protocol, the Waste Management Policy and Waste Disposal Procedures, and several policies relating to aspects of energy and water management. These are all refreshed and updated on a regular basis.

Sustainability is now referenced within the Trust's tender preparation guidance. Procurement procedures are being developed to ensure that lifecycle costings are appropriately covered in relation to energy, waste, water and transportation.

Partnerships and collaboration

Partnerships, networks of shared interest and less formal collaborative working arrangements are fundamental aspects of the sustainability journey for any organisation and the communities it serves.

In 2019/20 we have further developed, or maintained, productive relationships for the purposes of advancing environmental sustainability with the following external partners: Cambridge City Council, South Cambridgeshire District Council, Cambridge County Council, Greater Cambridge Partnership, Cambridgeshire and Peterborough Combined Authority, Connecting Cambridgeshire, NHS Sustainable Development Unit, East of England NHS Regional Sustainability Network, East of England Health Estates and Facilities Management Association, Cambridge Sustainable Food, Cambridge Carbon Footprint, Cambridge Cycling Campaign, University of Cambridge, Cambridge Judge Business School Circular Economy Centre, Medical Research Council, AstraZeneca, Royal Papworth Hospital, National Union of Students, Cambridge Cleantech and local community groups.

Section 2 – Performance

Sustainable Energy and Water Consumption
Energy

The two main energy sources for the Trust are natural gas for heating space and water, and electricity for powering plant, lighting and equipment (with oil available as a backup for both if required). In terms of performance and improvement there are important distinctions between the two. 45% of the energy use on site is electricity but this accounts for 85% of the total energy cost and 60% of the carbon emissions when compared to gas. The carbon intensity and, to an even greater extent, the unit cost of electricity are both significantly more than natural gas.

A percentage reduction in electricity consumption is therefore of comparatively greater material impact in terms of cost and carbon.

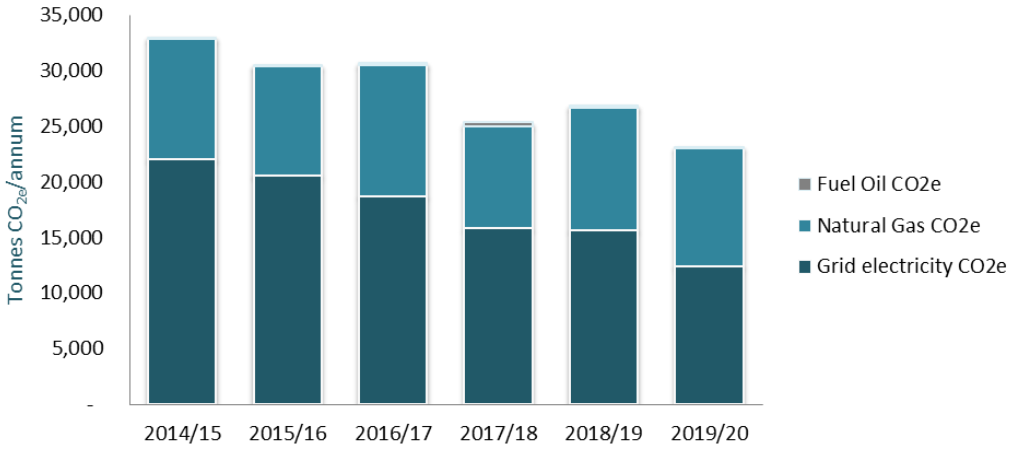
The Trust, however, like the majority of organisations, is increasingly dependent on electricity and demand can be expected to grow. The greatest immediate pressures are coming from:

- requests for air-conditioning in response to warmer weather conditions and higher electrical equipment and staffing levels per square meter;
- increasing intensity in the use of the hospitals' services and facilities;
- growth in the deployment of medical imaging and other new equipment that have high electrical power requirements.

In the medium to longer term, the transition to electric vehicles and the electrical heating and cooling of properties with heat pump technologies (replacing gas boilers) are both expected to create step-changes in demand for electricity.

Carbon emissions (CO_{2e}) from the on-site consumption of heat and power continue to fall. The overall target for the NHS is a 28% reduction by 2020 from a 2013/14 baseline. In terms of heat and power the Trust has currently achieved a 30% reduction since 2014/15 (re. Figure 3) - when we were obliged to reset the Trust's baseline due to the decommissioning of the combined heat and power (CHP) gas turbine. The 30% reduction since then has been achieved by: a.) working hard to hold, or marginally reduce, energy consumption through infrastructure improvements as the hospitals' services and the intensity of use have grown, and; b.) through the increasing contribution of low carbon electricity generation to the national grid.

Figure 3: CO_{2e} emissions from energy use in premises 2014/15-2019/20



Pressing on with the objective of net zero-carbon will require a step-change in on-site generation and heat-raising through the preparation and implementation of strategic plans for the restructuring of centralised plant, the use of renewables and options for the upgrading of existing facilities and associated distribution networks.

Two major projects have progressed well this year as a response to this need for a step-change. The first involves an option for the Trust to purchase a significant supply of renewable energy from a new array of photovoltaic (PV) panels proposed for installation by the County Council on their Park and Ride site in Babraham (not far from the CUH campus). The shared objective of this local

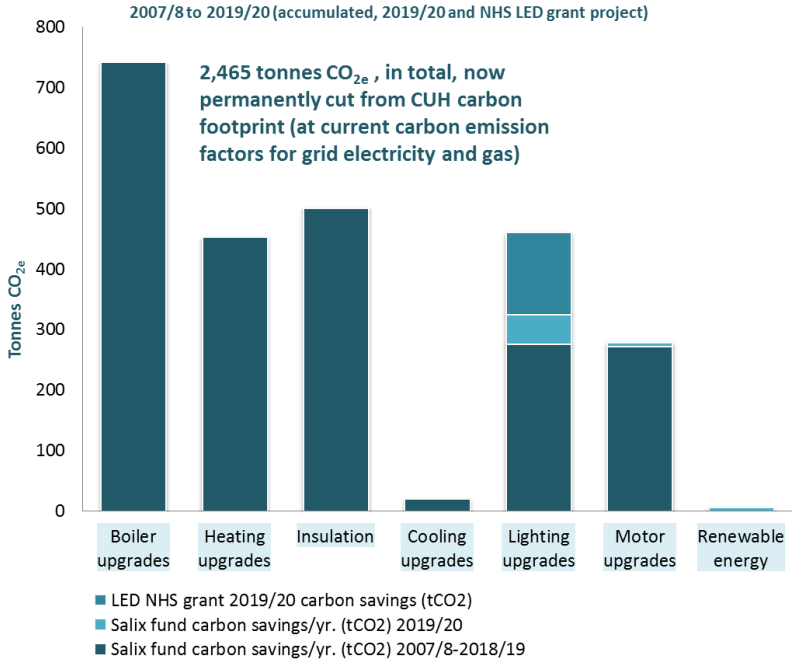
smart energy grid project is to provide an appropriate return on investment from electric vehicle charging and renewable energy generation for the Council whilst supplying competitively priced and very low carbon electricity into the Trust.

The second project involves a uniquely innovative approach to running large and essential plant on site in a fully resilient 'behind-the-meter' manner that maximises the provision of low carbon electricity. By connecting up one of our buildings' main chiller plants to a new roof-mounted PV array and battery storage unit (as well as maintaining a mains power connection) a smart switching interface can be programmed to run the plant from either solar, battery or mains supplies (and charge the battery from solar/mains) depending on the availability and the carbon intensity of the national grid. Once tried and tested, the replication and scaling opportunities for other high usage electrical plant units on the CUH campus stand to be significant.

The creation of the new Cambridge Children's Hospital, as an exemplar in sustainable design and construction, will begin the transition of the CUH campus new build programme towards a net zero-carbon future. Innovation, of the type highlighted in the two examples above, in developing local smart grids and balanced energy networks will be important in meeting the challenges of rapidly establishing a very low carbon working environment.
Alongside bringing forward new technologies it is essential that we also reduce the amount of energy we use through improving efficiencies and minimising losses across the existing estate – cutting the Trust's operational costs and carbon footprint in the process. 2019/20 has been an exceptionally strong year in the delivery of these demand-side reduction projects. The regular deployment of our revolving invest-to-save Salix fund was this year supported by an additional £400k (as part of a total £600k) grant for LED lighting upgrades from the NHS Energy Efficiency Fund (NEEF). Important ongoing upgrades to the on-site incineration plant have also cut utilities consumption, especially the replacement of the induced draught fans with much higher efficiency units.

The Trust's Salix Fund, which recycles savings from an initial investment of £220k, continues to deliver major returns. Without the projects that the fund has resourced the Trust would be consuming over 12,000 MWh of additional energy and paying an extra £650,000 a year. The carbon savings are similarly significant, at today's grid emission factors, total annual emissions are 2,500 tonnes CO_{2e} lower – the Trust's gas and electricity emissions would be 10% higher without the fund's programme (re. Figure 4).

Figure 4: Permanent annual carbon savings achieved from efficiency projects

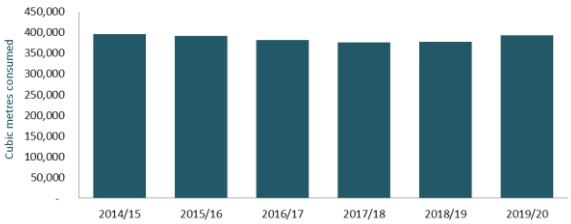


Encouraging positive staff behaviours to ensure energy is not unnecessarily consumed is an essential parallel to the upgrading of physical infrastructure – this is taken forward through both corporate communications and the Trust's Think Green Impact programme for local teams.

Water

2019/20 has seen water consumption across the site remain stable at approximately 36,500 m^3 per month (re. Figure 5). For operational and safety reasons, much of the water is treated, tanked and subject to a carefully managed pipe flushing regime. The water has many purposes: from washing, flushing and cleaning to drinking and food preparation, to research and testing, to running boilers and providing hydro-therapy and swimming facilities. Due to hospital regulatory issues, methods of reducing mains water consumption on campus have restrictions: especially in relation to the very necessary priority of infection control.

Figure 5: Mains water consumption 2014/15 - 2019/20



The main campus pressurisation control units, installed in 2011, continue to ensure that the twin high pressure mains supplies are matched to consumption requirements: thereby generating considerable savings by preventing over-pressured delivery.

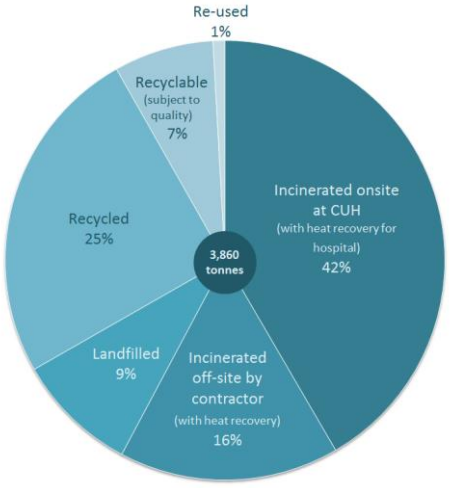
Sustainable Procurement and Waste Management

For the Trust to achieve a more circular local flow of goods and materials, that saves it both money and resources (whilst also contributing to the wider sustainability of its supply chains), it is essential that procurement works hand-in-hand with waste management. Almost all of the products we buy, we also subsequently throw away. Linear supply chains mean that we are, in effect, buying our own waste. We continue to make progress in identifying the more circular relationships between purchasing and waste management through the combined endeavours of our Environmental Services, Procurement and Sustainability teams. Good working links to identify 'circularity' benefits are developed through the assessment of tender specifications and Pre-Acceptance Waste Audits, and through periodic staff communications relating to waste segregation, collection and disposal queries (including links with the team-based Think Green Impact behaviour change programme).

The Trust furthered its commitment to sustainable waste management, alongside reducing pollution and some aspects of its carbon footprint, by signing up to the NHS Single-Use Plastics Pledge in October. The new commitment picks up on Government legislation on the use and availability of plastic straws, stirrers and cotton buds that took effect from 1st April 2020. The objective is to press for a broader review and, wherever possible, actions to curtail the deployment of single-use plastics across the public health sector. The initial focus is on catering items.

Performance across the Trust's main collated waste streams remains positive. The balance between the necessary on-site incineration of clinical waste and the recycling and off-site disposal of domestic waste continues to shift away from landfill. It should be noted, though, that some of the recent step-changes are a result of the transition from landfill to the energy-from-waste incineration of deemed non-recyclable domestic content, as opposed to improving recycling rates.

Figure 6: CUH total waste arising by disposal stream 2019/20



This year, the Trust has sustained an impressive six re-use, seventeen recycling and two energy-from-waste streams alongside repairs, where possible, to medical devices through Clinical Engineering and site infrastructure through the Estates

and Facilities Maintenance teams. The on-line intranet Swap Shop is still finding new homes for unwanted items, although we continue to review options to expand re-use capacity.

As an acute hospital campus, however, there are waste types for which value retention is not an option. CUH produces significant quantities of healthcare waste which is often hazardous or contaminated. This means it is bound by tight regulations as to how it can be disposed of: re-use and recycling are not available disposal routes for these types of waste. The Trust incinerates all clinical and offensive waste on site in what is, essentially, total destruction - with the exception of the recovery of heat from the burning process that is then used to warm the premises.

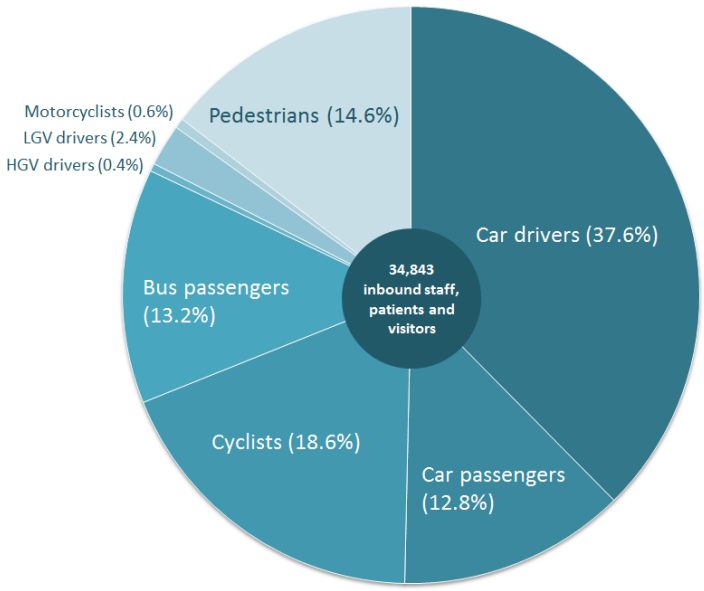
As with energy and water, however, we depend upon staff, patients and visitors to use the sustainability infrastructure that the Trust puts in place as effectively and responsibly as possible. For waste management this means users putting items in the correct bin or collection points when they have finished with them. The potential for bagged waste to hide mistakes and errors in this sorting at source are both perennial and significant in terms of safety and sustainability.

The Trust's dry-mixed recycling stream is going through a period of transition in response, externally, to a shifting marketplace and, internally, to quality issues relating to contamination of our green-bagged waste. In an effort to resolve this, the bin labelling, bagging, staff communications, training and chute room waste collection processes have been reviewed in detail. Revised and clearer labels have since been designed, consulted on and finalised together with improved bagging and chute room sorting processes. This integrated rebranding and alternative handling of the bagged waste streams is a major project and is scheduled to come on line in the second quarter of 2020/21.

Sustainable Travel

The Trust has a long track record of successfully enabling more sustainable modes of travel for work. Since 1993 the percentage of staff travelling to work by car has halved. This has been an outstanding and very necessary achievement as the total number of staff coming to work at CUH has grown from around 4,000 to over 10,000 for the same period.

Figure 7: Inbound access to Cambridge Biomedical Campus by mode 2019



This commitment has been especially valuable throughout 2019/20 as several new premises have opened on the Biomedical Campus in the form of the new Royal Papworth Hospital, the new Abcam building and two major University of Cambridge premises.

Managing the transport impacts of these important new wider campus developments has been a challenge shared between the Trust, other CBC existing occupants, the newly arriving occupants, the relevant local authorities with a combined lead through the Greater Cambridge Partnership (GCP) and commercial partners from public transport to cycle-share companies. GCP have continued to prioritise the role of the Biomedical Campus in transport planning improvements for the wider area.

Without the determination to deliver a major step-change in commuting modes and the ongoing commitment to sustain them, the number of cars coming to site would have created extreme congestion on the campus and its local feeder roads during peak times as well as creating issues of air pollution and excessive carbon emissions.

Travel on Trust business is another important area where there is real potential to take direct steps to reduce carbon emissions, improve air quality and cut costs. During the summer, the Trust introduced an on-line car club-style booking system and new fleet of vehicles for staff needing them for business purposes. Not only has this more accessible and convenient Ubeeqo pool car system seen an almost 20% increase in usage, it has also delivered a useful carbon reduction. The specification for the twelve new cars included a significant improvement in emissions. The business case for securing an average factor of 100gm/km was realised through ensuring that fuel costs were factored into the decision-making. To date this has saved in the region of 14t CO_{2e} when compared to the previous fleet as well as diverting mileage from greyfleet use to this much better value and lower carbon alternative.

In the early autumn our cyclists showed their commitment to the cause and benefits of active and sustainable travel by pushing CUH to the very top of the rankings of Love To Ride's international Cycle September competition, with the Trust finishing as convincing winners in their category.

Sustainable Behaviour Change

CUH's ongoing upgrade to the physical infrastructure and delivery systems of energy and water efficiency, waste segregation, travel choices and life-cycle-assessed procurement are all essential aspects of the transition to a secure and more sustainable future. This, however, is only part of the picture. The essential next step to infrastructure upgrade and process change is to ensure they are used effectively by real people in real situations: our staff, patients and visitors across a large, complex and intense hospital campus.

Few people want to see resources wasted or to cause avoidable damage to our natural environment. The pressures of a busy hospital often mean, however, that the environmental impacts of our day-to-day actions can easily be overlooked. Requests to power-down, recycle more or catch the bus will struggle to make a real difference on the ground unless they are tailored to individual teams and workspaces. When working in a hospital with over 60 buildings and over 7,500 occupied rooms, corporate communication can often struggle to put the message in the context of local area delivery.

While the more conventional rolling communications campaign tools are important in raising awareness and the profile of important sustainability matters and events (via CUH Daily, 08:27 meetings, Connect 2 and Think Green e-mail and Twitter accounts), the message often needs supplementing through local champions and team working.

Think green
Take action for a sustainable future
Cambridge University Hospitals

More focused engagement for more lasting change at the specific workspace or departmental level is essential. Working with section managers and their delivery teams places the all-important understanding of what is consumed and how we consume within a local sustainability frame that prompts action and innovation. Here the daily run of work processes is completely understood. This means that the options for more sustainable energy, waste, water, transport and purchasing can be tailored to fit with real-world routines and thereby become a natural part of day-to-day life. At this level of direct delivery, the door to new and rewarding approaches to sustainable working is typically wide open.

The Trust's Think Green Impact (TGI) programme is designed to deliver in this key area. It has proved that small teams are keen to ensure that their work areas and colleagues are really staying on top of energy and water consumption whilst minimising waste and promoting more sustainable travel and purchasing. All that is required is some support, and advice if necessary, with some recognition of achievement along the way. TGI provides exactly this through creating individual team action logs with at least four levels of ambition (Green, Bronze, Silver or Gold) together with detailed guidance, support sessions, newsletters, audits and awards over a timeframe that works locally. 2019/20 saw TGI open as a permanent programme that is accessible for teams to sign-up to and take forward whenever they choose. The window for joining is no longer constrained – allowing departmental and divisional leadership to structure the take-up and timing of the programme to suit their wider programmes of delivery and activity.

Being prepared for the impacts of climate change

The cumulative concentration of manmade greenhouse gasses in the atmosphere has already committed us to experience a significant degree of climate change. In Cambridge the most immediate of these is likely to be felt through building overheating from summer heat-waves. In 2019 Cambridge was subject to hottest UK outside air temperature on record at 38.7°C (101.7°F) on 25 July. All staff, patients and visitors on site during that period will remember the discomfort and potential vulnerability.

Heatwaves and extended periods of hot weather put significant pressure on the hospitals' ventilation and cooling systems and create extended spikes in electricity consumption and carbon emissions. Air-conditioning is not only costly to purchase and run (with a corresponding increase in carbon emissions) but it is also disruptive to install and in many cases not a viable option due to space constraints for the units, ducting and pipe-runs – especially in older buildings not designed to accommodate such services. Reflecting these constraints, portable air-conditioning units are now provided in a carefully controlled manner in the summer months for critical clinical areas. However, as climate change raises the likelihood and intensity of summertime heatwaves it is increasingly important to seek out and bring forward low energy solutions.

The Trust is currently in the process of trialling the deployment of a new solar rejection film to windows with a southerly aspect alongside the installation of small two-way window or wall-mounted fans (with timer controls to facilitate overnight 'free' cooling). If successful these interventions will be packaged up with the all-important local behavioural and management responses to provide an accessible low carbon and relatively low-cost solution to mitigating seasonal over-heating.

Surface water flooding from more frequent and intense storm events is also an anticipated outcome of climate change. The Trust has experienced some impact from such events over the past five years in the south-western corner of the site

– most significantly on 17th July 2015 when a 1-in-190 year heavy rainfall and flooding event caused the Trust to declare a 'major incident'. In response to this, and working with Cambridge City Council, a Surface Water Management Plan (SWMP) for CUH and mitigation outline business case was drafted. Interventions from this have now been implemented to reduce the risk of flooding in the future.

Looking forward

This report is being written during the third month of the very sudden and very immediate COVID-19 crisis. The impacts have been severe, and the response is unparalleled in modern history. No organisation, community or family has been unaffected.

The very real evidence and scientific understanding of climate change, pollution and the loss of natural resources across the whole world all warn of a potentially far greater crisis with far greater impacts.

A major difference between the COVID-19 crisis and the environmental crisis unfolding around us is that not only can we see the latter coming, we also know what to do to prevent it.

During 2019/20 the NHS has even more strongly aligned itself with the principles of a climate emergency response. Both the NHS Long Term Plan and Standard Contract being very clear that environmental sustainability is a priority topic. In March, a concerted programme to deliver a 'Greener NHS' was launched and an accelerated net zero-carbon workstream was commissioned. In the same vein, each region is establishing Senior Responsible Officers to engage their fellow NHS leaders in what needs to be done – starting with a raft of focused actions covering renewable electricity, business mileage, LED lighting, single-use plastics, inhalers and anaesthetic gases. Regional Sustainability Networks are also expected to be allocated additional resource (the East of England Network is currently chaired through CUH).

In direct support of this, the Trust will continue to bring forward innovative and extensive programmes of work wherever possible. It is, however, very important not to forget or account for the numerous lesser profile, more routine and regular activities. These jobs are not only delivering incremental carbon reductions and pointing towards a more circular economy, they are also improving the wellbeing of patients and staff. These lesser interventions are driven by the same environmental aspirations as a new solar PV array or upgrading 7,000 light fittings but just with smaller more local impacts. Taken together they make a big difference - A difference beyond the sum of their combined carbon-saving. This is because they get many more people involved as part of the progressive change to a new environmentally conscious normal. From sending a torn chair cover off to be re-upholstered by our first-class carpenters, to requesting a recycling bin, to choosing to cycle for work more often, to putting solar film on south-facing windows, to reporting a dripping tap, to taking a re-usable cup to the coffee shop, the list goes on – all these things add up. The more we can support them, make them easier to do, and just be a part of everyday life at CUH the more they become the foundation of our sustainable future: together.

Tackling COVID-19 has temporarily slowed the Greener NHS momentum but, importantly, the workstream has not been put on hold. This is in recognition of the continuing priority attached to climate change and, partly perhaps, because many sustainability actions – especially those relating to transport – resonate with the needs of containing the virus's spread and impact. The pressures of social-distancing have been partially off-set by the environmental benefits of increased levels of home-working and video-and-telephone-conferencing: reducing the carbon and air quality impacts associated with patient travel, business miles and commuting. Alongside these direct transport gains, the necessity of reduced occupation levels in offices and other areas should mitigate some of the impact of seasonal hot weather, and thereby the carbon emissions, associated with a heightened demand for mechanical cooling across the site.

The formal rebranding of NHS Sustainable Development Management Plans (SDMPs) into Green Plans and the rapidly emerging NHS net zero-carbon planning guidance have re-shaped the drafting schedule for a replacement to the Trust's existing SDMP (2013-2020). A brand new CUH Green Plan (2021-2025) will be in place by 31st March 2021. This will respond to the restructured central priorities and guidance that have come forward over the past six months and will be further advanced by the net zero-carbon direction due at the end of summer 2020.

In the meantime, 2020/21 needs to be another year of strong progress and growing urgency in the transition from a high carbon, take-make-use-dispose way of working to one where very low carbon and reduce-reuse-repair-recycle are the norm. As well as continuing to embed these tenets within the Trust's ongoing safe, kind and excellent healthcare delivery, they will also be key drivers in the design and engineering of the new Cambridge Children's hospital; the Cancer Research hospital, the Emergency hospital and planning for further progressive renewal of the site, delivering on our net zero carbon ambition for new hospital developments.

3.30 Other issues

The activities and policies of the CUH in the areas of social, environmental, community and human rights are outlined earlier in this chapter and specifically the equality and diversity report and sustainability and climate change report.

Roland Sinker
Chief Executive
23 June 2020

Cambridge University Hospitals NHS
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Accounts

Year Ended 31 March 2020

Presented to Parliament pursuant to Schedule 7, paragraphs 24 and 25 of the National Health Service Act 2006.

Independent auditor's report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust

Report on the financial statements

Qualified opinion on the financial statements

We have audited the financial statements of Cambridge University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20, and the Accounts Direction issued under the National Health Service Act 2006.

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

- give a true and fair view of the financial position of the Trust as at 31 March 2020 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

The carrying amount of the Trust's inventory balance held at 31 March 2020 is £12.58 million. We were unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust as at 31 March 2020 because we were unable to attend the year-end physical inventory counts due to COVID-19 related travel restrictions. We were unable to satisfy ourselves by alternative means concerning the existence and condition of inventory held by the Trust as at 31 March 2020 by using other audit procedures. Consequently we were unable to determine whether any adjustments to this amount were necessary.

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

Material uncertainty related to Going Concern

We draw attention to Note 1.2 in the financial statements, which indicates that the Trust incurred a deficit during the year ended 31 March 2020 of £37.1 million resulting in an accumulated deficit on the Statement of Financial Position of £282.7 million. No financial plan has been agreed for 2020/21 and there is no agreed plan to return the Trust to a recurrent break-even position.

These events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Key audit matters

In addition to the matter described in the 'Basis for qualified opinion' section of our report, key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit, and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Land and buildings valuation *Note 8 to the financial statements discloses information on the Trust's holding of property, plant and equipment (PPE) which includes £297 million of land and buildings (including PFI assets) held at current value at 31 March 2020. These assets are subject to periodic revaluation in line with the requirements of the Group Accounting Manual (GAM). Note 1.8 to the financial statements describes the Trust's accounting policy with respect to the valuation of land and buildings and note 1.20 includes disclosure of a material valuation uncertainty as a result of the Covid-19 pandemic.* Land and buildings are the Trust's highest value assets, we therefore consider valuation of land and buildings to be a significant risk. Management engaged the Valuation Office Agency (VOA) as an expert to assist in determining the current value of land and buildings to be included in the financial statements. Changes in the value of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the GAM. The Trust uses a modern equivalent asset (MEA) valuation for land and buildings on an alternative site basis which can involve a greater degree of estimation uncertainty and an increased level of judgement. The significant risk of material misstatement is further increased due to the additional estimation uncertainty arising from the Covid-19 pandemic.	Our audit procedures included, but were not limited to: • Obtaining an understanding of the skills, experience and qualifications of the valuer, and considering the appropriateness of the instructions to the valuer from the Trust. • Obtaining an updated understanding of the basis of valuation applied by the valuer in the year. This included understanding and assessing the methodology applied to estimate the gross replacement cost of the Trust's operational land and buildings on a modern equivalent asset basis. Specifically, we evaluated the Trust's application of a 'single-site' valuation methodology which covers its existing hospital sites. • Sample testing the completeness and accuracy of underlying data provided by the Trust and used by the valuer as part of their valuations. • Testing the accuracy of how valuation movements were presented and disclosed in the financial statements. • Making direct enquiries with the valuer and using relevant cost and market data to assess the reasonableness of the valuation as at 31 March 2020. We used this to assess the effect of the material valuation uncertainty disclosed in the valuation report and in the Trust's financial statements. **Key observations** We obtained sufficient appropriate evidence to conclude that the valuation of land and buildings included in the financial statements is reasonable.

Revenue recognition *The Trust recognised £1,005 million of revenue from activities in the Statement of Comprehensive Income. The Trust's primary source of revenue is through contracts with commissioning bodies in respect of the provision of acute healthcare services. Note 2 provides further information on the nature and source of the Trust's revenue.* Auditing Standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting leading to material misstatement and means that we are unable to rebut the presumption.	Our audit procedures included, but were not limited to: • Evaluating the Trust's accounting policy in respect of revenue recognition to ensure that it is in line with the requirements of the GAM. • Agreeing a sample of revenue recognised through contracts with commissioners, to the underlying contractual agreement and any agreed variations in the year to appropriate evidence. • Testing a sample of other revenue by agreeing the transactions to appropriate source documentation and obtaining assurance that each item was recorded in the correct financial year and at the correct value. • Considering information provided by the Department of Health and Social Care in respect of year-end intra-NHS transactions. We identified any significant differences between the Trust's position and that of the counterparty and obtained assurance that the Trust's position was supported by appropriate evidence. • Testing a sample of expenditure items for which the Trust has recognised additional funding from the Department of Health and Social Care to obtain assurance that these were correctly recorded as Covid-19-related expenditure items that were due to be reimbursed. **Key observations** We obtained sufficient appropriate evidence to conclude that revenue recognised in the financial statements is reasonable.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as follows:

Overall materiality	£10.2 million
Basis for determining materiality	Approximately 1% of operating expenses of continuing operations.

Rationale for benchmark applied	Operating expenses of continuing operations is a key measure of financial performance for users of the financial statements.
Performance materiality	£8.2 million
Reporting threshold	£300,000

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items. There were no changes to the scope of the current year audit from the scope in the prior year.

Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year;
- discussions with the Trust's internal auditor; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud (other than the key audit matter on revenue recognition outlined above).

The risks of material misstatement, including due to fraud, that had the greatest effect on our audit are discussed under 'Key audit matters' within this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we

identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

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.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2019/20; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2019/20; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.

Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a Director or officer of the 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; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2020, with the exception of the matters disclosed in the 'Basis for qualified conclusion' paragraph below, we are satisfied that, in all significant respects, Cambridge University Hospitals NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion

In considering the Trust's arrangements for sustainable resource deployment we identified that as well as reporting a deficit of £37.1 million, after receipt of Provider Sustainability Funding of £33 million in 2019/20, the Trust does not currently have a robust plan to achieve a sustainable annual balance of income and expenditure without significant changes in system funding. The Trust will require significant further cash support from the Department of Health and Social Care to continue to maintain statutory functions.

The actual deficits and the absence of a robust plan for restoring a sustainable financial position are evidence of significant weaknesses in the Trust's arrangements for planning finances for sustainable resource deployment and the maintenance of statutory functions.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust 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 Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of Cambridge University Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Lucy Nutley

Lucy Nutley
For and on behalf of Mazars LLP

Tower Bridge House, St Katharine's Way, London, E1W 1DD

30 June 2020

FOREWORD TO THE ACCOUNTS

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust ("the Trust") acts as an acute hospital and the main teaching hospital for the University of Cambridge. The Trust serves the local Cambridge area and also provides specialist services to the wider population throughout the East of England and beyond. The Trust hosts a number of clinical networks and the Cambridge Biomedical Research Centre.

These accounts for the year ended 31 March 2020 have been prepared by Cambridge University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed

Roland Sinker
Chief Executive

23 June 2020

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2020

	Note	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Operating income from patient care activities	2	807,898	730,209
Other operating income	2	196,916	146,183
Total operating income from continuing operations		1,004,814	876,392
Operating expenses of continuing operations	3	(1,026,881)	(958,629)
Operating (deficit)		(22,067)	(82,237)
Finance costs			
Finance income	6	257	212
Finance expense	6	(13,718)	(11,641)
Net finance costs		(13,461)	(11,429)
Other gains/(losses)	6	(1,342)	(569)
Share of (loss) of joint operations	9	(268)	-
(Deficit) from continuing operations		(37,138)	(94,235)
(Deficit) for the year		(37,138)	(94,235)
Other comprehensive income/(expenditure)			
Will not be reclassified to income and expenditure:			
Downwards revaluations charged to the revaluation reserve	8	(808)	(1,490)
Revaluations		-	2,235
Total comprehensive (expense) for the year		(37,946)	(93,490)
Allocation of (losses) for the year:			
(Deficit) for the year attributable to:			
Government		(37,138)	(94,235)
Total comprehensive (expense) for the year attributable to:			
Government		(37,946)	(93,490)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2020

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	7	28,189	29,256
Property, plant and equipment	8	344,237	340,701
Receivables	11	2,034	-
Total non-current assets		374,460	369,957
Current assets			
Inventories	10	12,580	11,755
Trade and other receivables	11	96,469	70,440
Cash and cash equivalents	12	18,385	35,099
Total current assets		127,434	117,294
Current liabilities			
Trade and other payables	13	(121,786)	(141,888)
Borrowings	14	(350,777)	(119,986)
Provisions	15	(270)	(744)
Other liabilities	13	(26,659)	(23,681)
Total current liabilities		(499,492)	(286,299)
Total assets less current liabilities		2,402	200,952
Non-current liabilities			
Borrowings	14	(102,911)	(268,088)
Provisions	15	(5,199)	(2,268)
Total non-current liabilities		(108,110)	(270,356)
Total assets employed		(105,708)	(69,404)
Taxpayers' equity			
Public dividend capital		139,627	137,985
Revaluation reserve		37,413	38,343
Income and expenditure reserve		(282,748)	(245,732)
Total taxpayers' and others' equity		(105,708)	(69,404)

These financial statements were approved by the Board on 23 June 2020 and signed on its behalf by:

Dr Mike More	Mr Roland Sinker	Mr Paul Scott
Chairman	**Chief Executive**	**Chief Finance Officer**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2020

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' and others' equity at 01 April 2019	(69,404)	137,985	38,343	(245,732)
(Deficit) for the year	(37,138)	-	-	(37,138)
Transfers between reserves	-	-	(122)	122
Downwards revaluations charged to the revaluation reserve	(808)	-	(808)	-
Public dividend capital received	1,642	1,642	-	
Taxpayers' equity at 31 March 2020	(105,708)	139,627	37,413	(282,748)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2019

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' and others' equity at 01 April 2018	21,368	132,881	37,701	(149,214)
Impact of implementing IFRS 9 on opening reserves	(2,386)	-	-	(2,386)
(Deficit) for the year	(94,235)	-	-	(94,235)
Transfers between reserves	-		(103)	103
Downwards revaluations charged to the revaluation reserve	(1,490)	-	(1,490)	-
Revaluations	2,235	-	2,235	-
Public dividend capital received	5,104	5,104	-	-
Taxpayers' equity at 31 March 2019	(69,404)	137,985	38,343	(245,732)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Cash flows from operating activities		
Operating (deficit) from continuing operations	(22,067)	(82,237)
Non-cash income and expense		
Depreciation and amortisation	21,788	20,557
Impairments	3,195	-
Income recognised in respect of capital donations (cash and non-cash)	-	(429)
(Increase)/decrease in receivables	(26,029)	10,486
(Increase)/decrease in inventories	(825)	94
(Decrease)/increase in trade and other payables	(20,568)	36,086
Increase in other liabilities	2,978	1,585
Increase/(decrease) in provisions	2,363	(1,961)
Other movements in operating cash flows	(268)	-
Net cash generated from / (used in) operations	(39,433)	(15,819)
Cash flows from investing activities		
Interest received	257	212
Purchase of intangible assets	(3,103)	(2,677)
Purchase of property, plant and equipment and investment property	(26,140)	(33,218)
Sales of property, plant and equipment and investment property	107	169
Receipt of cash donations to purchase capital assets	-	429
Net cash (used in) investing activities	(28,879)	(35,085)
Cash flows from financing activities		
Public dividend capital received	1,642	5,104
Movement in loans from the Department of Health and Social Care	67,189	75,333
Capital element of PFI, LIFT and other service concession payments	(1,817)	(1,931)
Interest on loans	(8,887)	(6,356)
Interest element of PFI, LIFT and other service concession obligations	(4,495)	(4,536)
Net cash generated from financing activities	53,632	67,614
(Decrease)/increase in cash and cash equivalents	(14,680)	16,710
Cash and cash equivalents at 1 April	35,099	18,389
Cash and cash equivalents at 31 March	20,419	35,099

The Foundation Trust held £0.4k cash at bank and in hand at 31 March 2020 (year ended 31 March 2019, £7k) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

NOTES TO THE ACCOUNTS

IFRS Accounting Policies

1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation 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 DHSC GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Going concern – material uncertainty

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

Financial position:

- The Trust achieved its Control Total for 2019/20, recording a financial deficit of £37.1 million for the 2019/20 financial year.
- The balance sheet at 31 March 2020 shows a cumulative deficit (i.e. negative income & expenditure reserve) of £282.7 million.
- There is currently no medium term plan in place to return the Trust to recurrent financial balance or to repay the cumulative deficit.
- The Trust is no longer in "special measures".
- The Trust drew down £77.3 million of additional working capital funding from the Department of Health and Social Care during 2019/20. This funding ensured that the Trust could continue to meet its liabilities during 2019/20 as they fell due.
- The Secretary of State has announced that historic working capital loans and emergency capital loans will be refinanced in 2020/21 and replaced with Public Dividend Capital, thereby reducing the interest and debt repayment burden on the Trust and returning the Trust to a positive net assets position.
- The interim NHS funding model will ensure the Trust has the necessary funding and support to respond to the coronavirus (COVID-19) pandemic and should result in a breakeven financial position for 2020/21.
- The Trust does not expect to require further working capital support from the Department of Health and Social Care in 2020/21.
- Contracts with the Trust's main Commissioners have been signed which give a significant level of assurance around continued service delivery and income cash flows for the Trust during 2020/21.
- The Trust has been successful in attracting significant new national strategic capital investment, including funding for a major hospital re-build and a new Children's Hospital, both of which are currently being worked up in more detail. This demonstrates a level of confidence in the Trust's long term future.

After making enquiries, and considering the matters described in the preceding paragraphs, which may represent a material uncertainty, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.3 Joint operation

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the net assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Where the joint arrangement is loss making the investment in the partnership is impaired to zero by the losses made, and remaining losses are recognised as a provision due to the constructive obligation.

1.4 Revenue from contracts with customers

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

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

Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of the number of occupied bed days and an average cost per bed day.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

At the year end, the Trust accrues revenue relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time. Revenue is recognised to the extent that collection of consideration is probable.

Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

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

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.

1.5 Other forms of income

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

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

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.

1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs - NHS Pension Scheme

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

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

Accounting valuation

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

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

Full actuarial (funding) valuation

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

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

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

1.7 Expenditure on other goods and services

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

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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.

Measurement

All property, plant and equipment 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.

Subsequently, land and buildings are measured at valuation and all other Property, plant and equipment assets are held at depreciated historical cost.

Land and specialised buildings are held at depreciated replacement cost on a modern equivalent asset (alternative site) basis. Non-specialised buildings are held at existing use value. Valuations are carried out by professionally qualified District Valuers in accordance with the Royal Institution of Chartered Surveyors

(RICS) Appraisal and Valuation Manual. Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust. The land and buildings valuation was undertaken as at the prospective valuation date of 31 March 2020, applying the modern equivalent assets valuation (alternative site) basis which is consistent with IAS (International Accounting Standard) 16.

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

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

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 existing carrying amount of the part replaced is de-recognised and charged to operating expenses. 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.

Depreciation

Items of property, plant and equipment are depreciated, less any residual value, on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction that are not yet being used are not depreciated.

Buildings, installations and fittings are depreciated on their current value for existing use over the estimated remaining life of the asset as assessed by professional valuers.

Useful lives of property, plant and equipment

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

Land	Infinite
Buildings	1 – 60 years
Plant and Machinery	5 – 15 years
Transport Equipment	7 years
Information Technology	5 – 12 years
Furniture and fittings	7 – 10 years

Revaluation gains and losses

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

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset (alternative site) basis.

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

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

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

Impairments

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

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

Donated, government grant and other grant funded assets

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

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

Private Finance Initiative (PFI) transactions

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

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

The finance cost is allocated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.9 Intangible assets

Recognition

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

Expenditure on research is not capitalised, it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operating of hardware, e.g. 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, e.g. 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 by reference to an active market. Where no active market exists, intangible assets are valued at the lower of depreciated cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The estimated life of purchased computer software is between 2 and 12 years.

1.10 Inventories

Inventories comprise mainly consumable medical products.

Inventories are valued at the lower of cost and net realisable value. The weighted average cost formula is used for drugs and the first in first out cost formula for all other inventories. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.12 Financial assets & financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provision 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.

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.

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 profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are recognised when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial liabilities are recognised when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

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.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Amortised cost financial assets

Amortised cost financial assets are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's amortised cost financial assets comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Amortised cost financial assets are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through profit and loss" are impaired. Financial assets are impaired and impairment losses are recognised if they meet the requirements of the expected credit loss model.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance

account/bad debt provision.

1.13 Leases

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially 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 and the classification for each is assessed separately.

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf is £339.7m (year ended 31 March 2019, £327.4m). This 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 as and when the liability arises.

1.15 Contingent assets and liabilities

The Trust had no contingent assets or liabilities as at 31 March 2020.

1.16 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance, based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- donated and grant funded assets
- average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of

PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

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

1.18 Third party assets

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

1.19 Losses and special payments

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

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

1.20 Critical judgments in applying accounting policies

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

The Trust's PFI scheme has been assessed and recognised on the Statement of Financial Position under IFRIC 12. The PFI scheme has been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2020. The £9.1m unitary charge is based on actual charges made by the PFI provider. The Department of Health and Social Care model has been used to determine the apportionment between the repayment of the liability, financing costs, the charges for services and lifecycle maintenance.

Key sources of estimation uncertainty

The most significant estimate within the accounts is the value of land and buildings. The land and buildings have been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2020. The District Valuer is independent of the Trust and is certified by the Royal Institution of Chartered Surveyors. The valuer has extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

This year the valuer has disclosed the additional uncertainty attached to the current valuations, in line with RICS guidance, as follows:*"The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on 11 March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries. Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of this property / these properties under frequent review."*

In order to report within the government guidelines, the value of patient care activity for the year ended 31 March 2020 has been estimated based on data available as at 1 April 2020.

Income for an inpatient stay can be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying beds as at 31 March 2020, the estimated income from partially completed patient spells was £5.4m (year ended 31 March 2019, £5.9m).

The Trust has a financial liability for any annual leave earned by staff but not taken by 31 March 2020, to the extent that staff, are permitted to carry leave forward in to the next financial year. The estimated cost of untaken annual leave as at 31 March 2020 is £2.4m (year ended 31 March 2019, £2.1m).

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency, expert legal opinion within the Trust and external advisors, regarding when the legal issue may be settled.

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining the carrying amounts of these assets. No significant variations are expected.

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

IAS 8, Accounting Policies, Changes in Accounting Estimates and Errors requires entities to disclose details where they have not applied a new IFRS Standard that has been issued but is not yet effective.

IFRS 14, Regulatory Deferral Accounts Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16, Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged. IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

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

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable.

IFRS 17 Insurance Contracts Application required for accounting periods beginning on or after 1 January

2021, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not expected to have a material impact.

IFRIC 23 Uncertainty over Income Tax Treatments Application required for accounting periods beginning on or after 1 January 2019. This is not expected to have a material impact.

2. Operating income

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

2.1 Operating Income (by nature)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Income from activities		
Acute services		
Elective income	123,428	122,234
Non-elective income	174,354	156,198
First outpatient income	69,759	65,871
Follow up outpatient income	50,079	45,705
A&E income	22,456	18,015
High cost drugs income from commissioners	98,938	88,427
Other NHS clinical income	226,862	213,975
Private patient income	10,645	9,400
AfC pay award central funding	-	6,285
Additional pension contribution central funding	21,341	-
Other clinical income	10,036	4,099
Total income from patient care activities	807,898	730,209

In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS England and NHS Improvement, providers' accounts are required to account for the additional expenditure arising from the 6.3% pension contributions paid by NHS England and related income on a gross basis.

2.2 Income from patient care (by source)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Income from activities		
NHS England	400,263	338,882
Clinical commissioning groups	380,538	362,629
NHS Foundation Trusts	-	293
NHS Trusts	132	54
Local authorities	60	-
Department of Health and Social Care	176	6,285
NHS other (including Public Health England)	3,712	3,727
Non NHS: private patients	10,645	9,400
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	488	345
Injury cost recovery scheme	4,178	3,754
Non NHS: other	7,706	4,840
Total income from activities related to continuing operations	807,898	730,209

2.3 Other operating income

	Year ended 31 March 2020 £000	Year ended 31 March 2019 (Restated *) £000
Other operating income		
Research and development (IFRS 15)	48,637	46,510
Education and training (excluding notional apprenticeship levy income)	40,277	39,647
Non-patient care services to other bodies	49,715	37,645
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET)	33,012	-
Other (recognised in accordance with IFRS 15)	23,093	19,682
Cash donations for the purchase of capital assets - received from other bodies	-	429
Other (recognised in accordance with standards other than IFRS 15)	259	814
Rental revenue from operating leases	1,923	1,456
Total other operating income related to continuing operations	196,916	146,183
Total operating income	1,004,814	876,392

Analysis of other operating income: Other

	Year ended 31 March 2020 £000	Year ended 31/03/2019 (Restated *) £000
Car parking income	1,295	1,196
Estates recharges (external)	6,737	6,729
Pharmacy sales	73	63
Staff accommodation rental	993	1,023
Staff contribution to employee benefit schemes	1	-
Clinical tests	293	355
Clinical excellence awards	5,239	5,136
Grossing up consortium arrangements	8,462	4,638
Other income not already covered (recognised under IFRS 15)	-	542
Total	23,093	19,682

* The year ended 31 March 2019 had been restated to separately disclose £1.456m "Rental revenue from operating leases", this was previously included in "Estates recharges (external)".

2.4 Overseas visitors (relating to patients charged directly by the Foundation Trust)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 (Restated *) £000
Income recognised this year	488	345
Cash payments received in-year (relating to invoices raised in current and previous years)	417	489
receivables (relating to invoices raised in current and prior years)	284	433
Amounts written off in-year (relating to invoices raised in current and previous years)	252	15

* The "Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)" has been restated for the year ended 31 March 2019 to disclose the current year impact. It previously disclosed the cumulative impact.

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

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	14,992	14,738

2.6 Transaction price allocated to remaining performance obligations (i.e. revenue not recognised this year)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Revenue from contracts entered into as at by the period end expected to be recognised:		
- within one year	20,010	15,460

3. Operating expenses (by type)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	4,008	6,402
Staff and executive directors costs	552,864	497,560
Non-executive directors	151	146
Supplies and services – clinical (excluding drugs costs)	156,622	151,102
Supplies and services - general	23,901	22,672
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	130,997	119,062
Consultancy	-	194
Establishment	11,902	12,747
Premises - business rates collected by local authorities	4,248	3,911
Premises - other	60,219	49,779
Transport (business travel only)	696	1,034
Transport - other (including patient travel)	1,744	2,235
Depreciation	17,552	16,642
Amortisation	4,236	3,915
Impairments net of (reversals)	3,195	-
Increase in impairment of receivables	2,699	1,289
Provisions arising / released in year	-	(68)
Change in provisions discount rate	184	(44)
Audit services - statutory audit (net of VAT)	60	55
Other auditor remuneration (payable to external auditor only) for audit-related assurance services (net of VAT)	5	9
Internal audit	111	123
Clinical negligence - amounts payable to NHS Resolution (premium)	17,965	18,757
Legal fees	629	407
Insurance	288	398
Research and development	4	4
Education and training	3,040	2,410
Operating lease expenditure	10,328	10,862
Early retirements	308	171
Redundancy costs	4	38
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,378	1,631
Car parking and security	1,808	2,040
Hospitality	614	488
Other losses and special payments - staff costs	35	43
Other losses and special payments	202	112
Grossing up consortium arrangements	8,664	9,577
Other operating expenses	6,220	22,926
Total operating expenses of continuing operations	1,026,881	958,629

4. Staff

4.1 Employee expenses

	Year ended 31 March 2020 Total £000	Year ended 31 March 2020 Permanent £000	Year ended 31 March 2020 Other £000
Salaries and wages	433,289	429,447	3,842
Social security costs	43,138	43,138	-
Apprenticeship levy	2,072	2,072	-
Pension cost - employer contributions to NHS pension scheme	48,774	48,774	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	21,341	21,341	-
Temporary staff - agency/contract staff	4,597	-	4,597
Total gross staff costs	553,211	544,772	8,439
Staff and executive directors costs	552,864	544,425	8,439
Redundancy	4	4	-
Early retirements	308	308	-
Special payments	35	35	-
Total employee benefits	553,211	544,772	8,439

In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS England and NHS Improvement, providers' accounts are required to account for the additional expenditure arising from the 6.3% pension contributions paid by NHS England and related income on a gross basis.

	Year ended 31 March 2019 Total £000	Year ended 31 March 2019 Permanent £000	Year ended 31 March 2019 Other £000
Salaries and wages	402,460	397,689	4,771
Social security costs	39,993	39,993	-
Apprenticeship levy	1,910	1,910	-
Pension cost - employer contributions to NHS pension scheme	45,377	45,377	-
Temporary staff - agency/contract staff	8,072	-	8,072
Total gross staff costs	497,812	484,969	12,843
Staff and executive directors costs	497,560	484,717	12,843
Redundancy	38	38	-
Early retirements	171	171	-
Special payments	43	43	-
Total employee benefits	497,812	484,969	12,843

4.2 Average number of employees (WTE basis)

	Year ended 31 March 2020 Total Number	Year ended 31 March 2020 Permanent Number	Year ended 31 March 2020 Other Number
Medical and dental	1,428	598	830
Administration and estates	2,440	2,158	282
Healthcare assistants and other support staff	1,969	1,614	355
Nursing, midwifery and health visiting staff	3,556	3,198	358
Scientific, therapeutic and technical staff	830	735	95
Healthcare science staff	550	518	32
Other	4	-	4
Total average numbers	10,777	8,821	1,956

	Year ended 31 March 2019 Total Number	Year ended 31 March 2019 Permanent Number	Year ended 31 March 2019 Other Number
Medical and dental	1,383	566	817
Administration and estates	2,343	2,096	247
Healthcare assistants and other support staff	1,901	1,487	414
Nursing, midwifery and health visiting staff	3,393	2,963	430
Scientific, therapeutic and technical staff	771	685	86
Healthcare science staff	541	503	38
Total average numbers	10,332	8,300	2,032

4.2 Early retirements due to ill health

	Year ended 31 March 2020 Number	Year ended 31 March 2019 Number
Number of early retirements on the grounds of ill-health	4	3
	£000	**£000**
Value of early retirements on the grounds of ill-health	308	171

4.3 Reporting of other compensation schemes - exit packages

Compulsory redundancies	Year ended 31 March 2020 Number	Year ended 31 March 2020 £000
Exit package cost band (including any special payment element)		
<£10,000	1	4

Compulsory redundancies	Year ended 31 March 2019 Number	Year ended 31 March 2019 £000
Exit package cost band (including any special payment element)		
<£10,000	2	12
£10,001 - £25,000	2	26
Total	4	38

Other departures agreed	Year ended 31 March 2020 Number	Year ended 31 March 2020 £000
Exit package cost band (including any special payment element)		
£10,001 - £25,000	2	35

Other departures agreed	Year ended 31 March 2019 Number	Year ended 31 March 2019 £000
Exit package cost band (including any special payment element)		
<£10,000	12	43

Other (non-compulsory) departure payment	Year ended 31 March 2020 Number	Year ended 31 March 2020 £000
Non-contractual payments requiring HMT approval (special severance payments)	2	35

Other (non-compulsory) departure payment	Year ended 31 March 2019 Number	Year ended 31 March 2019 £000
Contractual payments in lieu of notice	12	43

5. Operating income and expenditure miscellaneous

5.1 Operating lease income and future receipts (trust as a lessor)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Minimum lease receipts	1,923	1,456

5.2 Analysis of operating lease income, future minimum lease receipts due

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
On land leases:		
- not later than one year;	956	635
- later than one year and not later than five years;	3,825	2,542
- later than five years.	14,228	9,156
	19,009	12,333
On buildings leases:		
- not later than one year;	966	820
- later than one year and not later than five years;	3,024	3,082
- later than five years.	3,392	3,833
Total buildings leases	7,382	7,735
Total leases	**26,391**	**20,068**

5. Operating income and expenditure miscellaneous

5.2 Operating lease payments and commitments (trust as a lessee)

	Year ended 31 March 2020 Total £000	Year ended 31 March 2020 Buildings £000	Year ended 31 March 2020 Plant & machinery £000
Minimum lease payments	10,328	3,279	7,049

	Year ended 31 March 2019 Total £000	Year ended 31 March 2019 Buildings £000	Year ended 31 March 2019 Plant & machinery £000
Minimum lease payments	10,862	2,871	7,991

5.3 Analysis of operating lease expenditure, future minimum payments

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
On buildings leases:		
- not later than one year;	3,279	2,890
- later than one year and not later than five years;	11,566	11,069
- later than five years.	22,196	17,779
Total buildings leases	37,041	31,738
On plant and machinery leases:		
- not later than one year;	4,595	4,964
- later than one year and not later than five years;	4,846	7,441
- later than five years.	11	17
Total plant and machinery leases	9,452	12,422
Total leases	46,493	44,160

5.4 Limitation on auditor's liability

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Limitation on auditor's liability	nil	nil

5.5 Other audit remuneration

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Other auditor remuneration paid to the external auditor is analysed as follows:		
Audit-related assurance services - Quality report (net of VAT)	9	9

6. Finance income and expense

6.1 Finance revenue

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Interest on bank accounts	257	212

6.2 Finance expenditure

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Interest on loans from the Department of Health and Social Care		
Capital loans	2,702	2,928
Revenue support / working capital loans	6,427	4,075
Finance costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	2,484	2,585
Contingent finance costs	2,011	1,951
Total interest expense	13,624	11,539
Unwinding of discount on provisions	94	102
Total finance expenditure	13,718	11,641

6.3 Gains/(losses) on disposal of assets

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Gains on disposal of other property, plant and equipment	107	169
Losses on disposal of other property, plant and equipment	(1,449)	(738)
Total	(1,342)	(569)

6.4 Impairments of assets

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Changes in market price	3,195	-
Total impairments charged to operating deficit	3,195	-
Revaluations charged to the revaluation reserve	808	1,490
Total impairments	4,003	1,490

7. Intangible assets

7.1 Intangible assets for the year ended 31 March 2020

	Software £000
Gross cost at 1 April 2019	44,551
Additions - purchased	3,169
Disposals	(295)
Gross cost at 31 March 2020	47,425
Amortisation at 1 April 2019	15,295
Provided during the year	4,236
Disposals	(295)
Amortisation at 31 March 2020	19,236
NBV total at 31 March 2020	28,189

7.2 Intangible assets for the year ended 31 March 2019

	Software £000
Gross cost at 1 April 2018	42,345
Additions - purchased	2,733
Disposals	(527)
Gross cost at 31 March 2019	44,551
Amortisation at 1 April 2018	11,907
Provided during the year	3,915
Disposals	(527)
Amortisation at 31 March 2019	15,295
NBV total at 31 March 2019	29,256

Intangible assets represent a comprehensive electronic patient record system called e-Hospital.

8. Property, plant and equipment

8.1 Property, plant and equipment for the year ended 31 March 2020

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2019	419,954	38,375	199,366	60,748	7,990	86,855	34	18,453	8,133
Additions - purchased	26,540	1,889	10,894	1,441	1,436	10,256	-	515	109
Downwards revaluations charged to the revaluation reserve	(2,322)	-	(140)	(2,182)	-	-	-	-	-
Impairments charged to operating expenses	(11,441)	-	(11,441)	-	-	-	-	-	-
Reclassifications	-	-	5,597	-	(5,808)	176	-	18	17
Disposals	(10,082)	-	-	-	-	(8,507)	(19)	(1,216)	(340)
At 31 March 2020	422,649	40,264	204,276	60,007	3,618	88,780	15	17,770	7,919
Depreciation									
At 1 April 2019	79,253	-	6,406	-	-	52,155	32	13,461	7,199
Provided during the year	17,552	-	9,747	1,514	-	4,970	2	1,092	227
Downwards revaluations charged to the revaluation reserve	(1,514)	-	-	(1,514)	-	-	-	-	-
Impairments charged to operating expenses	(8,246)	-	(8,246)	-	-	-	-	-	-
Disposals	(8,633)	-	-	-	-	(7,058)	(19)	(1,216)	(340)
At 31 March 2020	78,412	-	7,907	-	-	50,067	15	13,337	7,086
Net book value									
Owned	270,518	40,264	183,276	-	3,506	38,239	-	4,433	800
On-SoFP PFI contracts	60,007			60,007					
Government granted	31	-	-	-	-	31	-	-	-
Donated	13,681	-	13,093	-	112	443	-	-	33
At 31 March 2020	344,237	40,264	196,369	60,007	3,618	38,713	-	4,433	833

No assets were held under finance leases or hire purchase contracts, with the exception of the PFI asset, which is financed by a PFI contract recognised on the Statement of Financial Position.

8.2 Property, plant and equipment for the year ended 31 March 2019

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2018	405,176	38,375	195,878	58,146	3,305	82,978	34	18,289	8,171
Additions - purchased	31,599	-	9,535	1,849	7,877	10,473	-	1,840	25
Additions - assets purchased from cash donations/grants	302	-	-	-	113	189	-	-	-
Downwards revaluations charged to the revaluation reserve	(9,333)	-	(9,333)	-	-	-	-	-	-
Impairments charged to operating expenses	-	-		-	-	-	-	-	-
Reclassifications		-	3,286	-	(3,305)	-	-	-	19
Revaluations	753			753					
Disposals	(8,543)	-	-	-	-	(6,785)	-	(1,676)	(82)
At 31 March 2019	419,954	38,375	199,366	60,748	7,990	86,855	34	18,453	8,133
Depreciation									
At 1 April 2018	79,741	-	5,632	-	-	53,003	30	14,115	6,961
Provided during the year	16,642	-	8,617	1,482	-	5,199	2	1,022	320
Downwards revaluations charged to the revaluation reserve	(7,843)	-	(7,843)	-	-	-	-	-	-
Revaluations	(1,482)	-	-	(1,482)					
Disposals	(7,805)	-	-	-	-	(6,047)	-	(1,676)	(82)
At 31 March 2019	79,253	-	6,406	-	-	52,155	32	13,461	7,199
Net book value									
Owned	266,570	38,375	180,320	-	7,877	34,122	2	4,990	884
On-SoFP PFI contracts	60,748	-		60,748					
Government granted	37	-	-	-	-	37	-	-	-
Donated	13,346	-	12,640	-	113	541	-	2	50
At 31 March 2019	340,701	38,375	192,960	60,748	7,990	34,700	2	4,992	934

9. Investments

9.1 Investments in joint ventures and associates (equity accounting)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Investments in JVs and associates outside of the WGA boundary		
Carrying value at 1 April	-	-
Additions	(268)	-
Share of (loss)	268	-
Carrying value at 31 March	-	-

10. Inventory

10.1 Inventory movements for the year ended 31 March 2020

Carrying value	**Total £000**	**Drugs £000**	**Consumables £000**	**Energy £000**
At 1 April 2019	11,755	2,966	8,529	260
Additions	204,051	131,704	72,324	23
Inventories consumed (recognised in expenses)	(203,226)	(130,997)	(72,129)	(100)
At 31 March 2020	12,580	3,673	8,724	183

10.2 Inventory movements for the year ended 31 March 2019

Carrying value	**Total £000**	**Drugs £000**	**Consumables £000**	**Energy £000**
At 1 April 2018	11,849	2,878	8,757	214
Additions	188,663	119,150	69,444	69
Inventories consumed (recognised in expenses)	(188,757)	(119,062)	(69,672)	(23)
At 31 March 2019	11,755	2,966	8,529	260

11. Trade receivables

11.1 Trade receivables and other receivables

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Current		
Contract receivables (IFRS 15): invoiced	31,608	24,226
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	65,002	47,895
Allowance for impaired contract receivables / assets	(10,562)	(8,091)
Prepayments (non-PFI)	7,927	4,021
VAT receivable	2,177	1,930
Clinician pension tax provision reimbursement funding from NHSE	70	-
Other receivables	247	459
Total current receivables	96,469	70,440
Non-current		
Clinician pension tax provision reimbursement funding from NHSE	2,034	-
Total non-current receivables	98,503	70,440

11.2 Allowances for credit losses (doubtful debts)

	Contract receivables and contract assets Year ended 31 March 2020 £000
At 1 April 2019	8,091
IFRS 9 adjustment	-
New allowances arising	5,609
Reversals of allowances (where receivable is collected in-year)	(2,498)
Utilisation of allowances (where receivable is written off)	(228)
Changes arising following modification of contractual cash flows	(412)
At 31 March 2020	10,562

Prepayments and accrued income are neither past their due date nor impaired.

Other trade receivables become due immediately as we offer no credit terms.

In line with IFRS 9 the Trust must immediately recognise a loss allowance at an amount equal to lifetime expected credit losses. The Trust recognises impairment losses on other trade receivables when there is a breach of contract. This is deemed to have occurred if the outstanding receivable has not been settled within 3 months (previously 12 months) or more of the invoice date or if a medical insurance company has underpaid.

12. Cash and cash equivalents

12.1 Cash and cash equivalents movements

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
At 1 April	35,099	18,389
Net change in year	(16,714)	16,710
At 31 March	18,385	35,099

12.2 Breakdown of cash and cash equivalents

Total cash and cash equivalents balance at period end is broken down into:

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Cash at commercial banks and in hand	2,250	4,090
Cash with the Government Banking Service	16,135	31,009
Total cash and cash equivalents as in SoFP	18,385	35,099

13. Trade Payables

13.1 Trade and other payables

Current	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Trade payables	21,114	26,350
Capital payables (including capital accruals)	4,412	3,946
Accruals (revenue costs only)	76,869	93,368
Social security costs	11,793	11,122
Other payables	7,598	7,102
Total current trade and other payables	121,786	141,888

13.2 Other liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Deferred income: contract liability (IFRS 15)	20,010	15,460
Deferred income: other (non-IFRS 15)	6,383	7,857
Deferred grants	266	364
Total other liabilities	26,659	23,681

14. Borrowings

Current	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Normal Course of Business Capital loans from the Department of Health and Social Care	7,216	7,781
Interim Capital loans from the Department of Health and Social Care	43,752	3,221
Revenue support / working capital loans from the Department of Health and Social Care	298,145	107,167
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,664	1,817
Total current borrowings	350,777	119,986
Non-current		
Normal Course of Business Capital loans from the Department of Health and Social Care	59,143	65,541
Interim Capital loans from the Department of Health and Social Care	-	17,031
Revenue support / working capital loans from the Department of Health and Social Care	-	140,084
Obligations under PFI, LIFT or other service concession contracts	43,768	45,432
Total non-current borrowings	102,911	268,088
Total borrowings	453,688	388,074

The Secretary of State has announced that historic working capital loans and emergency capital loans will be refinanced in 2020/21 and replaced with Public Dividend Capital. This will apply to both "Interim Capital loans from the Department of Health and Social Care" and "Revenue support / working capital loans from the Department of Health and Social Care", thereby reducing the interest and debt repayment burden on the Trust. The liability for "Normal Course of Business Capital loans from the Department of Health and Social Care" will remain. This matter has been treated as an adjusting event and the relevant borrowings have been reclassified as current rather than non-current.

14.1 Reconciliation of liabilities arising from financing activities

	DHSC loans 31 March 2020 £000	PFI, LIFT and other service concession obligations 31 March 2020 £000
Carrying value at 1 April 2019	340,825	47,249
Cash movements:		
Financing cash flows - principal	67,189	(1,817)
Financing cash flows - interest (for liabilities measured at amortised cost)	(8,887)	(2,484)
Non-cash movements:		
Interest charge arising in year (application of effective interest rate)	9,129	2,484
Carrying value at 31 March 2020	408,256	45,432

15. Provisions

15.1 Provisions for liabilities and charges

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Current		
Pensions relating to other staff	55	55
Pensions Injury benefits	135	132
Clinician pension tax reimbursement	70	-
Legal claims	10	108
Other	-	449
Total current	270	744
Non-current		
Pensions relating to other staff	459	460
Pensions Injury benefits	1,942	1,808
Clinician pension tax reimbursement	2,034	-
Legal claims	64	-
Other	700	-
Total non-current	5,199	2,268
Total provisions	5,469	3,012

The provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill health these are not funded by the NHS Pension Scheme. The full amount of such liabilities is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement.

15.2 Provisions for liabilities and charges analysis

	Total £000	Pensions - Early departure costs	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax reimbursement £000	Other £000
At 1 April 2019	3,012	515	1,940	108	-	449
Change in the discount rate	184	23	161	-	-	-
Arising during the year	2,411	3	8	45	2,104	251
Utilised during the year - cash	(187)	(46)	(107)	(34)	-	-
Reversed unused	(45)	-	-	(45)	-	-
Unwinding of discount	94	19	75	-	-	-
At 31 March 2020	5,469	514	2,077	74	2,104	700
Expected timing of cash flows:						
In one year or less	2,304	55	135	10	2,104	-
In more than one year but not more than two years	879	33	82	64	-	700
In more than two years but not more than five years	463	133	330	-	-	-
In more than five years	1,823	293	1,530	-	-	-
Total	5,469	514	2,077	74	2,104	700

15.3 Clinical negligence liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
NHS Resolution in respect of clinical negligence liabilities of Cambridge University Hospitals NHS Foundation Trust	339,664	327,351

16. Related party transactions

The Trust is a body corporate established by order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties.

In addition, the Trust has had a significant number of material transactions 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 Her Majesty's Revenue and Customs in respect of deduction and payment of PAYE, and Cambridge City Council in respect of payment of rates.

During the year, none of the Board members, members of the key management staff or parties related to them have undertaken any material transactions with the Trust, with the exception of the University of Cambridge, which is a related party by virtue of the fact that Professor Patrick Maxwell is both a Non-Executive Director of the Trust and Regius Professor of Physic with the University. All transactions between the Trust and University are undertaken on an arms-length basis.

16.1 Related party transactions

	Year ended 31 March 2020 Revenue £000	Year ended 31 March 2020 Expenditure £000
Department of Health and Social Care	38,342	-
Other DHSC group bodies	876,793	59,678
Other Government bodies	4,337	121,247
University of Cambridge	10,451	16,857
	929,923	197,782

	Year ended 31 March 2019 Revenue £000	Year ended 31 March 2019 Expenditure £000
Department of Health and Social Care	43,126	-
Other DHSC group bodies	781,498	44,296
Other Government bodies	4,307	91,810
University of Cambridge	11,987	10,762
	840,918	146,868

16.2 Related party balances

	Year ended 31 March 2020 Receivables £000	Year ended 31 March 2020 Payables £000
Department of Health and Social Care	1,490	125
Other DHSC group bodies	70,230	21,346
Other Government bodies	13,379	19,427
University of Cambridge	4,617	11,161
	89,716	52,059

	Year ended 31 March 2019 Receivables £000	Year ended 31 March 2019 Payables £000
Department of Health and Social Care	281	900
Other NHS bodies	53,312	15,766
Other Government bodies	12,346	18,428
University of Cambridge	3,273	1,102
	69,212	36,196

17. Contractual capital commitments

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Property, plant and equipment	5,389	3,762
Intangible	-	1,670
Total contractual capital commitments	5,389	5,432

18. Private Finance Initiative (PFI) scheme

The PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 128 bed Elective Care, Genetics and Diabetes Centre at the Trust. The centre became operational in April 2007. The contract start date of the PFI scheme was 13 February 2007 and the end date is 12 February 2037.

The facilities within the centre include Diabetes Research Facilities which are utilised by the University of Cambridge. These facilities are funded by the University of Cambridge and the Medical Research Council and have no effect on the Trust's cost structures.

The contract requires the Trust to make a unitary payment that totals £9.1m annually. It is charged monthly and adjusted for any penalties relating to adverse performance against output measures describing all relevant aspects of the contract.

18.1 On-SoFP PFI obligations (finance lease element)

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Gross PFI liabilities of which liabilities are due		
In one year or less	6,093	6,312
In more than one year but not more than two years	6,177	6,097
In more than two years but not more than five years	19,564	18,902
In more than five years	98,842	105,758
Gross Liabilities	130,676	137,069
Finance charges allocated to future periods	(85,244)	(89,820)
Net Liabilities	45,432	47,249
Net PFI obligation of which liabilities are due		
In one year or less	1,664	1,817
In more than one year but not more than two years	1,708	1,664
In more than two years but not more than five years	5,734	5,333
In more than five years	36,326	38,435
Total	45,432	47,249

18.2 Total On-SoFP PFI commitments

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Total future payments committed in respect of PFI arrangements		
In one year or less	10,252	10,006
In more than one year but not more than two years	10,508	10,252
In more than two years but not more than five years	33,127	32,319
In more than five years	158,097	169,413
Total	211,984	221,990

Under IFRS the unitary charge is apportioned between the repayment of the liability, financing costs and the charges for services. The service charge is recognised in operating expenses under "Premises" and the finance costs are charged to finance costs in the Statement of Comprehensive Income.

The Trust has not entered into any 'off-Statement of Financial Position' arrangements.

18.3 Analysis of amounts payable

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Unitary payment payable to PFI operator consisting of:		
- Interest charge	2,484	2,585
- Repayment of finance lease liability	1,817	1,931
- Service element	1,378	1,631
- Capital lifecycle maintenance	1,420	1,077
- Contingent rent	2,011	1,951
Total amount paid to service concession operator	9,110	9,175

19. Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and NHS England and the way those NHS organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Credit risk

The Trust can borrow within affordable limits and NHS Improvement will assess the affordability of material borrowing. The Trust can invest surplus funds in accordance with NHS Improvement's guidance on Managing Operating Cash. This includes strict criteria on permitted institutions, including credit ratings from recognised agencies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to manage the risks facing the Trust in undertaking its activities.

Liquidity risk

The Trust's net operating income is received under legally binding contracts with local Clinical Commissioning Groups (CCGs) and NHS England, which are financed from resources voted annually by Parliament. The Trust has financed capital expenditure from internally generated resources, and net borrowing within its affordable limits. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

The main potential market risk to the Trust is interest rate risk. The Trust's financial liabilities carry nil or fixed rates of interest. Cash balances are held in interest bearing accounts for which the interest rate is linked to bank base rates and changes are notified to the Trust in advance. The Trust is not, therefore, exposed to significant interest-rate risk.

19.1 Carrying value and fair value of financial assets

	Year ended 31 March 2020	Year ended 31 March 2019
	Financial assets at amortised cost £000	Financial assets at amortised cost £000
Financial assets as per SoFP		
Receivables (excluding non financial assets) - with DHSC group bodies	71,536	53,567
Receivables (excluding non financial assets) - with other bodies	14,759	10,922
Cash and cash equivalents	18,385	35,099
Total	104,680	99,588

19.2 Carrying value and fair value of financial liabilities

	Year ended 31 March 2020 Financial liabilities at amortised cost £000	Year ended 31 March 2019 Financial liabilities at amortised cost £000
Financial liabilities per the SoFP		
DHSC loans	408,256	340,825
Obligations under PFI, LIFT and other service concession contracts	45,432	47,249
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	15,418	13,312
Trade and other payables (excluding non financial liabilities) - with other bodies	87,679	110,893
IAS 37 provisions which are financial liabilities	5,469	3,012
Total	562,254	515,291

19.3 Maturity of financial liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
In one year or less	456,178	244,935
In more than one year but not more than two years	8,985	61,374
In more than two years but not more than five years	25,393	123,612
In more than five years	71,698	85,370
Total	562,254	515,291

20. Losses and Special Payments

Losses and special payments (approved cases only)

	Year ended 31 March 2020 Total number of cases Number	Year ended 31 March 2020 Total value of cases £000's	Year ended 31 March 2019 Total number of cases Number	Year ended 31 March 2019 Total value of cases £000's
Losses of cash due to				
Other causes	26	2	79	20
Bad debts and claims abandoned in relation to				
Overseas visitors	5	252	16	15
Other	-	-	1	11
Total losses	31	254	96	46
Special Payments, Ex gratia payments in respect of				
Compensation under court order or legally binding arbitration award	1	1	-	-
Loss of personal effects	45	14	-	-
Personal injury with advice	5	57	2	3
Other	1	2	-	-
Special severance payments	2	35	-	-
Total special payments	54	109	2	3
Total losses and special payments	85	363	98	49

21. Events after the reporting period

Covid-19 was declared a pandemic on 12 March 2020 and the UK Government made announcements about how the population should act as a result before the end of March 2020. This has been taken into account in the preparation of the annual report and accounts for the year ended 31 March 2020.

The Secretary of State has announced that historic working capital loans and emergency capital loans will be refinanced in 2020/21 and replaced with Public Dividend Capital. This will apply to both "Interim Capital loans from the Department of Health and Social Care" and "Revenue support / working capital loans from the Department of Health and Social Care", thereby reducing the interest and debt repayment burden on the Trust. The liability for "Normal Course of Business Capital loans from the Department of Health and Social Care" will remain.