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Annual report and accounts **2020/21**

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Contents

1. Chair's statement

Over the last year, the lockdown and social distancing measures to control the spread of Covid-19 mean we have been cut off from our neighbours, friends and families like never before.

At the same time, I can say that at CUH we have never felt more connected to our local community. Whether it was through weekly clapping for essential workers, generous donations of food and gifts delivered to our hospitals, rainbows painted on our local roads, or the ongoing stream of thank you cards and letters from members of the public, our local communities have been there to support us during this very difficult past year.

It has been a year like no other. So much has been asked of our 11,000 staff at CUH, and each time they have risen to the challenge. As the battle against Covid has shifted throughout the year, we have had to respond on many different fronts, and each time, our staff have delivered.

Our experiences and those of our colleagues have reinforced the importance of working as a system, alongside primary, community and social care. We will all continue to promote good public health alongside colleagues in the local authorities, the Director of Public Health, the voluntary sector and local communities.

At CUH we have cared for almost 2,000 patients with Covid-19. We acknowledge with deep sadness more than 330 patients who died from Covid here, and we stand united alongside all those who have lost beloved family and friends.

As we now seek to recover – both individually and as a health system – from the wave of infections earlier this year, we once again look to each other for support.

We have learnt from summer 2020, when we restarted routine care after much activity was suspended during the first wave. This time round, we have been able to move more quickly into recovery mode, and begin to address the significant backlog of waiting lists.

In order to address the bed capacity lost through infection control measures requiring greater spacing between patients, and to increase flexible bed space going forwards, we will soon have access to additional capacity as part of a regional surge centre at CUH. This building development is taking place across a number of construction sites on the campus and in total, it will provide an additional 116 beds.

Working together, our estates and operational teams have achieved a huge amount in a short space of time and the first of those units, ward T2, was operational from late May 2021. Work continues on further additional units, due to open at various points over the next year.

Nonetheless, despite the additional capacity and extra flexibility being built into the system, we recognise how difficult it is for many people waiting far longer for treatment than they would have done before the pandemic. I want to assure you that we are doing everything within our power to streamline and innovate, to find faster and more efficient ways of providing patient-focussed care. We understand the anxiety and stress caused by these long waiting lists, because our own friends and relatives are on those lists too. We know how important this is, although it is going to take time to work through the backlog of patients waiting for treatment.

Working with our partners in the emerging integrated care system for Cambridgeshire and Peterborough presents opportunities for us to reshape how we offer care for our patients. We have learnt how to work remotely, including offering medical appointments and consultations, without the patient having to leave home. Whilst this is not always desirable, we do now know it is possible, and many patients will prefer to continue virtual appointments as much as possible. Remote working also enables clinicians at different locations around the region to collaborate more easily and share specialism and expertise where needed. We can harness these developments to provide better access to care for patients across our system in the future.

The pandemic has sped up many research and development processes, and has turbocharged the life sciences sector in the UK. Situated as we are on the Cambridge Biomedical Campus, alongside such illustrious academic and industry partners as the University of Cambridge (UoC), Cancer Research UK Cambridge Institute, the MRC Laboratory of Molecular Biology, AstraZeneca and Abcam, we are perfectly placed to deliver against the government's ambition to tackle the most pressing healthcare challenges through clinical research excellence.

With two other centres of clinical excellence alongside us on the campus, The Royal Papworth NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), the Campus is a vibrant, international healthcare community and a global leader in medical science, research, education and patient care.

Turning to the future, we have this year continued developing plans for the future of healthcare on the campus, alongside caring for patients in the present. With increasingly strong partnerships forming with our patients, communities, primary care colleagues, community and mental health

providers, we have set out a road map to build a new hospital, Addenbrooke's 3, designed for the future needs of our local and regional communities.

In the shorter term, we are pushing ahead with planning and designs for two critically important specialist hospitals on the Campus - Cambridge Children's Hospital, in partnership with CPFT and UoC, and Cambridge Cancer Research Hospital, in partnership with UoC.

Both these new world-class hospitals are moving at speed through the government's business development stages, as we seek to explore more patient-focussed care pathways alongside improved ways to deliver significant research benefits. Our fundraising teams are supporting this work through an ambitious programme seeking major philanthropic support.

Looking even further into the future, this year we have come together as a campus to demonstrate our commitment to Cambridge through the development of a new 2050 Vision. This vision seeks to keep us at the forefront of globally significant research and development that saves lives and addresses key challenges in public health.

But it is also focuses on the role we play in city life. The campus is the largest employment site in Cambridge, but we want to become more integrated with the city, offering attractive and welcoming places which are better connected to existing neighbourhoods. Over the next few months we will be seeking the views of our neighbours on this vision, and explore future possibilities.

Partnership working is the bedrock of life at CUH and on the campus. Collaboration powered us through the pandemic, and being connected to our neighbours and communities is what will take us forward from here.

We thank you for your support over the last year, and we look forward to the next step of the journey – together.

Mike More
Chair
28 June 2021

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

Last year as I wrote this report the pandemic was unfolding, and I reflected on how the world had changed almost overnight in such unimaginable ways. Now, having been privileged to lead Cambridge University Hospitals (CUH) through this unprecedented time, I have been repeatedly struck by how resilient humankind can be, and how quickly we adapt to new ways of living and working. I am also hugely grateful for our many partners who we have worked alongside over the last year - friends and colleagues in general practice, community services, local government, industry, the University of Cambridge and many, many more have all been extraordinary.

Nothing about working in healthcare during this last year has been easy. We have lived through a year we will never forget. As a family here at CUH, we have experienced the full range of emotions, from fear, grief and hopelessness through to determination, compassion and exhilaration. We have plummeted unknown depths, drawn on reserves of strength of which we were previously unaware, and been lifted up by the unprecedented generosity of friends, colleagues and our wider community.

The speed at which we had to respond to Covid-19 meant turning our hospitals inside out and upside down almost overnight. We had teams working around the clock to reconfigure wards, roll out new patient pathways, source equipment, and procure huge amounts of PPE – in fact, we had to review all our ways of working in light of the new threat, and revise very many of them.

All in all, more than 500 staff at CUH were redeployed into different roles, and at the peak of the waves, 12 of our 34 adult inpatient wards were designated “red” or “amber”. This represents multiple ward reconfigurations, vast amounts of moving equipment and furniture, repeated deep cleaning, and incredible flexibility and resilience from staff of whom we asked so much. Thank you also to the family of friends of all our staff, who we know have been a huge source of support.

Our strategy throughout the pandemic was threefold: to care for Covid and non-Covid patients, keeping our own staff safe, and building for the future.

Along with providing physical care for our patients, enabled through the reorganisation of our hospitals and redeployment of staff, we were faced with the heartbreaking challenge of needing to provide emotional care and support for our patients whose families were unable to be with them because of visiting restrictions.

We developed innovative ways of virtual visiting, keeping families in contact remotely, or via our “Letters from Loved Ones” service; but we recognise what a tremendous toll being apart took on our patients, their families, and on our staff, who did everything they could to provide personal and compassionate care for each and every patient.

As we emerge from the latest wave of infections, we are seeking ways to recover ourselves, mentally and physically. Many members of staff who were on the front line have been through a traumatic experience, and we are encouraging them to seek help and take time to heal.

As a hospital we are now redoubling our efforts to treat those waiting for non-Covid procedures. While we did maintain emergency non-Covid treatment throughout the pandemic, there is no doubt that many patients have been forced to wait far longer than we would wish for treatment. This can cause huge anxiety, discomfort and pain, and we know this is not acceptable.

It will take significant time to treat all the patient on our waiting lists. But we are doing everything we can to find new ways of working more efficiently, treating people remotely where possible, and using technology to speed processes up. This includes some weekend working, off-site treatment such as drive-through blood testing, and using artificial intelligence to save doctors time in doing routine preparation, freeing them up to provide patient care.

As you would expect from a leading teaching hospital like CUH, in partnership with the University of Cambridge and others on the campus, we activated a huge research programme to increase understanding and treatment of Covid. The vast majority of non-Covid research programmes were halted, and scientists and students turned their attention to the new frontier of beating Covid. In collaboration with our campus partners, and informed by our clinical work, we carried out research into the fundamental biology of the virus, causes of serious Covid, testing, treatment, vaccines and whole genome sequencing to identify variants.

Every patient being admitted to CUH with Covid was invited to take part in research, and we are so grateful to every single person who signed up to take part in trials. Without patients agreeing to take part in research, we simply would not have new vaccines, treatments and tests. We would not have made the strides forward that we have done.

At the same time we have remained focused on the core elements of providing the best care we can. This includes the many domains of quality, reducing waiting times, and sound financial management. Financially, the Department of Health and Social Care provided significant additional funding to NHS organisations to support the clinical and operational response to Covid-19. As a result, we operated under a different financial regime during the 2020/21 financial year which included a fixed financial envelope plus additional funding to cover the direct costs of our Covid response.

Under this new regime the Trust achieved a surplus of £0.1m (before technical accounting adjustments of £14.23m), whilst also supporting partner organisations in the Cambridgeshire and Peterborough ICS to achieve a breakeven or better financial position. This, combined with the conversion of £347m of historical loans to Public Dividend Capital during 2020/21, puts us in a much stronger financial position than has been the case in recent years.

There does however remain significant uncertainty about the financial regime for the 2021/22 financial year and we continue to work closely with partners to ensure best use of health and care resources across the whole service to support a sustainable health and care system to provide better outcomes for our population.

Turning to the future, despite the pandemic we have continued to invest in our estate, equipment and digital infrastructure as part of the strategic objective of ‘building for the future’. Overall the Trust invested £85.2m through its capital programme, which included specific investments to support our Covid response, and much needed additional bed capacity as part of a £65m programme to provide an additional 120 beds. This work will reach completion during the 2021/22 financial year.

We also continue at pace with plans for two exciting new hospitals, the Cambridge Children’s Hospital (in partnership with Cambridgeshire & Peterborough NHS Foundation Trust and the University of Cambridge) and the Cambridge Cancer Research Hospital (in partnership with the University of Cambridge), both of which will create state-of the art facilities from which we can provide excellent patient care, supported by cutting edge research. These developments will clearly be shaped by the needs of our local population and through our emerging integrated care system

which we continue to lead, regional needs for specialised services, and the opportunities to push forward with new treatments with our partners in the University and industry on the Cambridge Biomedical Campus and beyond. As we move through this year the huge success of the vaccination campaign gives us hope that we will be able to return to something closer to normality. Indeed, our own staff at CUH mobilised at great speed early in the year to vaccinate more than 44,000 individuals, including our own staff along with health and social care staff from the campus and surrounding areas – an incredible achievement.

The future looks hopeful, if uncertain. We will have to live with the threat of Covid for years to come. But what I know for sure, is that our CUH extended family has the capacity to respond and adapt to whatever comes our way, if we stand together, show kindness, and dig deep, bringing out the finest qualities in us all. I feel so proud to have worked as part of this remarkable organisation over the past year.

Roland Sinker
Chief Executive
28 June 2021

2.3 About CUH

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.

We are one of the largest NHS teaching hospital trusts in the country, with a national and international profile. We have 11,000 staff of over 100 nationalities, and annual turnover of around £1 billion. Our hospitals are at the forefront of the NHS delivering expert care for patients locally, regionally and nationally. Our vibrant teaching community equips and empowers our staff for the future.

Addenbrooke's provides emergency, surgical and medical care for local people and is the Major Trauma Centre for the East of England. It is also a regional centre of excellence for specialist services such as transplantation, cancer, neurosciences, paediatrics and genetics. The Rosie Hospital is a women's hospital and the regional centre of excellence for maternity care. CUH also provides satellite and outreach services at other locations to meet the needs of patients, e.g. in other hospitals, GP practices and in patients' homes.

We are uniquely situated on the Cambridge Biomedical Campus (CBC), bringing together healthcare, academia, business and the best life science researchers to lead some of the most important biomedical research in the world today. Our partners on the CBC include the University of Cambridge, Royal Papworth Hospital NHS Foundation Trust, Astra Zeneca, GlaxoSmithKline, the Wellcome Trust, Cancer Research UK and the Medical Research Council. Over 20,000 people currently work on the CBC covering 157 acres – and this is growing.

We are also a key part of the Cambridgeshire and Peterborough Integrated Care System with its focus on greater collaborative working across health and care partners. We want to run services in a more coordinated way to improve health outcomes and reduce health inequalities for our local and regional populations.

Responding to Covid-19

The above is set within the context of what has been an extremely challenging year for our hospitals and the wider NHS. Our staff have faced the immense challenge of reorganising the hospitals on multiple occasions to treat Covid-19 patients, while continuing to provide emergency and urgent care to our population. Since March 2020, we have treated over 2,000 inpatients with Covid-19. The majority have recovered and been discharged but sadly over 300 Covid-19 have died in our hospitals. In the most recent wave in early 2021, we more than doubled our critical care capacity and received critical care transfers from across the region and further afield.

Inevitably this has had a major impact on our non-Covid services and we are now focused on recovering these services as quickly as possible and

reducing the elective waiting lists which have increased during the pandemic. At the same time, we must ensure that we can continue to treat effectively Covid patients during potential further waves of the pandemic.

The pandemic has placed huge demands on our staff who have responded with professionalism, commitment and compassion. Supporting our staff has been, and continues to be, a top priority for the Board, recognising that the experiences of the past year have affected colleagues in many different ways. Providing the right support to individuals and teams, including psychological support, is a critical part of the sustainable recovery of our clinical services.

Alongside the recovery of non-Covid services and supporting our staff, the Board is committed to building for the future through partnership working both on the Cambridge Biomedical Campus and as part of the Cambridgeshire and Peterborough ICS.

We are progressing new hospital programmes including a regional Children's Hospital for the east of England which will integrate physical and mental health, and a world-leading Cancer Research Hospital, alongside the development of longer-term plans for the redevelopment of other parts of the hospital site.

The Board's key objectives for the next 18 months, including a focus on driving the equality, diversity and inclusion agenda, can be summarised as follows:

Improving patient care	• Safely restore all the services we provide both as a local hospital and a specialist teaching hospital for the East of England, and prioritise those patients with greatest clinical need in reducing waiting lists; • Work with our partners to maximise our capacity to treat both COVID19 and non-COVID19 patients in hospital and in the community, enabled by technology; and • Provide consistently high standards of patient care and experience in and outside the hospital using agreed clinical standards and protocols, embedding a culture of sustainable continuous improvement, and maintaining a safe environment.
Supporting our staff	• Ensure that we have sufficient numbers of appropriately skilled and trained staff to deliver our plans now and in the future; • Provide a comprehensive package of support to keep our staff safe, engaged, healthy and able do their jobs to the best of their abilities; and • Develop further actions to achieve greater equality and diversity in the CUH family across all the protected characteristics.
Building for the future	• Develop and secure national support for the next major stages of the business cases for the Cambridge Cancer Research Hospital, Children's Hospital and the Addenbrooke's 3 programme of work; • Develop an Integrated Care System across Cambridgeshire and Peterborough that improves our population's health, outcomes and experience within the available resources; and • Play a leading role with partners on the Cambridge Biomedical Campus in the national COVID19 research effort and powering economic growth through life sciences.

We are particularly grateful to Addenbrooke's Charitable Trust (ACT) for its financial support and the fundraising efforts of everyone within the Trust, and in the wider local community, who raise charitable funds which help us to provide improved services for our patients. This has been a key source of support to our staff and our hospitals during the Covid-19 pandemic.

2.4 Key risks

Key risks are identified by the Board of Directors through the Board Assurance Framework (BAF). At the end of 2020/21, the most significant risks to achieving the organisation's strategic objectives as identified by the Board are outlined in Table 1.

Table 1: Board Assurance Framework (BAF)

The top seven 'risks' identified in the 2020/21 BAF as reviewed by the Board of Directors on 10 March 2021 were as set out in the table below. Risks are scored using a risk matrix with 1 to 5 scores for both the consequence (1 being negligible and 5 being catastrophic) and likelihood (1 being rare and 5 being almost certain). The highest risk score is therefore 25.

Risk ref.	Target risk score (Jul 21)	Current risk score	Risk description	Lead Executive	Board monitoring committee
001	16	20	As a result of needing to manage the impact of further waves of Covid-19, there is a risk that the Trust is not able to safely and sustainably restore local and specialist services to previous levels of capacity which results in increased waiting times and poorer outcomes and experience for patients, and impacts on the ability to function as a regional surge centre.	Chief Operating Officer	Performance and Quality
005	20	20	A failure to address estate backlog maintenance and statutory compliance priorities caused by insufficient capital funding and decant capacity impacts	Director of Capital, Estates and Facilities Management	Performance and Quality

Risk ref.	Target risk score (Jul 21)	Current risk score	Risk description	Lead Executive	Board monitoring committee
			on patient and staff safety and continuity of clinical service delivery.		
006	20	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 and Facilities Management	Board of Directors
007	12	20	Due to national shortages of trained health care professionals and the impact of the Covid-19 pandemic on the ability to recruit internationally, there is a risk that the Trust will not be able to meet increased workforce demand to support the necessary capacity growth (surge centre, critical care expansion).	Director of Workforce	Workforce and Education
002	8	20	As a result of a reduced ability to identify, review and treat patients in a timely way due to the ongoing impact of Covid-19, there is a risk that the Trust is not able to effectively prioritise those patients in greatest clinical need which results in patient harm and poorer outcomes	Chief Nurse and Medical Director	Quality

Risk ref.	Target risk score (Jul 21)	Current risk score	Risk description	Lead Executive	Board monitoring committee
			and experience for patients.		
011	12	16	There is a risk that as a result of the Covid-19 pandemic and as part of the wider Cambridgeshire and Peterborough health and care system which has an underlying financial deficit, the Trust is unable to achieve a financially sustainable position leading to regulatory action and/or impacts on the ability to invest for the future and provide high quality services for patients.	Chief Finance Officer	Performance
008	16	16	The Trust does not develop and implement effective actions to achieve greater equality and diversity in the CUH workforce and therefore does not realise the benefits of being a truly diverse and inclusive organisation from a workforce perspective, which impacts adversely on staff wellbeing and the quality of patient care.	Director of Workforce	Workforce and Education

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) at Section 3.27.

The processes outlined 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

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

2.6 Performance management approach

Our 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. The Quality Account will be published on the Trust website, and following changes to the reporting arrangements is no longer subject to external audit review.

Performance is monitored by the Board of Directors through a monthly Integrated Performance Report, with detailed scrutiny and assurance sought by the Performance, Quality and Workforce and Education Committees 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

Information about the financial performance of the Trust is included in Section 2.2.

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 affecting 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. The Chief Operating Officer, who has the role of the Accountable Emergency Officer for the Trust, sponsors this plan. The Major Incident Plan was reviewed following the first waves of the Covid-19 pandemic and lessons learned were embedded into the revised document. The Trust's Lead Resilience Manager, who has the responsibility for ensuring it is reviewed in line with organisational policy, owns this plan.

The Trust has completed the annual self-assessment against the NHS England and NHS Improvement Emergency Planning, Resilience and Response (EPRR) core standards in conjunction with a peer review conducted by the Cambridgeshire and Peterborough CCG. The Trust was declared as 'fully compliant' against the core standards in October 2020.

The Trusts' Resilience Manager was appointed in July 2020, thereby strengthening the resilience team and providing the much-needed additional EPRR support.

The Trust continues to participate in emergency planning exercises and training and is an active member of the Local Resilience Forum working groups. There has been closer working with Royal Papworth Hospital since its relocation to the Cambridge Biomedical Campus and joint planning is underway to develop an evacuation plan that looks to incorporate mutual aid while recognising the unique benefits of co-location on the Campus.

As part of the Trust's EU Exit planning and preparedness, a review of divisional business continuity plans was conducted and remains ongoing. 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. An incident management team was activated and appropriate governance arrangements put in place, which are still in operation (as of April 2021). 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. CUH's strategic objectives for managing the outbreak are to maximise survivorship for patients with and without Covid-19 and to keep staff safe.

Emergency Planning priorities for 2021/22 include:

- Supporting the incident response and recovery for the Covid-19 pandemic
- Supporting any further contingency work related to EU Exit
- Continuing to review and update Business Continuity Plans and Business Impact Analysis
- Ensuring that the Trust's EPRR policies and procedures are current and fit for purpose
- Continuing to prepare and deliver a range of training and 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 2020/21, 198 people raised concerns directly with the Speaking Up service. Across the concern themes, 26% related to behaviour and relationships, 37% to Trust policy and procedure, 17% to management support, 12% were patient-related and 8% were about capacity/workload/training. The staff groups accounting for the greatest proportions of concerns raised were nursing and midwifery and administrative and clerical staff.

During the Covid-19 pandemic period, particularly from April to June 2020, the Raising Concerns service saw a significant increase in staff contacts primarily in relation to staff and patient health, safety and wellbeing.

Overall, the number of staff raising concerns has steadily increased year-on-year as awareness of, and confidence in, the service grows.

While the number of concerns raised is broadly comparable with the national average, the Trust is slightly lower than average on concerns raised about behaviour/relationships and patient-related concerns. Trends continue to be monitored through twice-yearly reporting to the Board of Directors.

The 2020 NHS national staff survey results showed an improved position in relation to the historical questions relating to raising concerns and placed the Trust significantly better than the Picker national average in respect of the two new speaking up questions. 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 England's guide for boards as a self-review tool to evaluate our strategy and further improve our speaking up culture. Two national e-learning packages are also being launched within the hospitals: Speaking Up for all staff and Listening Up for all leaders and managers.

2.11 Significant events after the balance sheet date

There are no post-balance sheet events to disclose.

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 demonstrates 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 18 times during the year under review, six times in public and 12 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 the 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 having been on the CUH Board since 2013. In December 2019 Mike was re-appointed for a further term of three years starting in April 2020. In 2018, he assumed the interim chair role for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership, which serves a population of 1 million people with a health and social care spend of £1.5 billion. He was confirmed to continue in this role in September 2020 until March 2022 to guide the partnership to Integrated Care System (ICS) status. The ICS and the hospital trust are heavily focused on innovation, improvement, tackling health inequalities and promoting population health in the county.

He retired from a career in local government at the end of 2013, his two most recent roles having been Chief Executive of Westminster City Council for six years until 2013, following being Chief Executive of Suffolk County Council for six years before that. Mike began his career at the National Audit Office in 1981. His first local government role was for Cambridgeshire County Council and his first assignment for them was at Addenbrooke's Hospital in 1986.

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 and the London Prevent Panel for the Home Office. 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 member of the Board of Cambridge University Health Partners (CUHP) and 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 was first appointed to the Board of Directors in September 2017, and was re-appointed a further three year term starting on 1 September 2020 in March 2020.

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, and a consultant to a private equity firm. 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 was first appointed to the Board of Directors in September 2017, and was re-appointed a further three year term starting on 1 September 2020 in March 2020.

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 Remuneration Committee for Alfa Financial Software Holdings plc and Volex plc.

Dr Annette Doherty, OBE – Non-Executive Director

Annette was first appointed to the Board of Directors in September 2017, and was re-appointed a further three year term starting on 1 September 2020 in March 2020.

Annette has 33 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 UK Government Technology Strategy Advisory Board and an industry participant in a House of Lords session on Genomic Medicine. She has been a Board member of the Medical Research Council (2008-2012), a Trustee and Member of the Medical Research Council Technology charity (now LifeArc) (2015-2020) and Board member of the Medicines Manufacturing Industry Partnership (2017-2019). She has been and remains a Trustee of the Council of the Royal Society of Chemistry (2011-2015 and 2021-present).

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 (NATA) 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 was first appointed to the Board of Directors as a Non-Executive Director with effect from April 2013. Mike was subsequently re-appointed in 2016 and 2019, in each instance for terms of three years.

Mike holds an MA in physiology from the University of Cambridge, a bachelor of medicine and 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 is the Board Level Safety Champion for maternity and neonatal services in the Rosie Hospital, chair of the Organ Donation Committee, non-executive director champion for sustainability and also a Trustee of Addenbrooke's Charitable Trust.

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.

Professor Patrick Maxwell – Non-Executive Director

Patrick is an ex-officio Non-Executive Director and was first appointed in 2012. Patrick is not subject to term limits as a Non-Executive Director.

Patrick is the Head of the University of Cambridge's School of Clinical Medicine, and CUH is the principal teaching hospital for the University. Patrick is also the Regius Professor of Physic, one of the oldest professorships at the University, established by Henry VIII in 1540 and appointed by Her Majesty The Queen.

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 (until 31 March 2021)

Doris was first appointed to the Board of Directors in November 2019. Doris resigned from the Board of Directors with effect from 31 March 2021.

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 (returned to the Board on 7 September 2020 following leave of absence)

Sharon was first appointed to the Board of Directors in October 2015. Sharon was re-appointed in 2018 for a second term of three years commencing on 1 October 2018.

Sharon Peacock CBE FMedSci is Professor of Public Health and Microbiology in the Department of Medicine at the University of Cambridge. She is also Executive Director and Chair of the COVID-19 Genomics UK Consortium (COG-UK), and is on secondment to Public Health England (PHE) as Director of Science (Pathogen Genomics).

She is known for her work on public health microbiology and developing diagnostic health innovations from genome sequencing technologies. Her research specialities include work on MRSA and the bacterium Burkholderia pseudomallei, which causes the tropical infection melioidosis.

Sharon studied medicine at Southampton University. After graduating in 1988, she obtained MRCP (Membership of the Royal Colleges of Physicians) during four years of post-graduate training in general internal medicine in Brighton, Oxford and London. Clinical microbiology training at Oxford University followed, leading to MRCPath and completion of training in clinical microbiology and virology in 1997. She was awarded a PhD for work on the bacterium Staphylococcus aureus in 2003. Sharon also obtained a BA in History through the Open University. She has supervised 21 PhD students to completion, published around 450 publications including 21 book chapters, and is active in teaching and scientific peer review.

Sharon is a Fellow of the Academy of Medical Sciences, a Fellow of the American Academy of Microbiology, and an elected Member of EMBO. She was awarded a CBE for services to medical microbiology in 2015, and the Unilever Colworth Prize for outstanding contribution to translational microbiology in 2018.

Shirley Pointer – Non-Executive Director and Senior Independent Director

Shirley was first appointed to the Board of Directors in December 2015. Sharon was re-appointed in 2018 for a second term of three years commencing on 1 December 2018.

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 and Chair of the Remuneration Committee for a medium-sized Housing Association. 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.

Roland is a Director of Cambridge University Health Partners (CUHP).

Nicola Ayton – Chief Operating Officer (on maternity leave since 26 March 2021)

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/ Interim Chief Operating Officer (from 29 March 2021)

Areas of responsibility as Director of Improvement and Transformation 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.

Mike Keech – Chief Finance Officer (from 9 November 2020)

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

Mike is a chartered accountant with the Institute of Chartered Accountants in England and Wales (ICAEW) and joined the Trust as Chief Finance Officer in November 2020.

Having initially trained with the accountancy firm Deloitte, Mike has significant experience working in NHS finance related roles, including most recently as Director of Finance of Milton Keynes University Hospital NHS Foundation Trust. Mike has also worked for NHS Improvement, the provider regulator of the NHS, where he held a number of roles involving financial due diligence, strategy and financial recovery.

Marianne Monie - Director of Major Projects and Specific Incident Projects (2 April to 31 May 2020)

Marianne was an interim member of the Board of Directors between the above dates during which time there was no Director of Strategy and Major Projects in post.

Daniel Northam Jones - Director of Strategy and Incident Management Support (2 April to 31 May 2020)

Daniel was an interim member of the Board of Directors between the above dates during which time there was no Director of Strategy and Major Projects in post.

Paul Scott – Chief Finance Officer (until 31 July 2020)

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. Paul left the Trust with effect from 31 July 2020.

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.

Ed Smith – Interim Chief Finance Officer (from 1 August to 8 November 2020)

Ed was an interim member of the Board of Directors between the above dates.

Claire Stoneham – Director of Strategy and Major Projects (from 1 June 2020)

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.*

Claire joined CUH in June 2020 from the Department of Health and Social Care, following a secondment in to the role of Executive Programme Director for the Cambridgeshire and Peterborough STP.

During a 15 year career, her national roles included the Director of Provider Efficiency and Performance, covering NHS performance standards, hospital discharge, efficiency savings and cost recovery; and Principal Private Secretary to the Secretary of State for Health.

Claire is responsible for the Trust's strategy, including how we work with partners across the Integrated Care System and on the Cambridge Biomedical Campus, and for the programme of major projects under the Addenbrooke's 3 umbrella, including the Cambridge Children's and Cancer Research Hospitals.

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 Florence Nightingale Scholar.

Ian Walker – Director of Corporate Affairs

Areas of responsibility include: *corporate governance, communications, public engagement, legal services, 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 took up the role of Director of Workforce in April 2014. He leads on all aspects of the Trust's workforce agenda including staff health and wellbeing, equality, diversity and inclusion, learning and development and volunteering.

David has worked in human resources for over 25 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 is an exceptional organisation to work and train with, supporting staff as they develop through their career. David's ambition is that all staff experience CUH as a safe, kind and excellent place to work. He is proud of the progress that has been made in recent years, and committed to continue this journey. David works collaboratively with system, regional and national partners on the health and care workforce agenda.

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 ongoing 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 governors, two patient governors, one staff governor and one partnership governor. 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 for subsequent terms of up to three years each 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 2020/21

Meeting dates

2020: 8 April, 17 April, 13 May, 10 June, 8 July, 9 September, 14 October, 11 November, 9 December

2021: 13 January, 10 February, 10 March

For the duration of the reporting period, due to the impact of the Covid-19 pandemic, the Board met remotely, primarily via video conference.

There were two separate meetings of the Board of Directors on the dates listed above in each of May, July, September and November 2020 and in

January and March 2021. A total of 18 Board meetings were therefore held in 2020/21.

Table 2: Attendance at Board meetings in 2020/21

Name	Title	Attendance
Dr Michael More	Trust Chair	18/18
Daniel Abrams	Non-Executive Director	18/18
Nicola Ayton	Chief Operating Officer	16/18
Dr Ewen Cameron	Director of Improvement and Transformation	18/18
Adrian Chamberlain	Non-Executive Director	15/18
Dr Annette Doherty	Non-Executive Director	18/18
Mike Keech	Chief Finance Officer	8/8
Dr Michael Knapton	Non-Executive Director	18/18
Professor Patrick Maxwell	Non-Executive Director	15/18
Marianne Monie	Director of Major Projects and Specific Incident Projects	4/4
Daniel Northam Jones	Director of Strategy and Incident Management Support	4/4
Doris Olulode	Non-Executive Director	13/18
Professor Sharon Peacock	Non-Executive Director	11/11
Shirley Pointer	Non-Executive Director	18/18
Paul Scott	Chief Finance Officer	7/7
Dr Ashley Shaw	Medical Director	18/18
Roland Sinker	Chief Executive	18/18
Ed Smith	Interim Chief Finance Officer	5/5
Claire Stoneham	Director of Strategy and Major Projects	14/14
Lorraine Szeremeta	Chief Nurse	17/18
Ian Walker	Director of Corporate Affairs	18/18
David Wherrett	Director of Workforce	18/18

3.10 Committees of the Board of Directors

The Board of Directors is required to establish and maintain an Audit Committee and a Remuneration Committee. Further details about the Audit

Committee and the Remuneration Committee are contained in Sections 3.11 (Audit Committee) and 3.22 (Remuneration and Nomination Committee).

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

- Addenbrooke's 3 Committee
- 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 at 31 March 2021

Committee	Membership
Addenbrooke's 3 Committee (from January 2021)	NEDs: Dr Mike Knapton (Chair), Dr Annette Doherty and Professor Patrick Maxwell. Executive Directors: Director of Strategy and Major Projects, Chief Nurse and Medical Director.
Audit Committee	NEDs: Daniel Abrams (Chair), Annette Doherty and Doris Olulode.
Remuneration Committee	All Non-Executive Directors. Chaired by Shirley Pointer.
Quality Committee	NEDs: Professor Sharon Peacock (Chair), Adrian Chamberlain, Dr Mike Knapton and Doris Olulode. Executive Directors: Chief Nurse and Medical Director.
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 and Professor Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director

Table 4: Attendance of committee members at Board Committee meetings 2020/21

Addenbrooke's 3 Committee

Name	Title	Attendance
Dr Mike Knapton	Committee Chair	2/2
Dr Annette Doherty	Non-Executive Director	2/2
Professor Patrick Maxwell	Non-Executive Director	1/2
Dr Ashley Shaw	Medical Director	2/2
Claire Stoneham	Director of Strategy and Major Projects	2/2
Lorraine Szeremeta	Chief Nurse	1/2

Audit Committee

Name	Title	Attendance
Daniel Abrams	Committee Chair	4/4
Dr Annette Doherty	Non-Executive Director	4/4
Doris Olulode	Non-Executive Director	3/4

Performance Committee

Name	Title	Attendance
Adrian Chamberlain	Committee Chair	10/11
Daniel Abrams	Non-Executive Director	11/11
Nicola Ayton	Chief Operating Officer	11/11
Mike Keech	Chief Finance Officer	4/4
Shirley Pointer	Non-Executive Director	11/11
Paul Scott	Chief Finance Officer	4/4
Ed Smith	Interim Chief Finance Officer	3/3
Dr Ashley Shaw	Medical Director	11/11

Quality Committee

Name	Title	Attendance
Professor Sharon Peacock	Committee Chair (1 January 2021 onwards)	3/3
Adrian Chamberlain	Non-Executive Director	5/6
Dr Michael Knapton	Non-Executive Director (Committee Chair from (1 April 2020 to 31 December 2020)	6/6
Professor Patrick Maxwell	Non-Executive Director	5/5
Doris Olulode	Non-Executive Director	5/6
Dr Ashley Shaw	Medical Director	5/6
Lorraine Szeremeta	Chief Nurse	5/6

Remuneration and Nomination Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	2/2
Daniel Abrams	Non-Executive Director	1/2
Adrian Chamberlain	Non-Executive Director	2/2
Dr Annette Doherty	Non-Executive Director	2/2
Dr Michael Knapton	Non-Executive Director	2/2
Professor Patrick Maxwell	Non-Executive Director	1/2
Dr Michael More	Trust Chair	2/2
Doris Olulode	Non-Executive Director	2/2
Professor Sharon Peacock	Non-Executive Director	0/1

Workforce and Education Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	5/5
Dr Michael Knapton	Non-Executive Director	5/5
Professor Patrick Maxwell	Non-Executive Director	3/5
Dr Ashley Shaw	Medical Director	4/5
Lorraine Szeremeta	Chief Nurse	3/5
David Wherrett	Director of Workforce	5/5

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 the risk management system 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:

- 2020: 17 June, 15 July and 23 September
- 2021: 3 February

A summary of attendance at Audit Committee is included in Table 4 in Section 3.10.

Significant issues

The Audit Committee met on 9 June 2021 to consider the financial statements for the period for the period 2020/21. The Audit Committee reviewed the financial statements and identified no significant issues with the statements.

External auditors

During 2020/21, following a tender process, the Council of Governors re-appointed Mazars LLP as the Trust's external auditors for three years from 1 April 2021.

Mazars LLP 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 Code of Audit Practice as issued by the National Audit Office. 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 2019/20, following a tender process, KPMG were re-appointed as the internal auditors for the Trust with effect from 1 April 2020.

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 at Section 3.27.

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 2020/21.

3.14 Better payment practice code

The Trust's performance against the better payment practice code in 2019/20 and 2020/21 was as follows:

Better payment practice code	Expected Sign	19ACTYTD01 Actual 31/03/2021 YTD Number	19ACTYTD Actual 31/03/2021 YTD £'000
Non NHS			
Total bills paid in the year	+	131,326	490,528
Total bills paid within target	+	89,690	275,504
Percentage of bills paid within target	%	68.3%	56.2%
NHS			
Total bills paid in the year	+	3,471	58,138
Total bills paid within target	+	972	24,702
Percentage of bills paid within target	%	28.0%	42.5%
Total			
Total bills paid in the year	+	134,797	548,666
Total bills paid within target	+	90,662	300,206
Percentage of bills paid within target	%	67.3%	54.7%

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 plan is aligned to the Trust's overarching strategy, 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 undertaken during the previous five years, outlining plans to increase in capability and capacity for improvement. The Trust has commenced working with the Institute for Healthcare Improvement as its improvement partner.

The Quality Plan outlines how success 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 the leaflet is clear, understandable and helpful to patients. The members provide recommendations to improve the readability of the leaflets.

The Reader Panel membership, which includes individuals from a range of backgrounds, increased to 35. During 2020/21 they reviewed 188 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 (AIS) sets out the requirements for NHS organisations to identify, record, flag, share and meet patients' and carers' information and communication support needs. Systems are in place across the Trust to meet our obligations, and over the year a steering group continued to work towards improving our performance against the Standard. Significant progress has been made with making the Trust's external website accessible to all users. The website has been completely redesigned during 2020/21 and has an 'accessibility toolbar', enabling ease of use by people with a range of needs. Patients and carers are invited to tell us about their communication and information needs, and staff - supported by the CUH Accessibility Team - work to meet the needs.

It is acknowledged however, that provision of communication and information in appropriate formats is not always consistent for all patients and carers. Work continues on the development of an automated system for the provision of individual patient communications in accessible formats.

Staff training was reviewed by the working group: while all staff receive information about the AIS on induction and certain staff groups receive AIS training specific to their roles, the working group considered that all staff who have contact with patients and carers would benefit from further training on the AIS and an application has been made for an AIS training module to be added to the mandatory training programme.

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 2020/21 CUH received 483 complaints, a 27% decrease on the previous year's total of 660. This is in contrast to the previous year-on-year increase and is due to significantly lower numbers of complaints being received during the Covid-19 pandemic.

The overall rate of complaints was 0.05% of activity compared with 0.06% in 2019/20 ('activity' here means patient episodes, e.g. an inpatient stay or an outpatient attendance).

Of the total number of complaints received in 2020/21, investigated and closed at the date of reporting (443 as of 10 May 2021), 13% were fully upheld, 47% were partially upheld and 40% 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 and apology is provided for the patient's negative experience.

The complaints regulations require NHS organisations to acknowledge complaints within three working days. In 2020/21, 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 2020/21, investigated and closed at the date of reporting, we responded to 34% of complaints within the initial set timeframe. We agreed and met an extension to the responding timeframe in a further 64% of cases, meaning that we responded to 98% of complaints either within the initial set timeframe or by the later date agreed, above our internal target.

Due to the Covid-19 pandemic the NHS complaints process was paused at the end of March 2020 until July 2020, although the Trust's Complaints team attempted to continue investigations and provide responses wherever possible. The Complaints team also provided support to the PALS team to manage the PALS Helpline during lockdown and restricted visiting, responding to over 1,500 contacts.

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: staff to receive additional training in relation to the importance of timely medication administration, a review is being undertaken of the palliative care information available to patients and carers in clinics, medical ward arranging an educational programme for staff regarding pressure area care, and a ward information board is being arranged to provide further information for patients and visitors. The operational team are looking at being able to flag the number of bed moves a patient has on Epic, particularly elderly patient moves at night.

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. Eight cases were accepted for investigation by the PHSO in 2020/21, compared with six in 2019/20. Five PHSO investigations concluded over the year with a decision to not uphold the complaints. The PHSO also suspended their casework in mid-March 2020 due to Covid-19, therefore the length of time taken for investigations has been extended. Three cases remain under investigation.

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. 4565 cases were managed and recorded on the database compared with 3980 in 2019/20, an increase this year of 12%.

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

540 compliments were received by the PALS team in 2020/21, (3% increase from 525 in 2019/20), 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 76% of cases in 2020/21. This performance is slightly lower due to the work that has been focused on the Covid-19 Helpline,

Letters from Loved Ones, and property deliveries and should improve over 2021/22.

3.19 Stakeholder engagement

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 focused 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.

Results of the Friends and Family Test surveys show that the Trust continues to be rated very positively by patients. Nationally, the scoring system was changed last year so results are not directly comparable with previous years. 'Good' scores over the year were as follows: Inpatient and Day Case 97.1%, Emergency Department 92%, Outpatients 95.5%, Maternity 95.7%. Response rates to the Friends and Family Test surveys were significantly affected by the Covid-19 pandemic, although data continued to be collected in those areas which operate surveys via text messages to patients' phones.

The national survey programme was also disrupted by the pandemic, although the Inpatient and Urgent and Emergency Care surveys were undertaken over the year. The Trust received positive results from the national 2020 Cancer survey. A local survey was run in outpatients, collecting data from patients who had either attended an outpatient appointment at the hospital, or whose appointment had been undertaken over the telephone or via a video link ('virtual' appointments increased very significantly in response to Covid-19 restrictions).

No focus groups were held, or '15 steps' visits made to wards and clinics, due to restrictions necessitated by the pandemic.

Patient participation groups are active in several services across the Trust, and the groups continued to meet virtually and undertake projects over the year. Work continued to support unpaid 'family' carers, with Carers Champions undertaking training over Zoom.

MyChart provides patients with electronic access (via a mobile app or website) to their clinical records held at the Trust. Over the past year there has been a significant increase in the volume of MyChart users. This includes both patients and staff: the latter were encouraged to access Covid-19 screening results via MyChart. At the end of March 2021 there were 71,400 patients with a MyChart account, over twice as many as at the end of the previous year. Over 22% of patients who have had an outpatient appointment in the last year used a MyChart account.

ACTIVE (the Children's and Young People's Board) has continued to meet during the reporting period.

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.

At CUH, we work in partnership with 12 higher education institutions to facilitate 900 clinical placements for pre-registration Nursing, Midwifery and Allied Health Professionals per year. The clinical education support team provide teaching, clinical supervision and facilitation of learning to these students alongside the practice educators, supervisors and assessors within the clinical environment. In addition to the traditional university degree programmes, CUH also provides a 'grow your own' apprenticeship pathway to professional registration with degree apprenticeships for Nursing, Physiotherapy, Occupational therapy and Operating Department Practitioners. CUH is currently supporting 220 clinical apprenticeships within the trust.

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.

Research during 2020/21 was dominated by the Covid-19 pandemic. At the start of the pandemic 750 research studies were paused, and during the 2nd wave of infection parts of Addenbrooke's Centre for Clinical Research (ACCR) were used for delivery of clinical care. ACCR has now fully re-opened for research studies, and focusing on restarting paused studies. Covid-19 research has been supported by the NIHR Cambridge Biomedical Research Centre and ACCR, and included the TACTIC-R trial (a mulTi-Arm Therapeutic study in pre-ICu patients admitted with Covid-19 – Repurposed Drugs) led by Cambridge University Hospitals. TACTIC-R tests the ability of two drugs that are licensed to reduce immune inflammation. The NIHR COVID-19 BioResource offers patients and staff the opportunity to participate in research by providing biological samples and health data that allow us to better understand the disease and its impact. Over 7000 patients and healthcare workers have been recruited to the COVID-19 BioResource, supporting a number of studies that are providing insights into the clinical features, transmission and biology of COVID-19 infection.

The national COVID-19 Clinical Neuroscience Study (COVID-CNS) is using the COVID-19 BioResource infrastructure to investigate the neurological and neuropsychiatric effects of COVID-19. The EpiCov database utilises de-identified routinely collected data from Cambridge University Hospitals to enable research related to COVID-19 aimed at improving health, treatment or services.

3.20 Trust membership

The membership

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

Public Membership

Any person who is 16 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 16 years or over.

Staff membership

All staff at CUH with contracts of employment of at least 12 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 that employees of partner organisations on the Campus make to CUH and for this reason staff membership includes, on application, all employees of organisations based on the campus who provide services to CUH.

Membership numbers

At 31 March 2021, there were 20,201 members (2020: 19,555). The breakdown is as follows: patients 3,955 (2020: 4,122); public 4,800 (2020: 4,877) and staff 11,446 (2020: 10,556).

Membership strategy

The current membership strategy 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

A process for refreshing the membership engagement strategy was initiated in early 2021 and this is intended to be completed during 2021/22.

3.21 Council of Governors

The Council of Governors is composed of 19 elected governors (eight patient, seven public and four staff) and 10 partnership governors. The Council is chaired by the Trust Chair.

Dr Julia Loudon was elected as the Lead Governor from 1 July 2016 for a two-year term. Julia was subsequently re-elected for a further term of two years to 30 June 2020. Due to the impact of the pandemic (see below), with the agreement of the Council of Governors and the Board of Directors, the term of office for the current Lead Governor was extended until 30 September 2021.

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

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. In September 2020 the Trust agreed to schedule the deferred elections alongside the scheduled 2021 elections.

The Board of Directors also authorised the extension of the terms of office for elected Governors whose terms of office were due to expire on 30 June 2020 for a maximum period of 12 months. These terms will now end on 30 June 2021. Governors whose term of office was scheduled to expire in 2020, and who are successfully re-elected in the deferred elections, will be limited to a maximum term of two years for the next term only.

Table 6: Patient governors

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 first one-year term in 2019. Term extended by 12 months due to the impact of the pandemic.
Dr Julia Loudon	Re-elected in 2018 for a second three-year term.
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. Term extended by 12 months due to the impact of the pandemic.
Mrs Adele White	Elected in 2018 for a first three-year term.
Mr Simon Whitworth	Elected for a first one-year term in 2019. Term extended by 12 months due to the impact of the pandemic.

Table 7: Public governors

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. Term extended by 12 months due to the impact of the pandemic.
Mrs Dawn Chapman OBE	Re-elected in 2018 for a second three-year term. Resigned from the Council of Governors in November 2020. The vacancy will be filled at the next scheduled election to the Council of Governors.
Mr David Dean	Elected in 2017 for a first three-year term. Term extended by 12 months due to the impact of the pandemic.
Mr Graham Green	Elected in 2019 for a first two-year term.
Ms Melisa Lee	Elected in 2019 for a first three-year term.
Ms Anna Miller	Elected in 2018 for a first three-year term.

Table 8: Staff governors

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. Term extended by 12 months due to the impact of the pandemic.

Governor elections 2020

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. As noted above, 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 for a maximum period of 12 months.

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%

Table 10: Partnership governors

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

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. Resigned with effect from 1 September 2020.
Cambridge Biomedical Campus Research Organisations	Karen Woodey	Appointed by Cancer Research UK to represent research organisations on the Biomedical Campus site with effect from 1 January 2021.
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. Reappointed in June 2020.
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 and 2021.
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)	Vacancy	The role has been vacant for the duration of the reporting period.
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. Left the Council

		of Governors in October 2020.
Royal Papworth Hospital NHS Foundation Trust	Dr Stephen Webb	Appointed as partnership governor in October 2020 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 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 ongoing 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.

Table 11

Attendance at Council of Governors' meetings 2020/21

Name	Title	Attendance
Dr Michael More	Trust Chair	6/6
Ms Jessica Bawden	Partnership Governor	1/6
Dr Jane Biddle	Public Governor	5/6
Mr Simon Chaplin	Partnership Governor	0/1
Mrs Dawn Chapman	Public Governor	1/2
Prof John Clarkson	Partnership Governor	6/6
Mr Bill Davidson	Staff Governor	6/6
Mr David Dean	Public Governor	6/6
Mr Graham Green	Public Governor	5/6
Ms Ruth Greene	Patient Governor	5/6
Dr Jeremy Griggs	Patient Governor	5/6
Cllr Mark Howell	Partnership Governor	5/6
Mrs Hannah Jackson	Staff Governor	4/6
Dr Deepa Krishnakumar	Staff Governor	4/6
Ms Melissa Lee	Public Governor	6/6
Mr Stephen Legood	Partnership Governor	4/6
Dr Julia Loudon	Patient Governor	6/6
Cllr Nicky Massey	Partnership Governor	5/6
Ms Anna Miller	Public Governor	5/6
Dr Colin Roberts	Patient Governor	6/6
Ms Josie Rudman	Partnership Governor	0/2
Dr Patricia Set	Staff Governor	3/6
Dr Howard Sherriff	Patient Governor	6/6
Professor Peter St George Hyslop	Partnership Governor	4/6
Dr Neil Stutchbury	Patient Governor	6/6
Dr Annette Thomas-Gregory	Partnership Governor	5/6
Dr Stephen Webb	Partnership Governor	2/3
Mrs Adele White	Patient Governor	6/6
Simon Whitworth	Patient Governor	3/6
Karen Woodey	Partnership Governor	0/2

There were six meetings of the Council of Governors during 2020/21, four in public and two confidential. The Chief Executive, Non-Executive Directors and Executive Directors also attended.

Governor activities

During 2020/21 the Council of Governors reviewed and revised its ways of working, with a continued focus on ensuring that:

1. Non-Executive Directors are held to account for the performance of the Board of Directors.
2. The views of members, patients and the wider local community are brought directly to the directors.
3. Governors remain up-to-date on key issues of concern and interest.

Governors' 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.

The Annual Public Meeting took place in September 2020. The meeting covered the presentation of the annual report and accounts; and provided attendees with a review of 2019/20 with an update on current and future developments.

Representatives 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 held in public. 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 assurance committees in an observer capacity. These interactions assist them in fulfilling their duty to hold the Non-Executive Directors to account.

3.22 Remuneration report

Annual statement on remuneration

In 2020/21, 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/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	09.11.20	Permanent	Six months
Chief Nurse	23.07.18	Permanent	Six months
Chief Operating Officer	20.10.19	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	01.06.20	Permanent	Six months
Director of Workforce	01.04.14	Permanent	Six months
Medical Director	01.11.17	1 year	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 twice during 2020/21. The Committee was chaired by Shirley Pointer, Non-Executive Director and Senior Independent Director. A summary of attendance at the committee is included in Section 3.10.

The role of the Committee is 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 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 their 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 2020/21 was £270,000 to £275,000. This was 8.27 times (year ended 31 March 2020, 8.68 times) the median remuneration of the workforce, which was £33,489 (year ended 31 March 2020, £30,812).

Table 13: Statement of remuneration 2020/21 - Subject to Audit

Name of senior manager	**2020/21 Salary & fees (in bands of £5k) £000s (Band of £5k)*** **	**2020/21 All taxable benefits (total to the nearest £100) £s (nearest £100)**	**2020/21 Annual performance related bonuses £000s (Band of £5k)**	**2020/21 Long-term performance related bonuses £000s (Band of £5k)**	**2020/21 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)**	**2020/21 Other (total to the nearest £5k) £s to nearest £5k**	**2020/21 Total (bands of £5k) £000s (Band of £5k)**
Nicola Ayton, Chief Operating Officer	185-190	-	-	-	40-42.5	-	225-230
Dr Ewen Cameron, Director of Improvement and Transformation	55-60	-	-	-	-	155-160	210-215
Michael Keech, Chief Finance Officer (from 9 November 2020)	65-70	-	-	-	17.5-20	-	80-85
Marianne Monie, Director of Strategy and Major Projects (From 2 April 2020 to 31 May 2020)	20-25	-	-	-	-	-	20-25

Daniel Northam-Jones, Director of Strategy and Major Projects From 2 April 2020 to 31 May 2020)	20-25	-	-	-	-	-	20-25
Paul Scott, Chief Finance Officer (until 31 July 2020)	70-75	-	-	-	72.5-75	-	145-150
Dr Ashley Shaw, Medical Director	75-80	-	-	-	-	175-180	255-260
Roland Sinker, Chief Executive	270-275	11,400	-	-	-	-	280-285
Edward Smith, Chief Finance Officer (from 1 August 2020 to 8 November 2020)	45-50	-	-	-	37.5-40	-	85-90
Claire Stoneham, Director of Strategy and Major Projects from 1 June 2020	120-125	-	-	-	22.5-25	-	140-145
Lorraine Szeremeta, Chief Nurse	155-160	-	-	-	40-42.5	-	195-200

Ian Walker, Director of Corporate Affairs	140-145	-	-	-	35-37.5	-	175-180
David Wherrett, Director or Workforce	165-170	-	-	-	240-242.5	-	405-410
Daniel Abrams, NED	15-20	-	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Dr Annette Doherty, NED	0	100	-	-	-	-	0-5
Dr Michael Knapton, NED	10-15	-	-	-	-	-	10-15
Professor Patrick Maxwell, NED**	10-15	-	-	-	-	-	10-15
Dr Michael More, Chair	55-60	-	-	-	-	-	55-60
Doris Olulode, NED	10-15	300	-	-	-	-	10-15
Professor Sharon Peacock, NED	5-10	-	-	-	-	-	5-10
Shirley Pointer, NED	10-15	100	-	-	-	-	10-15

*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 2020/21 to the University of Cambridge in recognition of his time spent undertaking duties as a Non-Executive Director.

*** Includes any payments made for untaken annual leave during the COVID period

Table 14: 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	50-55	-	-	-	195-197.5	150-155	400-405

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)
Improvement and Transformation*							
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

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)
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
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.

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

	Mileage (Car/Cycle)	Rail/bus Travel	Taxis	Hotel Accom.	Meals/Subsistence and parking	Conference fees	Other	Total 2020/21	Total 2019/20
Jessica Bawden	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£25.00
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	£0.00
Dawn Chapman	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£262.20
John Clarkson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Bill Davidson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Dean	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Laurence Gibson	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Roberto Gherseni	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Graham Green	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ruth Greene	£0.00	£0.00	£81.80	£0.00	£0.00	£0.00	£0.00	£81.80	£266.10
Jeremy Griggs	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£25.00
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
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	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£230.50
Stephen Legood	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Julia Loudon	£167.40	£0.00	£0.00	£0.00	£27.00	£0.00	£0.00	£194.40	£976.45
Wendy Menon	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Nicola Massey	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Anna Miller	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£293.80
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	£0.00
Peter St George-Hyslop	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Neil Stutchbury	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Andi Thornton	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Annette Thomas-Gregory	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Adele White	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£244.10
Simon Whitworth	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£157.40

Notes

1. The travel claims for Ruth Greene and Julia Loudon relate to expenses incurred during 2019/20 financial year, but reclaimed in 2020/21 financial year.

Table 16: Directors' expenses

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels /	Meals and Parking	Other	Total	Total 2019/2020
Daniel Abrams	£0.00	£0.00	£96.15	£0.00	£0.00	£0.00	£0.00	£96.15	£543.20
Nicola Ayton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£262.90
Ewen Cameron	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Adrian Chamberlain	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Doherty	£71.74	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£71.74	£1163.20
Sam Higginson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A	£193.30
Michael Keech	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Michael Knapton	£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
Marianne Monie	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Michael More	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£197.04
Daniel Northam Jones	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Sharon Peacock	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Shirley Pointer	£84.13	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£84.13	£997.02
Doris Olulode	£349.81	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£349.81	£0.00
Paul Scott	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1744.78
Ashley Shaw	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£670.39
Edward Smith	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Claire Stoneham	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Roland Sinker	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£656.15
Lorraine Szeremeta	£0.00	£0.00	£0.00	£0:00	£0.00	£8.00	£0.00	£0.00	£475.00

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels /	Meals and Parking	Other	Total	Total 2019/2020
Ian Walker	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Wherrett	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£60.49	£60.49	£622.65

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.
3. The travel claims for Daniel Abrams, Annette Doherty and Doris Olulode relate to expenses incurred during 2019/20 financial year, but reclaimed in 2020/21 financial year.

Table 17: Pension benefit

2020/21

Name and title	Real increase / (decrease) in pension at pension age (bands of £2500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5000) £000	Cash equivalent transfer value at 1 April 2020 £000	Real increase / (decrease) in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2021 £000	Employer's contribution to stakeholder pension £000
Nicola Ayton	2.5-5	0		0	100	6	133	25

Chief Operating Officer			15-20					
Ewen Cameron Director of Improvement and Transformation	0	0	40-45	80-85	797	0	731	18
Michael Keech Chief Finance Officer (from 9/11/2020)	0-2.5	0	10-15	0	74	6	100	9
Marianne Monie Director of Major Projects and Specific Incident Projects (from 02/04/2020 to 31/05/2020)	0-2.5	0	5-10	0	88	0	96	3
Daniel Northam Jones Director of Strategy and Incident Management Support (from 02/04/2020 to 31/05/2020)	0-2.5	0	5-10	0	50	0	56	3
Paul Scott	0-2.5	2.5-5	45-50	110-115	713	35	840	9

Chief Finance Officer (Until 31/07/2020)								
Ashley Shaw Medical Director	0	0	40-45	105-110	835	0	737	3
Roland Sinker Chief Executive	0	0	0	0	645	0	0	0
Edward Smith Chief Finance Officer (from 01/08/2020 to 08/11/2020)	0-2.5	0-2.5	30-35	15-20	288	19	359	5
Claire Stoneham Director of strategy and Major Projects (from 01/06/2020)	0-2.5	0	0-5	0	0	2	20	17
Lorraine Szeremeta Chief Nurse	2.5-5	0-2.5	50-55	115-120	846	32	916	23
Ian Walker Director of Corporate Affairs	2.5-5	0-2.5	30-35	45-50	448	26	502	20

David Wherrett Director of Workforce	10-12.5	25-27.5	60-65	140-145	1030	241	1311	22

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 Director of Corporate Affairs	2.5-5	(0-2.5)	25-30	45-50	398	40	448	0
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.

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
28 June 2021

3.23 Staff report

Staff numbers

As of 31 March 2021 the Trust had 18 directors (eleven male and seven female) and 11,446 employees (3,041 male and 8,405 female).

Table 18: Staff numbers

Average number of employees (WTE basis)	2020/21 Total Number	2020/21 Permanent Number	2020/21 Other Number	2019/20 Total Number	2019/20 Permanent Number	2019/20 Other Number
Medical and dental	1,526	614	912	1,428	598	830
Ambulance staff	0	0	0	0.0	0.0	0.0
Administration and estates	2,569	2,256	312	2,440	2,158	282
Healthcare assistants and other support staff	2,061	1,678	383	1,969	1,614	355
Nursing, midwifery and health visiting staff	3,600	3,186	414	3,556	3,198	358
Nursing, midwifery and health visiting learners	0	0	0	0.0	0.0	0.0

Average number of employees (WTE basis)	2020/21 Total Number	2020/21 Permanent Number	2020/21 Other Number	2019/20 Total Number	2019/20 Permanent Number	2019/20 Other Number
Scientific, therapeutic and technical staff	864	765	99	830	735	95
Healthcare science staff	567	534	34	550	518	32
Social care staff	0	0	0	0.0	0.0	0.0
Agency and contract staff	0	0	0	0.0	0.0	0.0
Bank staff	0	0	0	0.0	0.0	0.0
Other	0	0	0	4	0.0	4
Total average numbers	**11,188**	**9,034**	**2,154**	**10,777**	**8,821**	**1,956**

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. The trust has enhanced its Psychological wellbeing offer for staff since in response to the COVID-19 pandemic.
- 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 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

	2020/21	**2019/20**
Total days lost	79.288	81,872
Total staff years	10,305	10,004
Average working days lost per WTE	7.7	8.2

Equality diversity and inclusion

The Trust's Equality Diversity and Dignity Committee chaired by the Chief Nurse with Vice Chair Director of workforce provides governance and oversight for our Equality Diversity and Inclusion strategy, policies and action plans.

The following groups support service equality and engage with community groups meeting virtually in the last year:

- Accessible Information implementation group
- Learning Disability and autism working group
- Carers Strategy group

The Trust engages with staff networks to coproduce EDI action plans. These networks have been meeting virtually during the pandemic:

- **BAME staff network** to support race equality and inclusion which has coproduced our Workforce Race Equality Standard (WRES) action plan and the chair and members have been part of the BAME staff health task force to review the staff risk assessment during COVID.
- **The Purple Network** is for staff with hidden or visible disabilities, physical, neuro-diverse or mental health conditions and allies to work together to promote inclusion for everyone at CUH. The Purple network has co-produced our Workforce Disability Equality Standard (WDES) action plan.
- **The Time to Change Network** is for staff who are committed to changing the way we all think and act about mental health in the workplace and creates a safe space for staff to share ideas on how to achieve this.
- **LGBT+ staff network** is a group for CUH staff members who are part of the LGBT+ community and allies who wish to support us in promoting equality and championing LGBT+ staff.

Key EDI activity in 2020/21 included:

- Review of the Equality impact assessment process with launch of new Rapid EIA toolkit for rapid decisions during the pandemic with EIA training briefing sessions to command structures.
- Transgender care policy coproduced with LGBT+ staff network, Encompass network the Kite Trust.
- Transitioning at work policy launched.
- Carers' passport promoted.
- Launch of Hidden Sunflower scheme.
- Launch of refreshed accessible public website with accessible Recite Me toolbar.
- Learning disability gap analysis.
- Development by clinical engineering team of clear face mask for use in green areas during the pandemic to aid communication.

Workforce Race Equality Standard (WRES)

- Our latest 6th Workforce Race Equality Standard WRES data reporting template and action plan, which is coproduced with BAME staff and directors was approved by the Board is published on the Trust public website. The Trust's WRES implementation group meets to ensure the action plan has traction. The group has carried out deep dives in the WRES data and reviews of the diverse interview panel process and the cultural ambassador scheme that was introduced in 2019.
- Reverse Mentoring scheme launched in 2020 with first cohort of BAME staff, LGBT+ and disabled staff mentoring executive director and Chair and NEDs completed in April 2021.
- BAME health staff health task force set up, a multidisciplinary group coproduce with BAME staff network members risk assessments.
- BAME staff network worked to support Covid-19 vaccination campaign.
- Investment in Cultural Intelligence (CQ) for Inclusive leadership masterclasses for leaders with external provider Above Difference
- Anti-rascism at work webinars from Pearn Kandola provided
- Allyship resources curated on staff portal.

Workforce Disability Equality Standard (WDES)

- The Trust's Workforce Disability Equality Standard (WDES) action plan, co-created with disabled staff is approved by the Trust Board and published on the Trust's website. The Trust is a 'Disability Confident employer and is a signatory of the 'Mindful Employer Charter' for 'Employers who are Positive about Mental Health' and the trust is a member of Purple Space.
- The second WDES data set was submitted in July 2020. The WDES implementation group provides governance and oversees WDES action plan progress.
- Disabled staff have curated their own stories with help from Patient Voices which are to be used in training.
- Disabled staff reverse mentored directors and NEDs as a result one of the directors is now executive sponsor for the Purple Network.
- Coproduction and launch of the *Purple Passport* –a tool for disabled staff to have a conversation with their line manager to discuss their disability/health condition and agree reasonable adjustments.
- Central adjustments budget agreed and the EDI team and Occupational health are working on process for implementation in 2022.
- LGBT+ awareness training sessions by the Kite Trust held virtually.

- Selection of guest speakers talks recorded and live streamed on Facebook: LGBT History month Dr Michael Brady National LGBT+ health advisor; Autism awareness with Alex Manners and neurodiversity talk with Sean Gilroy and Leena Haque from BBC CAPE
- Hospital chimney was lit up in November to celebrate Diwali the festival of lights and in December Purple for Purple Light Up to celebrate UN International Day for Disabled Persons.

External partnerships to support EDI

- The trust has joined ENEI, Employers Network for Equality and Inclusion so all staff have access to ENEI resources.
- Purple Space member.
- Stonewall diversity champion.
- The Kite Trust.
- Encompass Network.
- NHS Employers Diversity and Inclusion partner.

The following workforce polices support Equality Diversity and Inclusion

- Equality Diversity and Inclusion in employment.
- Recruitment and Selection.
- Grievance and Dignity at Work.
- Cultural Ambassador policy introduced in 2019 as part WRES action plan and a Just and fair learning culture to eliminate bias in disciplinary processes.
- Gender Transitioning at work.

Our equality monitoring reports are published on our public website equality diversity and inclusion pages.
https://www.cuh.nhs.uk/about-us/our-responsibilities/equality-and-diversity/workforce-equality-monitoring-information

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

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. Communication processes have been updated during the pandemic to ensure information is shared frequently and meetings have moved to virtual to meet Covid-secure guidelines.

- CUH Bulletin is a daily email update sent to all employees on 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.
- Monthly Q&A sessions with the Chief Executive and members of the management team. This is an open forum for all staff and provides the opportunity for them to ask questions on any subject matter.
- 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 and a staff portal is available to provide information relating to the Trust's approach to the pandemic, relevant to staff. During the pandemic a CUH staff portal was developed with information relating specifically to Covid-19 information such as PPE requirements, testing and policies and protocols.
- A staff Facebook page is used by staff to share feedback and discuss issues that are important to them.
- The CUH Reflects programme provides an opportunity for staff to reflect on what matters most to them. This supports our other staff voice activities such as the National Staff Survey.

Health and safety

2020/21 has been a very different year for all of us with the World Health Organisation announcing COVID-19 as a global pandemic. The Trust's health and safety department responded swiftly to the pandemic, assisting

with the fight to keep our staff, patients and visitors safe and striving to promote wellbeing at work and in the home office. A large amount of work has been done by the Trust to keep staff safe, healthy and well. This includes:

- implementing effective infection prevention and control procedures
- undertaking COVID-19 secure environment risk assessments
- providing personal protective equipment
- undertaking risk assessments for vulnerable staff
- providing homeworking support (for example, with appropriate equipment); and,
- providing access to psychological support and treatment.

As we enter a new phase of COVID-19 we will once again begin to remobilise our services and find a new 'normal', and we will continue to:

- assess and mitigate the risks associated with COVID-19;
- comply with health and safety legal obligations;
- support staff and help manage the pressures and uncertainty that will continue to be felt;
- support services to restart safely;
- reflect on and learn from experiences over the past year; and,
- prepare for any further waves of COVID-19 in order to mitigate its impact.

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 be 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.

This year, we have played a pivotal role in the Trust's Covid response. We have managed the Covid staff health incident centre, risk assessment, contact tracing, antibody testing, symptomatic and asymptomatic testing services.

We have, and will continue to, work closely with colleagues across the Cambridgeshire and Peterborough health system. We set up and ran the Covid Mass Vaccination Service - safely providing vaccines to 23,000 individuals in priority groups - health and social care workers and the over 80s. The service has also provided the annual influenza vaccination programme at scale with CUH staff receiving their vaccination onsite.

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 2020-2021, 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 has never been more important than it is now in supporting the recovery of our staff, team and services; continually placing great importance on ensuring that all staff have the best work experience, where they can be themselves and provide the best possible care for our patients**.**

For the first time in five years, CUH saw a decrease in its response rate for the National Staff Survey 2020 of 1.5% with a total response of 54% or 5884 staff. This figure remains above the National average of 45%. It is not surprising that there was a decrease in the response to the questions in the survey relating to job role and immediate managers given the significant disruption to both working and personal lives caused by the pandemic. Despite this CUH was proud to maintain its staff engagement score of 7.2 out of 10, again above the National average of 7.0. This demonstrates staff willingness to advocate for the organisation and alongside this position there were also improvements in both the recommendation scores as a place of work and treatment to 73.6% and 85.7% respectively and both above the National average.

Of the 10 National benchmarking themes there is a significant decrease in 4; immediate managers, Quality of care, Safe environment – Violence, and Team working. CUH is above the national average for acute and community trusts in 3 of the themes; health and wellbeing, safety culture and staff engagement. CUH is below the national average for acute and community trusts in 3 of the themes; Equality, diversity & inclusion, Team working and Safe environment – Violence.

Theme	2019 Score	2020 Score	Statistically Significant Change?	Average Acute & Community Trusts	Difference from Average	Best Acute & Community Trusts	Worst Acute & Community Trusts
Equality, diversity & inclusion	9.0	9.0	Not significant	9.1	-0.1	9.5	8.1
Health & wellbeing	6.2	6.3	↑	6.1	0.2	6.9	5.5
Immediate managers	7.0	6.8	↓	6.8	0	7.3	6.2
Morale	6.2	6.2	Not significant	6.2	0	6.9	5.6
Quality of care	7.6	7.5	↓	7.5	0	8.1	7.0
Safe environment - Bullying & harassment	8.0	8.1	Not significant	8.1	0	8.7	7.2
Safe environment - Violence	9.5	9.4	↓	9.5	-0.1	9.8	9.1
Safety culture	7.0	7.0	Not significant	6.8	0.2	7.4	6.1
Staff Engagement	7.2	7.2	Not significant	7.0	0.2	7.6	6.4
Team working	6.7	6.4	↓	6.5	-0.1	7.1	6.0

When comparing those specific themes to the Shelford Group, CUH scores the highest (6.3 out of 10) in relation to Health & Wellbeing, joint third place for Equality, Diversity and Inclusion (9.0 out of 10) and retains joint fourth place for providing a safe environment in relation to Bullying & Harassment. Although retaining 7.2 out of 10 for staff engagement CUH move to fourth place in the Shelford Group for this theme.

Future priorities and targets 2021/22

Improving the experience of staff remains of paramount importance and in line with staff feedback we are committed to realising the following ambitions focussed on five key areas of wellbeing, inclusion, education, resourcing and relationships. These ambitions encompass aspects of previous workforce priorities and have allowed us to refresh our workforce commitments in line with staff needs.

Analysis of staff costs - Subject to Audit

Table 20

2020/21

Employee expenses	Year ended 31 March 2021 Total £000	Year ended 31 March 2021 Permanent	Year ended 31 March 2021Other £000
Salaries and wages	478,430	475,660	2,770
Social security costs	48,262	48,262	-
Apprenticeship Levy	2,263	2,263	-
Pension cost – defined contribution plans employers contributions to NHS pensions	52,408	52,408	-

Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	22,853	22,853	-
Temporary staff – agency/contract staff	2,980	-	2,980
Total gross staff costs	**607,196**	**601,446**	**5,750**
Included within:			
Staff and executive directors costs	606,895	601,446	5,750
Redundancy	0	0	-
Early Retirements	102	102	-
Special Payments	199	199	-
Total employee benefits	607,196	601,446	5,750

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

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
44	41.25

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%	23 (including medical reps)
1-50%	21
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	£38,789.20
Total pay bill	£607,196,000.00
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.00638%

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 as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	3.72%

Off-payroll engagements

Table 25: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months.

Number of existing engagements as of 31 March 2021	
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 2020 and 31 March 2021, 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 2020 and 31 March 2021	
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 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	18

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 2020/21 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	0	0	8	74	8	74	0	0
£10,001 - £25,000	2	39	0	0	2	39	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	1	160	0	0	1	160	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	3	199	8	74	11	273	0	0

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

Exit packages: other (non-compulsory) departure payments - 2020/21	2020/21 Payments agreed Number	2020/21 Total value of agreements £000	2019/20 Payments agreed Number	2019/20 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	8	74		
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval*i*			2	35
Total	8	74	2	35
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 until October 2020 the Chief Nurse of Royal Papworth Hospital NHS Foundation Trust was 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.

The representatives of Royal Papworth Hospital NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust are partnership governors appointed to reflect the views of key partner organisations.

3.25 NHS Improvement's Single Oversight Framework

NHS England and 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.

As of 31 March 2021 the Trust is in segment 2 - Targeted support: support needs identified in finance and use of resources and operational performance.

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

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
28 June 2021

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 2021 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. The Corporate Risk Register (CRR) includes operational risks escalated by clinical divisions and corporate directorates.

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 reviewed and approved by the Board of Directors in November 2020. 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 and reviews the BAF and the CRR. It is chaired by the Chief Executive and membership includes all members of the Management Executive. 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, specifically in the context of its response to the Covid-19 pandemic (see below).

The 2020/21 internal audit report on the BAF and risk management provides an overall assessment of 'Significant assurance with minor improvement opportunities'. The recommendations of the report have been accepted by the Executive Team and will be actioned during 2021/22. The internal audit report identified no outstanding recommendations from previous years.

As at 31 March 2021, the Trust identified through the BAF the most significant risks to the achievement of its strategic objectives as being:

- As a result of needing to manage the impact of further waves of Covid-19, there is a risk that the Trust is not able to safely and sustainably restore local and specialist services to previous levels of capacity which results in increased waiting times and poorer outcomes and experience for patients, and impacts on the ability to function as a regional surge centre.
- 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.
- Due to national shortages of trained health care professionals and the impact of the Covid-19 pandemic on the ability to recruit internationally, there is a risk that the Trust will not be able to meet increased workforce demand to support the necessary capacity growth (surge centre, critical care expansion).
- As a result of a reduced ability to identify, review and treat patients in a timely way due to the ongoing impact of Covid-19, there is a risk that the Trust is not able to effectively prioritise those patients in greatest clinical need which results in patient harm and poorer outcomes and experience for patients.
- There is a risk that as a result of the Covid-19 pandemic and as part of the wider Cambridgeshire and Peterborough health and care system which has an underlying financial deficit, the Trust is unable to achieve a financially sustainable position leading to regulatory action and/or impacts on the ability to invest for the future and provide high quality services for patients.
- The Trust does not develop and implement effective actions to achieve greater equality and diversity in the CUH workforce and therefore does not realise the benefits of being a truly diverse and inclusive organisation from a workforce perspective, which impacts adversely on staff wellbeing and the quality of patient care.

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.

Responding to Covid-19 during 2020/21

As referenced in last year's Annual Governance Statement, some temporary changes to the Trust's governance structure and risk and control framework were introduced from mid-March 2020 in response to the Covid-19 pandemic. These changes were agreed by the Board of Directors and clearly documented.

An incident management command structure was put in place in line with national guidance. The frequency of Management Executive meetings was increased to twice weekly during the main waves of the pandemic and taskforces were established to address key issues including staff safety and well-being, cohorting and configuration, critical care, personal protective equipment, testing and vaccination.

Formal monthly updates were provided to the Board on all aspects of the Trust's Covid response, with more informal updates each week, and there were regular briefings with the Council of Governors.

The Board and Board assurance committees continued to meet through the period, albeit virtually and with amended agendas during some of the period. Major decisions were recorded and deferred non-Covid agenda items were tracked and re-scheduled appropriately. Management Executive tracked regularly which executive-led committees had been temporarily suspended and which were meeting with revised frequency.

Risk management remained a key priority during this period. The Risk Oversight Committee continued to meet monthly with a specific focus on Covid-related risks but also to discuss any material impact of the pandemic on other risks on the Board Assurance Framework and the Corporate Risk Register.

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*".

Pre-pandemic governance and risk management arrangements were restored, taking account of appropriate learning, by the end of the 2020/21 financial year.

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 Executive Directors, the Trust's lead commissioner and the CQC. 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.

For rapid learning, the After Action Review (AAR) methodology is increasingly being used as a method to reflect on what happened in an incident.

In addition to the above, the Management Executive has a standing item at its weekly meeting on quality issues and risks to ensure that appropriate and timely action has been taken in response to any issues and risks which have arisen in the past week.

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 (2019/20) of compliance with the Toolkit is 'standards met', except in relation to information governance training which is 'standard not met' - due to the Covid-19 pandemic, 88% of staff completed their training against the 95% requirement. An action plan is in place to meet the 95% standard. Due to the pandemic, the finalisation of the Toolkit submission for 2020/21 has been deferred to June 2021.

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 reports to the Digital Board.

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 Trust's strategy has been reviewed and refreshed in response to the Covid-19 pandemic and the Board has reviewed progress against the Trust's key 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.

An additional Board committee was established in January 2021 to provide assurance to the Board of Directors on the progress of the Addenbrooke's 3 hospitals redevelopment programme and key issues and risks.

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 supporting meetings. They are also involved in the development of the Trust's strategy and operational plans, specifically through the Governor Strategy Group.

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.
The Trust continues to undertake regular CQC and Use of Resources self-assessments and peer reviews.

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

A draft system-led Operational Plan was submitted to NHSE/I in March 2020 but, due to the Covid-19 pandemic, the requirement to submit final versions of the Operational Plan and the Trust Forward Plan were suspended by NHSE/I. The requirement for a system-led Operational Plan has been reinstated for 2021/22.

The key elements of the Operational Plan has been monitored by the Management Executive and the Performance Committee has 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 Review meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Information Governance

During 2020/21 the Trust recorded two incidents relating to information governance, including data loss or confidentiality breach, which were classified as reportable Information Governance Incidents. These cases have been reported to the Information Commissioner's Office (ICO) and have been fully investigated. No action has been taken by the ICO in relation to these incidents.

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 2020/21 to incorporate revised metrics to allow the Trust to effectively monitor performance, including in response to the impact of the Covid-19 pandemic. In addition to an ongoing programme of 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, other Board assurance committees 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 with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and 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:

- Along with all other NHS providers, the Trust suspended a significant amount of non-Covid clinical activity during the two main waves of the Covid-19 pandemic resulting in a significant increase in elective waiting lists. As services were restored, the Trust continued to take actions internally to improve patient flow, as well as working with partners to reduce delayed transfers of care and provide additional physical capacity, including as part of the regional surge centre project. A robust clinical prioritisation and harm review process was put in place to support the management of increased waiting lists.

- Insufficient capital funding and decant capacity, in addition to the direct effects of the pandemic, have continued to impact 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 and has continued to escalate and work closely with its regulators on these issues.

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
28 June 2021

3.28 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 2020/21 - 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 2020/21 – a process of continuous transition and improvement in line with the Board adopted Sustainable Development Management Plan 2013-2020 and its ongoing progress and evolution since, as presented through these annual reports.

Section 2: details performance and achievements during 2020/21 and provides a brief look forward to the delivery priorities for the coming year.

Section 1 - Commitment (net zero carbon and COVID-19)

Since the publication of its Long Term Plan in 2019, the NHS has recognised that it must inject more urgency into action to realise its well-established direct commitments to tackling climate change. In January

2020 the launch of a new *Greener NHS* campaign was backed up with a set of tangible objectives and actions in the 2020/21 Service Contract. The COVID-19 outbreak saw these requirements put on hold as the nation's healthcare was rapidly restructured to manage the pandemic.

Despite the dominance of dealing with the COVID-19 crisis, the NHS has continued to prioritise the ongoing 'climate emergency' with the publication of its *Delivering Net* Zero plan in October 2020.

The *Net Zero*[1] plan makes it very clear why all NHS organisations need to take action to reduce their carbon emissions on route to achieving a net zero target by 2045. It sets out what the opening phase of actions should include and when they must be delivered by. The 2021/22 Service Contract has subsequently been strengthened to set these actions as formal requirements.

The Trust is fully committed to pursuing these objectives and to deliver against all the relevant associated actions.

Context – the impact of COVID-19 and the imperative of net zero carbon

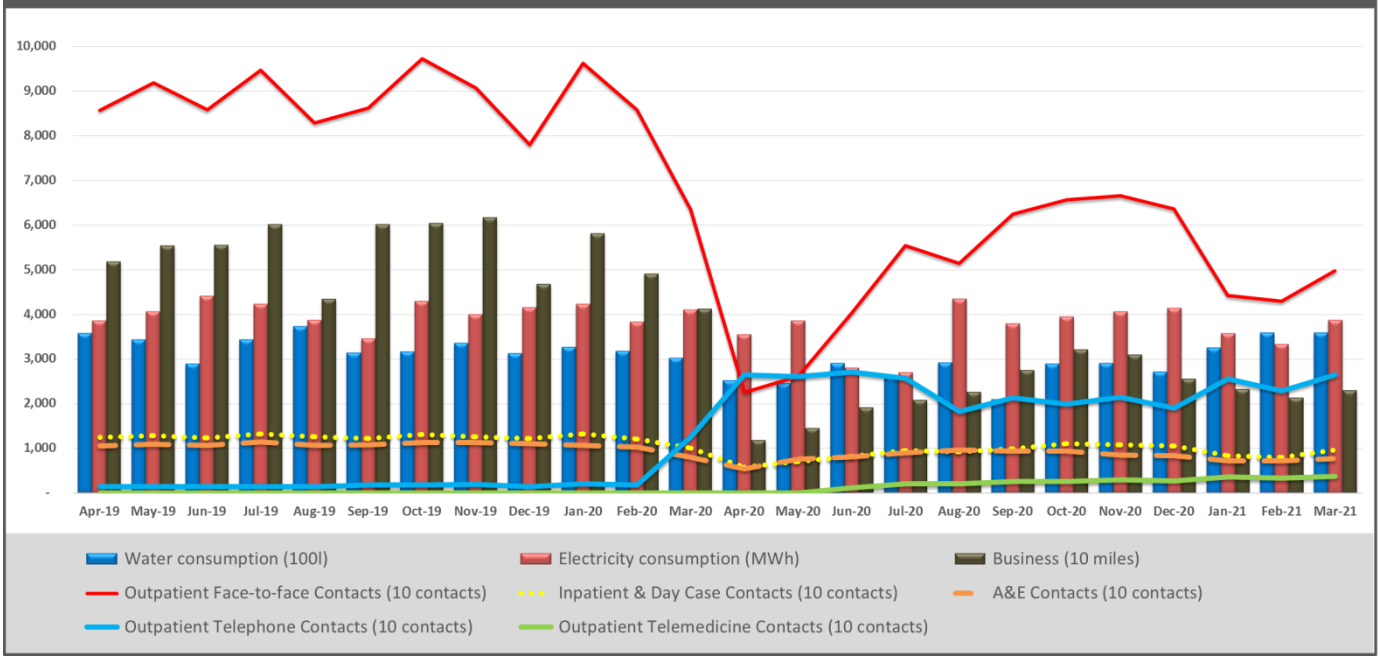
For CUH, like every other hospital, 2020/21 was a year operationally dominated by COVID-19. The pandemic had, and continues to have, an unprecedented impact on the delivery of its services. Physical infrastructure was re-arranged, organisational processes re-orientated and behavioural responses re-shaped.

For CUH, like every other NHS hospital, 2020/21 was also a year in which coming to terms with the imperatives of how to rapidly put all services on a net zero carbon trajectory became a reality.

[1] The term 'net zero carbon' or just 'net zero' has become shorthand for the objective of not increasing the concentration of human-made greenhouse gasses in the atmosphere. They are referred to as 'carbon' emissions because carbon dioxide is the most prevalent (approximately 80%) and other gasses (such as methane, hydrocarbons, and nitrous oxide) are converted into a carbon equivalent according to their impact in terms of adding to global warming. The term 'net zero' refers to the fact that some human-made carbon emissions will be almost impossible to remove and that these must be balanced or off-set by measures to absorb them (known as sequestration) elsewhere (e.g. tree planting).

The race to bring COVID-19 under control was a sprint, the race to bring carbon emissions under control is, by comparison, a marathon. If the impacts of COVID-19 had been understood in advance then a pandemic prevention effort would have eclipsed anything previously thought possible. The impacts of more than a 1.5ºC rise in average global temperatures[2] are well understood as being far more calamitous than COVID-19. We know this in advance. In 2020 the measured rise was 1.2ºC (+/- 0.1ºC)[3] with an average increase of approximately 0.2ºC per decade. With global carbon emissions having already returned to pre-COVID-19 levels and continuing to rise, the climate emergency is still very much here and now. The next ten years are crucial: at least half of the journey to convert what and how we consume into a very low carbon format must be completed by 2030.

Figure 1: Graph showing the impact of the COVID-19 pandemic on monthly markers of hospital activity (lines) set against consumption of electricity, water and business miles (bars) (2019-20 to 2020-21)



As can be seen from Figure 1, the impact and upheaval of COVID-19 on what and how the Trust consumed was exceptional. Many operational changes had to be implemented in very short periods of time and often required a significant reorientation in CUH's healthcare delivery. Some aspects of the changes may well persist as longer term legacies of the pandemic.

The professionalism and determination to do whatever was required to navigate the COVID-19 crisis (whilst remaining committed to the Trust's

[2] Above what it was in terms of a global pre-industrial era, generally set at approximately 150 years ago.

[3] World Meteorological Organisation, 20.04.21, *The State of the Global Climate 2020.*

values of ‘together: safe, kind and excellent’) should be taken as proof that the inspiration and tenacity to tackle the rapidly escalating climate emergency is very much within our reach.

Visualising net zero carbon consumption for a hospital

As outlined above, 2020/21 brought two huge challenges to CUH: COVID-19 and net zero carbon. Both managing infection and cutting carbon emissions are established elements of running a modern hospital but the escalation to an emergency condition renders existing ways of working inadequate. Having to do much more of something, much more quickly in a crisis situation, typically means that the existing approach needs to urgently and radically change. This was true of COVID-19 in 2020/21 and was acknowledged as true for the climate emergency in the NHS’s new Net Zero Plan.

Drafting, launching and promoting the delivery of the NHS ‘net-zero’ plan in the midst of the greatest healthcare crisis in NHS history is the most telling marker of just how incredibly important and urgent it is to reduce carbon emissions. The targets are necessarily very challenging (especially when reset to a current baseline): a 47% cut in directly controllable emissions by 2032 at the latest, and 73% cut in those less directly controllable by 2039 at the latest – leading to net zero in all emissions by 2045. The term ‘net zero’ recognises that some emissions are unavoidable and so balancing actions must be taken to ensure that the concentration of greenhouse gasses (expressed as ‘carbon’ equivalents) in the atmosphere does not increase

The new national Plan is very clear on ‘why’ and ‘when’ NHS organisations need to respond, it also provides the first steps in terms of ‘what’ needs to be done. Working out ‘how’ to make these things happen needs to be worked up locally (and from this follows ‘who’ does them and ‘where’).

The state of readiness of a hospital’s physical infrastructure, the current content of its policies and processes and the views of its key players all vary from location to location. The support and activity of local partners across sub-regions (e.g. Integrated Care Systems) and wider areas (e.g. NHS Regional Sustainability Networks) are also key parts of delivering sustainable change.

Hospitals are intense consumers – their carbon emissions and environmental credentials are defined by:

- what they consume (the actual quantities and types of energy, water, travel miles, goods, materials, equipment and medicines) and whether they lead to high or low carbon emissions and pollution, and whether they derive from over-exploited natural resources or not and,

- how they consume it (either wastefully with total loss or sustainably with strong reuse and high value recycling).

The *unsustainable* high-carbon/high-waste outcomes arise from using fossil fuels to follow a 'linear' take-make-use-throwaway approach to consumption in which almost all the inputs are lost as unwanted carbon emissions, pollution and waste (re. Figure 2a).

The *sustainable* net-zero/zero-waste outcomes arise from a rapid and determined transition to a renewable energy powered 'circular' approach to consumption. Here, raw materials are taken, manufactured into goods and materials and then used with as little pollution and loss as possible – the idea of 'waste' does not really exist, it is replaced with reuse and recycling (re. Figure 2b)

Figure 2a:
The 2020 'linear' supply-use-dispose chain of consumption predominantly powered by fossil fuels. This has real and inherent problems when it comes to embedding environmental sustainability and the transition to net-zero.

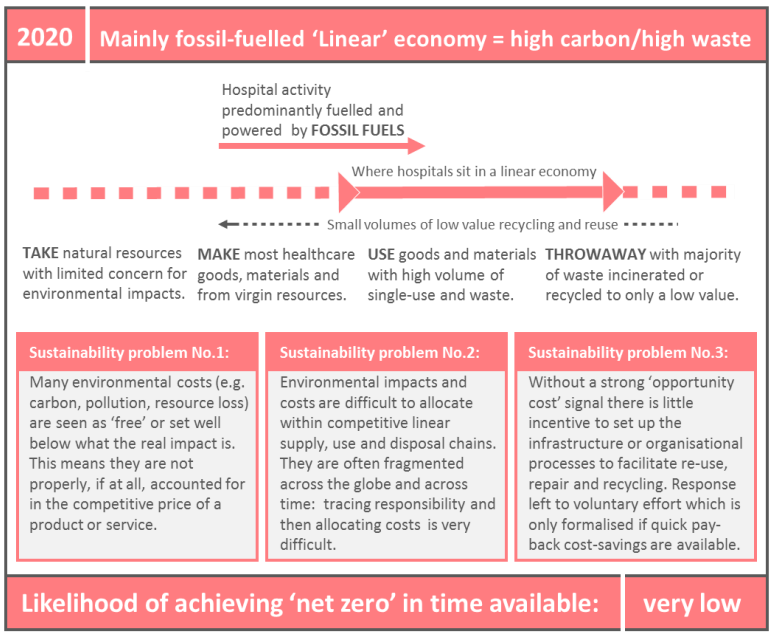
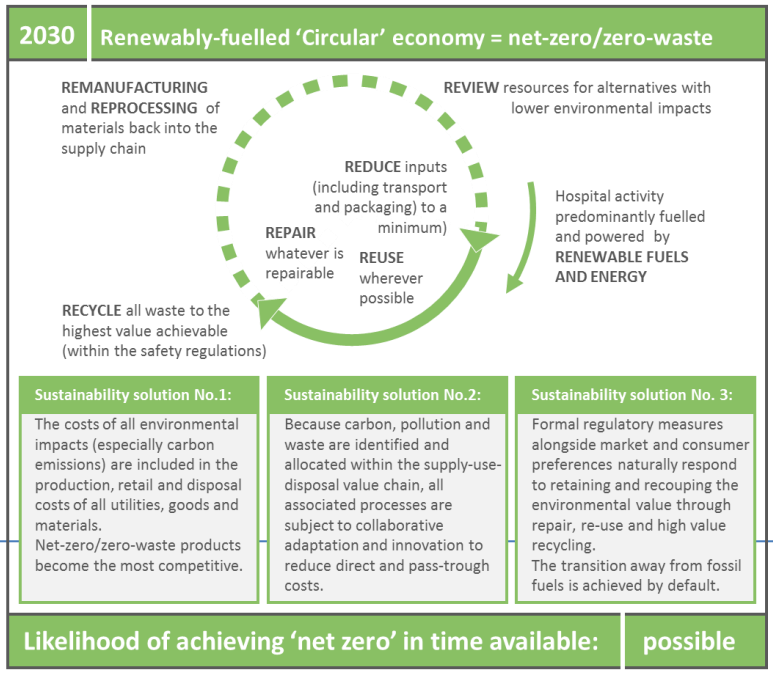


Figure 2b:
The 2030 'circular' reuse and high value recycling chain of consumption predominantly powered by renewable energy. This delivers environmental sustainability and a rapid and lasting transition to net-zero by default.



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 it covered 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.

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 often referenced within the Trust's tender preparation guidance. Procurement procedures will be developed through the new Green Plan to ensure that lifecycle costings are appropriately covered in relation to energy, waste, water, and transportation.

2020/21 has also seen the Trust rapidly progress the design phases for three important new build projects (the Cambridge Children's Hospital, the Cambridge Cancer Research Hospital, and a Regional Surge Centre) alongside a comprehensive masterplan review process for the redevelopment of the CUH campus as "Addenbrooke's 3". A unified approach and required standards for net-zero enabled sustainable design have been brought forward within the specification for each of these projects. This has been carefully aligned to account for the publication of an NHS net-zero standard for new hospital buildings (due in November 2021) and existing and emerging Local Plan land-use policies.

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.

Throughout 2020 the Trust has continued to chair the NHS East of England Regional Sustainability Network. The role and accountability of the network has developed significantly in order to much more formally facilitate the shared responsibilities that NHS organisations across the region now have to rapidly adjust to a net-zero trajectory (re. Standard Contract Service Conditions for 2021/22).

In September, CUH was one of the first signatories in the launch of Cambridge City Council's new Cambridge Climate Change Charter. The initiative, run on the ground by Cambridge Carbon Footprint, offers guidance and information on how companies and individuals can act in more environmentally friendly ways that fit in with their objectives and day-to-day activities. Active participation in the project further develops CUH's recognition of its role as an 'anchor' institution within the local community.

In 2020/21 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, Greener NHS Team, NHS England/Innovations, The Shelford Group, 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 Institute for Sustainability Leadership, Cambridge Judge Business School Circular Economy Centre, Medical Research Council, AstraZeneca, Cambridgeshire and Peterborough NHS FT, Royal Papworth Hospital, Cambridge Cleantech and local community groups.

Section 2 – Performance

As related in Section 1, above, two key factors have shaped the performance and direction of the Trust's environmental sustainability performance in 2020/21. Both have brought, and will continue to bring, a new set of rules and direction to the delivery of sustainable healthcare in the 2020s.

The COVID-19 crisis has inevitably limited the resources and attention available to push the Trust's environmental sustainability agenda to the extent envisaged eighteen months ago. At the same time, however, the impacts of lockdown and reductions in some on-site activity have reduced utility consumption and travel miles by default.

Despite the constraints, important streams of work have been taken forward and delivered as described in the sections below. These are being increasingly shaped and defined by the NHS's doubling down on the gravity of finding and following a net-zero trajectory that limits average global warming to as far below 2^{o}C as possible.

Sustainable Energy and Water Consumption (premises)

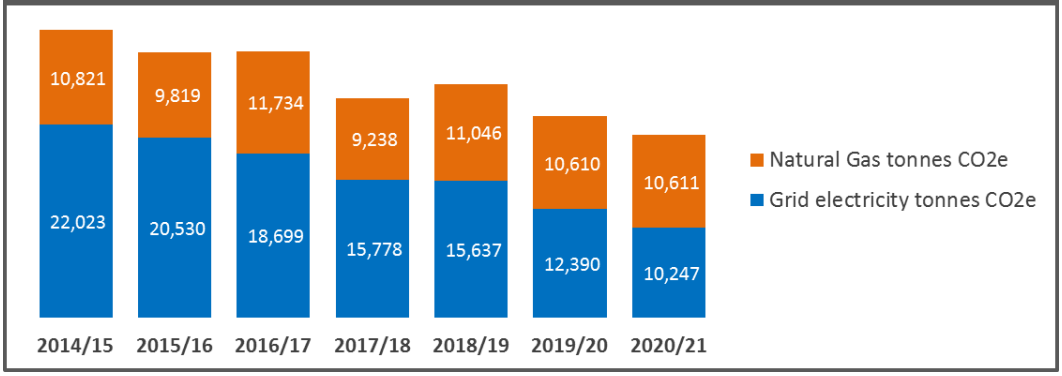
Energy

The two main energy sources for the Trust's premises are natural gas for heating space and water, and electricity for powering plant, lighting and healthcare equipment (with oil available as a backup for both if required). In terms of both carbon and cost there are important distinctions between the two. In 2020/21 43% of the energy used was electricity but this accounted for 80% of the total energy cost and 49% of the carbon emissions when compared to gas. This year, due to the increasing contribution of low carbon sources to the national grid, the carbon intensity of electricity has come even closer to that of natural gas.

This is very positive for the medium to long-term decarbonisation of CUH's building services. In terms of lowering on-site emissions, natural gas can now be replaced with high efficiency mains powered heating solutions on an almost kilowatt for kilowatt basis.

Carbon emissions (CO_{2e}) from the on-site consumption of heat and power continue to fall (re. Figure 3).

Figure 3: CO_{2e} emissions from energy use in premises 2014/15-2020/21



The previous overall target for the NHS was a 28% reduction by 2020 from a 2013/14 baseline. In terms of heat and power the Trust has currently achieved a 36% reduction since 2014/15 - when it was obliged to reset the internal baseline due to the decommissioning of the combined heat and power (CHP) gas turbine.

The 36% 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 as raised previously.

It is essential to note, however, that grid electricity remains five or six times more expensive per unit (kilowatt hour) than gas.

This means that it is even more important that every kilowatt hour is very carefully managed in all new build and retrofit/backlog maintenance projects - managed to take full account of each of the following parameters:

a.) 'lean': i.e., energy consumption is driven down to the lowest level possible (e.g. minimising demand through passive measures such as fabric insulation and summertime shading);
b.) 'clean': i.e., power is used as efficiently and with as little waste as possible (e.g. carefully automated control of pumps/motors/fans, LED lighting, and heat pumps with exceptional coefficients of performance), and;
c.) 'green': i.e., options for on-site behind-the-meter renewable energy sources are always assessed (e.g. electricity from roof-mounted photovoltaic solar panels).

The restructuring of hospital activity in response to COVID-19 had only a limited impact on electricity (approximately 9% less over 2019/20) and gas consumption (negligible change). With regards to electricity the fall-off in consumption from outpatient and day patient activity was partially off-set with an increase in intensity elsewhere to meet the COVID-19 response. With regard to gas, the change to the heating regime from COVID-19 was immaterial as space was not closed down and still needed to be heated.

The monthly reduction in electricity consumption closely matched the national lockdown periods and by March '21 was steadily approaching parity with the pre-COVID-19 trend in incrementally growing consumption.

The potential cost increases in switching from burning gas to using progressively lower carbon grid electricity for heating, outlined above, is only one half of the pressure that is being progressively applied to the Trust's electricity budgets.

CUH, like the majority of organisations, is increasingly dependent on electricity to deliver its full range of services. The greatest immediate pressures are coming from:

- requests for air-conditioning in response to warmer weather conditions
- higher electrical equipment levels per square meter;
- increasing intensity in the use of the hospitals' services and facilities; and
- 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 can also be expected to create additional demand.

The importance of embedding a ‘lean’, ‘clean’ and ‘green’ approach to the provision and consumption of electricity in all aspects of the Trust’s physical infrastructure, organisational procedures and behavioural responses has never been as important as it is now.

Lean

Reducing energy demand by design (being lean) has continued to prove to be the hardest objective of the three in a modern acute teaching hospital. The COVID-19 crisis has, however, implemented two significant changes that may become important legacies in terms of energy consumption. The first is the shift away from face-to-face contact unless completely necessary. The primary reduction here is in energy associated with travel. Building services consumption will only really be affected if outpatient and associated clinical areas are subsequently restructured to occupy less space. The second change is the direction to work from home whenever possible. Here again the primary reduction is in reducing the transport emissions from commuting and business travel. Any savings in on-site carbon emissions will be partially off-set by those generated in a ‘home-office’. The coming months will reveal the degree to which either of these ‘remote access’ changes may become permanent and potentially have a lasting impact on the demand for energy related building services.

Some further progress has also been made this year in working to reduce the impact of summertime overheating whilst avoiding the significant cost and carbon implications of installing fixed air-conditioning. The deployment of portable and temporary air-conditioning units for the core 3-4 months summer period in clinical areas with a high risk of over-heating is now a standard response. This was also the first year to fully trial the use of small wall mounted supply/extract fans with time clocks set to purge overheated air from unoccupied areas overnight. Despite some early teething difficulties this has now proved a useful relatively low-cost approach. When combined with solar control window treatments (film, blinds or brise soleil) these measures are helping to manage summertime over-heating in vulnerable areas of the estate.

Although corporate communication and engagement messaging has been dominated by COVID-19, the Trust continues to encourage all staff to turn off equipment when not required, and safe to do so to, ensure that the demand for energy is not higher than it needs to be.

Clean

Improving the efficiency with which building services (plant, equipment and controls) consume energy, and thereby reducing their carbon emissions, is an area in which the Trust has a strong track record of experience. Across an estate portfolio that can date back over 50 years, the use of capital project refurbishment, backlog maintenance and, most specifically, external

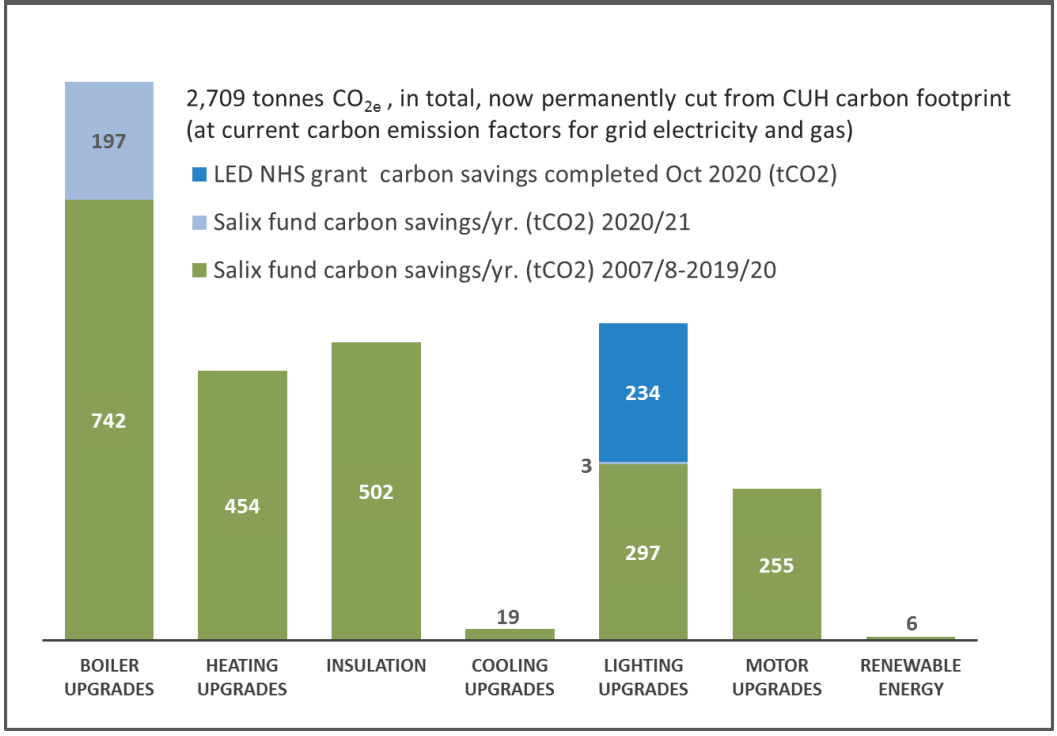
grants and the Trust's dedicated 'revolving' energy efficiency fund (independently validated through the fund's partner, Salix Finance) are all invaluable in driving down emissions.

This year, the extensive lighting upgrade project, using a £600,000 grant from the NHS Energy Efficiency Fund was completed. Overall, in excess of 6,000 fluorescent light fittings have been replaced with high efficiency LED units. These have not only cut 191t of CO_{2e} permanently from CUH annual emissions and saved £150k per year in running costs, but also significantly improved the lighting quality wherever they have been installed.

Even with this grant funding, however, only a little over 30% of the Trust's internal lights have been upgraded to date (almost all external lighting is now LED). In order to maintain the momentum, the Trust will use its dedicated revolving energy efficiency fund to continue the roll-out. To this end a three-year supply-and-install contract for this work has been successfully tendered and awarded.

CUH is one of very few NHS hospitals to run its own waste incinerators. The two units bring the twin benefits of being hugely beneficial in terms of effective waste management whilst helping to keep the hospital warm from the recovered heat. The engineering team who keep this essential plant running 24/7 brought forward an innovative upgrade to the waste incineration process through introducing high efficiency pre-burners. The very significant gas savings from this have meant that the project was compliant with the Salix invest-to-save parameters and funding/implementation was secured.

Figure 4: 2020-21 carbon savings added to total savings from CUH/Salix Energy Efficiency Project Fund (tCO_{2e})



As introduced above, the progressive decarbonisation of the national electricity grid, combined with improving the efficiency of electrical equipment, is on the way to satisfying one half of the challenge of halving these emissions by 2032 (from a 2019 baseline). The other half for CUH covers the transition from using gas-fired boilers for space and water heating. In recognition of this challenge, the Government offered direct grant support through its Public Sector Decarbonisation Scheme (PSDS) launched in September. The criteria for the scheme understood that financial investment for the transition to low-carbon heat in existing building stock was essential. CUH's bid for funding to pilot the installation of a partially solar powered air source heat-pump for The Rosie as a single replacement for an individual large chiller and gas boiler supplied domestic hot water was successful. The £460k fully granted funded project is now underway and due to complete by September 2021.

This is an important step for the Trust as it introduces all-important high-efficiency electrical heat-pump technology in a battery-backed 'solarised' design. The latter has already proved effective in a chiller conversion project on the roof of The Rosie Perinatal block. It is envisaged that the learning and benefits from the PSDS-funded project will allow it to be

adopted and scaled up for deployment as a decarbonisation retrofit across other existing facilities.

Site-wide decarbonisation is a process that needs careful and detailed planning. The Trust has a site-wide Energy Strategy that was drafted in 2015. Much has changed since then and work on a new Strategy has begun that focuses on the NHS decarbonisation timeline, the current new build programme (e.g. Cambridge Children's and the Cambridge Cancer Research Hospital), and the broader masterplan development for 'Addenbrooke's 3'.

Green

Once energy demand has been driven down to its lowest viable level, whilst being delivered as efficiently as possible, the final step is to provide the lowest carbon ('green') form of generation available.

For many hospitals this is difficult and CUH is no exception: clear and accessible roof space for solar panels is often in short supply; burning biomass comes with significant storage problems and inherent sourcing and transportation issues; wind turbines come at a scale that typically makes them unacceptable, and; whilst the greening of the national electricity grid is hugely beneficial, it has undermined the low-carbon credentials of gas-fired combined heat and power (CHP) units.

At CUH, as introduced above, relatively small-scale solar PV arrays will be installed where possible and with the power electronics (incorporating battery storage) to ensure every renewable kilowatt hour is used to best effect.

The only other alternative is to directly connect CUH's on-site high voltage network with a local commercial-scale renewable energy generation site. These direct local opportunities are rare but the Trust is working in partnership with Cambridgeshire County Council on what is known as a 'private-wire' power purchase agreement (PPA) to bring in surplus electricity from a 2MWp PV array that the Council is planning to install above the parking bays on their Babraham Park and Ride site. If successful, it is envisaged that this useful contribution of renewable electricity would come on-line in 2022.

Less direct alternatives, which the Trust has been reviewing, include establishing PPAs with remote generation via the national grid, or purchasing its primary electricity supplies under a standard 'green' tariff.

Lean, clean and green new build

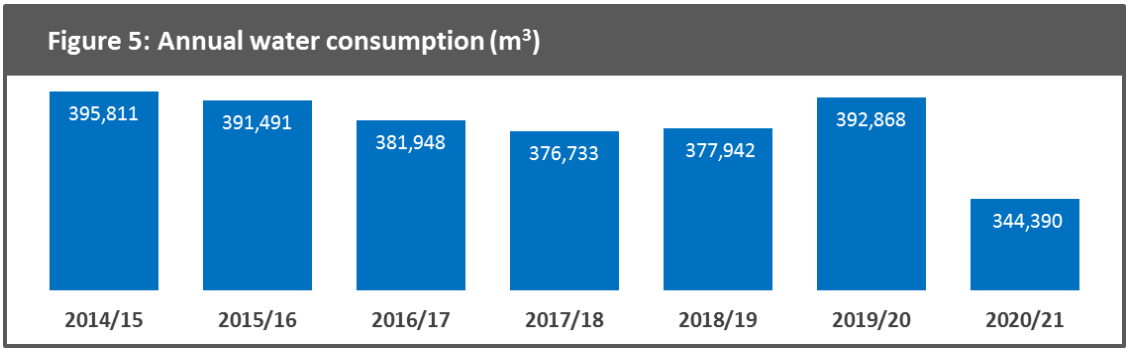
Throughout the year, CUH and its development partners, having been establishing design specifications for both the new Cambridge Children's Hospital and the Cambridge Cancer Research Hospital. As new builds,

these facilities will define the opening standard for net-zero design on site – setting this standard in their own right and also as part of the wider master planning programme. An NHS net-zero standard is due to be published in November 2021 The design teams for both projects have been working on anticipated compliance with a core focus on driving down energy use intensity for each new building with specifications that are both very lean and very clean.

Water

Water consumption across the site has historically been relatively stable at around 33,000m^3/month. Of the three mains supplied utilities, however, water consumption was affected the most by the pandemic (re. Figures 1 and 5). Water has many purposes at CUH: from washing, flushing and cleaning to drinking and food preparation, to research and testing, to running boilers and providing hydro-therapy and swimming facilities. The reduction in the number of staff, patients and visitors on site has had a big impact on water used for personal hygiene and toilet flushing.
For operational and safety reasons, much of the water is treated, tanked and subject to a carefully managed pipe flushing regime. 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: Annual water consumption (m^3)



The main campus pressurisation control units, installed in 2011, continue to ensure that the twin high pressure mains supplies are matched to consumption.

Sustainable Procurement and Waste Management

Circular supply chains, in which use and disposal are integral parts, mean that the Trust can retain and recoup as much of the value as possible from what it purchases. This ‘circularity’ of value plays a vital role in reducing

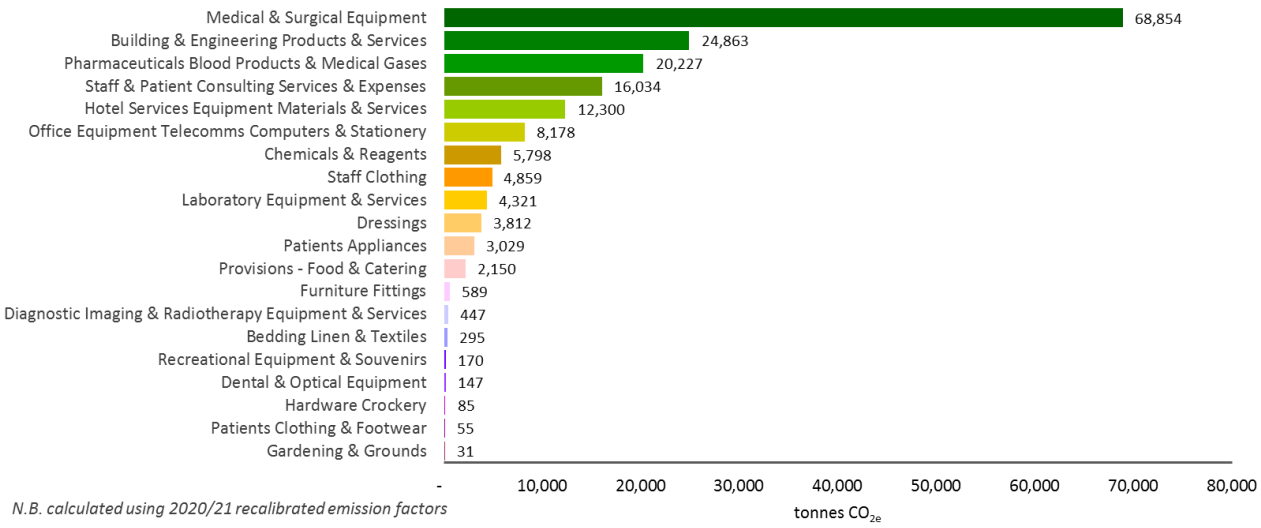
carbon emissions. When goods, materials and equipment are re-used, repaired or recycled then the 'embedded' carbon emissions (and other pollutants) generated during the extraction and refinement of the raw materials, subsequent manufacturing, packaging and finally distribution are going to be entirely emitted again in the production of the items from scratch. The amount of carbon saved against the total loss of them to incineration or landfill depends on how much value is retained with reuse as the greatest, followed by repair and then high and, finally, low value recycling.

As a very intense consumer of goods, materials and equipment, the Trust has a crucial role to play in the transition to circularity. As a responsible consumer, the infrastructure, process and behaviours need to be in place that clearly recognises the left-overs from what we consume as ongoing resources and not as waste. The importance of this responsible stewardship towards carbon that has already been emitted on our behalf (as well as the pollution and the natural resources extracted/harvested) is well illustrated in Figure 6.

Using the indicative emissions factors against spend for the main procurement categories, the carbon embedded in purchased goods, materials and equipment for 2020/21 is over seven times greater than that for gas and electricity used to heat and power the Trust's buildings. It should be noted that this excludes the majority of PPE that was provided to CUH through central distribution outside of standard procurement recording.

The Trust does what it can in influencing suppliers to provide products and services with lower 'upstream' environmental impacts. This is done via central NHS procurement processes, advice and guidance from the Sustainable Waste Management and internal Procurement Team and the content of tender briefs and specifications. However, this applying of pressure to suppliers is still universally underdeveloped with many constraints in terms of available and accurate reporting, uneven market competition and budgetary pressures.

Figure 6: Purchased good and materials 2020/21 indicative carbon footprints (tCO_{2e}) by main procurement category

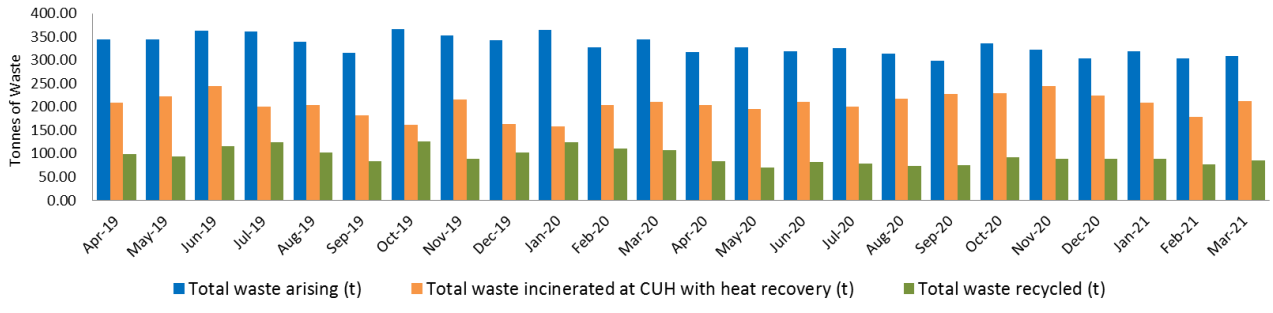


N.B. calculated using 2020/21 recalibrated emission factors

The stronger and more direct approach is for the Trust to take as much control as possible of the post-consumption options so as to facilitate reuse, repair and high value recycling. Not only does this reduce costs through lowering demand for new products (re-use and repair) and the lowering of disposal costs through clean streams of wastes and rebates (recycling) or, ideally, actually selling post-consumption products and materials directly back into the supply chain. CUH is currently engaged in a regional project to assess the options to do exactly this by identifying its most commonly purchased plastic clinical items and assess their circularity value.

This approach promotes a different and much clearer line of questioning to suppliers in which the emphasis is on facilitating re-use, repair and recycling 'downstream' from the point of consumption. Another alternative is to purchase goods as a service so that repair, re-use and recycling have direct commercial benefits to the supplier: this is a route the Trust already exercises where possible, e.g. linen and dynamic mattresses.

Figure 7: Total waste arising, on-site incineration with heat recovery, and recycling profiles pre- and post-COVID



This year, the Trust continued to sustain 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 and Equipment Team/Portering Supervisor are still finding new homes for unwanted items, although we continue to review options to expand re-use capacity.

As an acute hospital campus, 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 clinical and offensive waste on site in what is, essentially, total destruction - with the exception of the recovery of heat from the combustion 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. To help prevent this from happening a new and up-to-date waste segregation e-learning module has been created as an essential requirement for all clinical staff. This is being provided alongside the roll-out of a revised and redesigned set of bin labels.

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 and redefined for implementation.

It had been planned to fully embed all of these improvements during 2020/21. The impact of the COVID-19 crisis, however, brought an urgent set of new priorities temporarily into play for waste management. The restructuring and re-prioritising of hospital activity saw clinical waste

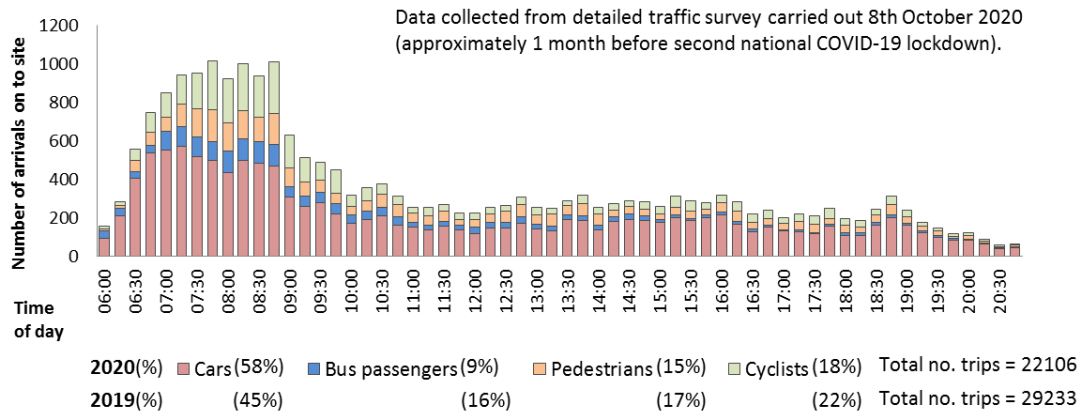
dominated by the orange infectious stream and the distribution, redistribution and reallocation of several hundred clinical waste bins – reflecting both the higher hazard and unprecedented volume of personal protective equipment (PPE). In the five months from April to August the volume of facemasks procured rose to 7,500,000 (from 250,000) and for gowns to 2,500,000 (from 135,000).

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 11,000 for the same period.

Of all the topic areas relating to what and how CUH consumes, travel miles and transport choice have been transformed the most by the COVID-19 crisis. In terms of reducing carbon emissions, and improving air quality, many aspects have been positive and with the very real potential that some of these could become permanent. Lockdown has dramatically accelerated what was previously an incremental shift to replace travelling and physical meetings with remote IT-based virtual screen contact.

Figure 8: Weekday inbound flow to CBC by arrival mode (2020)



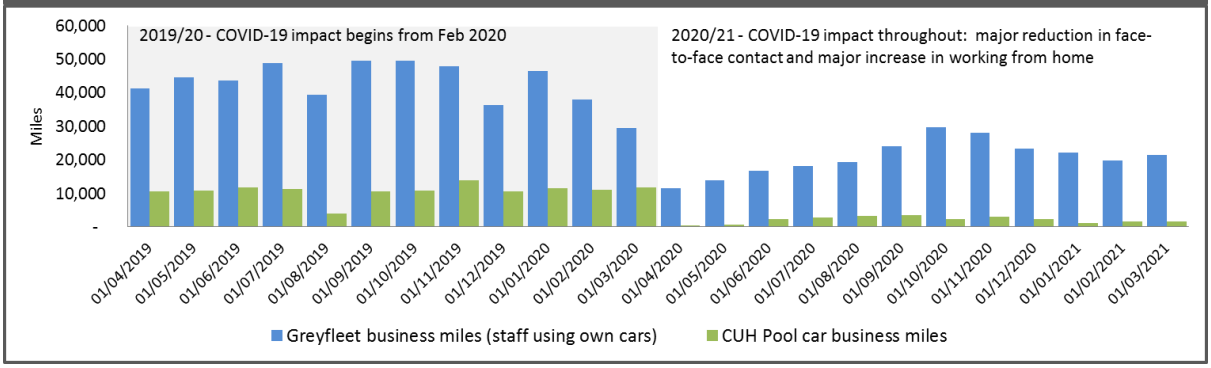
For CUH the two main changes have been: i.) the rise of telemedicine to replace some outpatient face-to-face contacts (re. Figure 1), and; ii.) the

shift to working from home where possible coupled with a step-change in the use of virtual on-line meetings.

The impact in terms of travel to site and business miles consumed has been exceptional. The annual traffic count survey for the whole of the Biomedical Campus shows a reduction of over 7,000 weekday inbound journeys – a 25% reduction across all modes (re. Figure 8). The significant increases in cars and cycling were to be expected as a direct consequence of social distancing and a relaxation of the constraints to staff parking on-site (the number of cycles parked on-site fell by up to 50% of the norm). The proportion of cyclists and bus passengers has been rising in step with the de-escalation of lockdown measures. A key question moving forward is whether the total number of inbound trips will rebalance as a consequence of permanent shifts towards tele-medicine and working from home.

Where the rebalancing point settles for the consumption of business miles is a similarly important question in relation to the impact on the Trust's net-zero trajectory and review of air quality objectives (re. Figure 9). An important aspect in managing this rebalance will be how far business travel policy can be restructured in favour of pool car (and electric bicycle) usage (lower emission vehicle and at a lower cost to the Trust) and public transport.

Figure 9: COVID-19 impact on CUH business miles by car



The Trust has worked, and continues to work, closely with City Council, County Council and greater Cambridge Partnership (GCP) colleagues, together with the local bus companies, in the provision of safe and socially-distanced active travel modes.

Throughout the year, the Campus Cycle Hub has remained open and we are very grateful to the team for looking after the Trust cyclists' repair and servicing needs alongside offering free cycle hire to all staff during the height of the pandemic.

On-site, an additional 34 cycle parking spaces have been provided as part of the relocation of the Infusion Unit.

2020/21 also saw the Mobike cycle-share scheme withdraw from Cambridge to be replaced by the CPCA-sponsored Voi electric bicycle and scooter share scheme which now provides important additional sustainable travel options for all staff, patients and visitors making short journeys to and from site.

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.

Of all the areas or environmental sustainability development work, the raising and mobilising of staff awareness and behaviour change has been the most impacted by the COVID-19 crisis. For most of the year it has been necessary to pare back this type of engagement work almost entirely.

However, from a more positive perspective, de-escalation and the national Greener NHS and net zero campaign is now driving renewed interest from several quarters. Clinical champions are coming forward with increasing commitment and hunger for change in policy, procedures and behaviour. This is being captured internally to bring forward new projects in support of national net-zero objectives and the re-shaping and relaunch of CUH's Think Green Impact programme for small teams.

It is also being linked to wider work that the Trust is both driving and supporting with the NHS Regional Sustainability Network for the East of England and the University of Cambridge's very progressive ThinkLab team. This project is urgently assessing what the essential drivers for the

drafting of the new NHS organisational Green Plans need to be – both for Trusts and the region as a whole.

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 (Cambridge holds the record in the UK for the hottest outside air temperature on record at 38.7ºC (101.7ºF) on 26.07.19).

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 has had some success in trialling the deployment of a new solar rejection film for 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). When packaged up with the all-important local behavioural and management responses, these interventions begin 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. Some viable interventions from this have now been implemented to reduce the risk of flooding in the future.

Looking forward: *there is a journey we must go on and no more delay*

When Addenbrooke's first opened its doors in 1766, the effect of the environment on our health was largely local and well appreciated. Improving the quality of our local environment improved our health. 255 years on and the quality of our environment is now very much both a local and a global issue. We are still working on local improvements but in much more advanced ways: using energy, technology, and the products and medicines from supply chains that span the world to provide exceptional healthcare and run a major hospital (now CUH, with additional regional and national responsibilities) in ways that would have astonished Addenbrooke's first doctors, nurses and patients.

The reach and volume of what CUH (and society as a whole) consumes and how it is consumed has dramatically grown and diversified in all aspects of what we do. Over the past 50 years the accumulated carbon emissions, pollution and over-exploitation of resources have pushed the quality of the global environment to the point where it is now set to change dramatically and severely threaten our health through the impacts of climate change and ecological breakdown.

The steps CUH does or does not take locally to resolve these global environmental issues over the next ten years will directly contribute to defining the future quality of public healthcare. It can either go on to be dominated by heatwaves, droughts, storms, flooding, new diseases and failing supply chains, or it can rapidly decarbonise and take a leading role through the transition to genuinely sustainable consumption in a net-zero circular economy.

2020/21 will be most strongly remembered as Year 1 of the COVID-19 crisis. But, even more importantly, it should also be remembered as Year 1-of-10 in the countdown to resolving the 'climate emergency' through halving carbon emissions by 2030. An objective that has been laid out with clarity by the NHS in its *Delivering Net Zero* plan.

For the wheel to turn, the Trust's new Green Plan 2021-2030 will first need to lay out how this will be achieved. A Board workshop in December started from the premise that the organisation knows 'why' it needs to respond, 'when' it needs to respond by, and to a large degree, 'what' it needs to do. The all-important 'how', though, is more challenging and even more so when faced with pre-existing priorities. It was recognised that some important progress has been made in upgrading physical infrastructure and some steps taken in adapting policies and developing more sustainable behaviours but that much more needs to be achieved and achieved quickly. As an anchor institution, CUH has an important part to play as a role model and as a driving influence to progress net-zero models of care and patient pathways. Discussion revolved around how the following three core

principles might find expression within the new Green Plan and go on to shape the Trust's trajectory towards a sustainable net-zero future:

Applying life-cycle assessments: assessing 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 with a priority focus on carbon emissions.

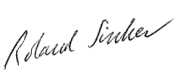
Connecting budgets: linking today's spending on goods, equipment and capital projects with tomorrow's operational revenue budgets. This allows for savings or additional spends in the future (operating, maintenance and remedial costs) to be accounted for in present day decision-making (invest-to-save).

Devolving 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.

Trying to overlay a net-zero carbon reduction agenda across the Trust's immediate and ongoing priorities of patient wellbeing, patient flow, treatment capacity and budget management can seem overwhelming. If the COVID-19 crisis has proved anything, it is that CUH, and the NHS as a whole, has the energy, tenacity and commitment to overcome the apparently overwhelming.

3.29 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
28 June 2021

Cambridge University Hospitals NHS Foundation Trust

Accounts

Year Ended 31 March 2021

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 2021 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 accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, 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 2021 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 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

We were unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust at 31 March 2020 of £12.58m because we were unable to attend the year-end physical inventory counts that took place due to COVID-19 related travel restrictions. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary, or whether there was any consequential effect on operating expenses in relation to inventory expenditure for the year ended 31 March 2021.

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.

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.

As described in the 'Basis for qualified opinion' section of our report, we were unable to satisfy ourselves concerning the existence and condition of the £12.58 million of inventory held by the Trust at 31 March 2020. We have concluded that where the other information refers to the inventory balance or related balances, it may be materially misstated for the same reason.

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 2020/21 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 financial statements 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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

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

Report on 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 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

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 work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21; 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 under the Code of Audit Practice

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 2020/21; 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; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; 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.

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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Lucy Nutley, Key Audit Partner
For and on behalf of Mazars LLP

Tower Bridge House

St Katharine's Way

London

E1W 1DD

29 June 2021

Audit Completion Certificate issued to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 29 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 29 June 2021 that would have a material impact on the financial statements on which we gave our unqualified opinion.

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

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 2021.

We have nothing to report in this respect.

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, Key Audit Partner

For and on behalf of Mazars LLP

Tower Bridge House

St Katharine's Way

London

E1W 1DD

15 September 2021

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 2021 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

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2021

	Note	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Operating income from patient care activities	2	877,888	807,898
Other operating income	2	265,201	196,916
Total operating income from continuing operations		1,143,089	1,004,814
Operating expenses of continuing operations	3	(1,146,615)	(1,026,881)
Operating (deficit)		(3,526)	(22,067)
Finance costs			
Finance income	6	1	257
Finance expense	6	(6,750)	(13,718)
PDC dividend charge		(3,935)	-
Net finance costs		(10,684)	(13,461)
Other gains/(losses)	6	56	(1,342)
Share of (loss) of joint venture	9	-	(268)
(Deficit) from continuing operations		(14,154)	(37,138)
(Deficit) for the year		(14,154)	(37,138)
Other comprehensive income/(expenditure)			
Will not be reclassified to income and expenditure:			
Downwards revaluations charged to the revaluation reserve	8	(2,935)	(808)
Total comprehensive (expense) for the year		(17,089)	(37,946)
Allocation of (losses) for the year:			
(Deficit) for the year attributable to:			
Government		(14,154)	(37,138)
Total comprehensive (expense) for the year attributable to:			
Government		(17,089)	(37,946)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	7	24,976	28,189
Property, plant and equipment	8	393,998	344,237
Receivables	11	2,711	2,034
Total non-current assets		421,685	374,460
Current assets			
Inventories	10	10,964	12,580
Trade and other receivables	11	59,879	96,469
Cash and cash equivalents	12	177,294	18,385
Total current assets		248,137	127,434
Current liabilities			
Trade and other payables	13	(165,565)	(121,786)
Borrowings	14	(8,846)	(350,777)
Provisions	15	(12,428)	(270)
Other liabilities	13	(88,096)	(26,659)
Total current liabilities		(274,935)	(499,492)
Total assets less current liabilities		394,887	2,402
Non-current liabilities			
Borrowings	14	(94,805)	(102,911)
Provisions	15	(5,132)	(5,199)
Total non-current liabilities		(99,937)	(108,110)
Total assets employed		294,950	(105,708)
Taxpayers' equity			
Public dividend capital		557,374	139,627
Revaluation reserve		34,432	37,413
Income and expenditure reserve		(296,856)	(282,748)
Total taxpayers' and others' equity		294,950	(105,708)

These financial statements were approved by the Board and signed on 28 June 2021 on its behalf by:

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2021

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' and others' equity at 01 April 2020	(105,708)	139,627	37,413	(282,748)
(Deficit) for the year	(14,154)	-	-	(14,154)
Transfers between reserves	-	-	(46)	46
Downwards revaluations charged to the revaluation reserve	(2,935)	-	(2,935)	-
Public dividend capital received	417,747	417,747	-	
Taxpayers' equity at 31 March 2020	294,950	557,374	34,432	(296,856)

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 CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2021

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Cash flows from operating activities		
Operating (deficit) from continuing operations	(3,526)	(22,067)
Non-cash income and expense		
Depreciation and amortisation	22,836	21,788
Impairments	19,056	3,195
Income recognised in respect of capital donations (cash and non-cash)	(5,003)	-
(Increase)/decrease in receivables	36,730	(28,063)
(Increase)/decrease in inventories	1,616	(825)
(Decrease)/increase in trade and other payables	15,840	(20,568)
Increase in other liabilities	61,437	2,978
Increase/(decrease) in provisions	12,041	2,363
Other movements in operating cash flows	-	(268)
Net cash generated from / (used in) operations	161,027	(41,467)
Cash flows from investing activities		
Interest received	1	257
Purchase of intangible assets	(1,241)	(3,103)
Purchase of property, plant and equipment and investment property	(57,814)	(26,140)
Sales of property, plant and equipment and investment property	69	107
Receipt of cash donations to purchase capital assets	609	-
Net cash (used in) investing activities	(58,376)	(28,879)
Cash flows from financing activities		
Public dividend capital received	417,747	1,642
Movement in loans from the Department of Health and Social Care	(346,595)	67,189
Capital element of PFI, LIFT and other service concession payments	(1,664)	(1,817)
Interest on loans	(4,049)	(8,887)
Interest element of PFI, LIFT and other service concession obligations	(4,429)	(4,495)
PDC dividend paid	(4,752)	-
Net cash generated from financing activities	56,258	53,632
(Decrease)/increase in cash and cash equivalents	158,909	(16,714)
Cash and cash equivalents at 1 April	18,385	35,099
Cash and cash equivalents at 31 March	177,294	18,385

The Foundation Trust held £0.1k cash at bank and in hand at 31 March 2021 (year ended 31 March 2020, £0.4k) 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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the 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

These accounts have been prepared on a going concern basis.

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

1.3 Joint arrangements

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust includes within its financial statements its share of the assets, liabilities, income and expenses of the joint venture. Where the joint venture 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.

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

Usually revenue relating to patient care spells that are part-completed at the year-end would be accrued in the same manner as other revenue. However in 2020/21, due to pandemic and in line with national guidance, the Trust has operated under guaranteed income arrangements. Previous incomplete spells have been bought out by commissioners and partially complete spells have not been accrued in 2020/21.

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

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Grants and donations

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

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 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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Full actuarial (funding) valuation

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

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

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

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 valued at depreciated replacement cost on a modern equivalent asset (alternative site) basis. Non-specialised buildings are valued 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 2021, 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 carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

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.

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 0.95% in real terms (2019-20: negative 0.50%) 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 £347.9m (year ended 31 March 2020, £339.7m). 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 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
- charitable funds

- 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
- approved expenditure on COVID-19 capital assets
- assets under construction for nationally directed schemes, 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.

1.16 Value Added Tax

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

1.17 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.

1.18 Losses and special payments

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

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

1.19 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 2021. The £8.6m 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 2021. 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.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

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. In 2020-21, the Trust agreed that we no longer accrue and carry partially completed patient spells for clinical income. Therefore for patients occupying beds as at 31 March 2021, the estimated income from partially completed patient spells was £nil (year ended 31 march 2020 £5.4m).

The Trust has a financial liability for any annual leave earned by staff but not taken by 31 March 2021, 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 2021 is £8.2m (year ended 31 March 2020, £2.4m).

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.

1.20 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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the 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 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 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 2022 on 20 November 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 2023, 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 2021	Year ended 31 March 2020
Income from activities	**£000**	**£000**
Elective income	-	123,428
Non-elective income	-	174,354
First outpatient income	-	69,759
Follow up outpatient income	-	50,079
A&E income	-	22,456
Block contract / system envelope income	361,359	-
High cost drugs income from commissioners	141,323	98,938
Other NHS clinical income	334,485	226,862
Private patient income	7,802	10,645
Additional pension contribution central funding	22,853	21,341
Other clinical income	10,066	10,036
Total income from patient care activities	**877,888**	**807,898**

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.

Due to the Covid-19 pandemic, there was a change in funding arrangements for 2020/21, see note 1.4 for details.

2.2 Income from patient care (by source)

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	**£000**
Income from activities		
NHS England	418,806	400,263
Clinical commissioning groups	444,563	380,538
NHS Foundation Trusts	4	-
NHS Trusts	46	132
Local authorities	-	60
Department of Health and Social Care	2	176
NHS other (including Public Health England)	2,407	3,712
Non NHS: private patients	7,802	10,645
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	436	488
Injury cost recovery scheme	3,822	4,178
Non NHS: other	-	7,706
Total income from activities related to continuing operations	**877,888**	**807,898**

2.3 Other operating income

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Other operating income		
Research and development (IFRS 15)	29,360	48,637
Education and training (excluding notional apprenticeship levy income)	42,496	40,277
Education and training - notional income from apprenticeship fund	1,462	-
Non-patient care services to other bodies	36,836	49,715
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET)	-	33,012
Reimbursement and top up funding	119,017	-
Other (recognised in accordance with IFRS 15)	19,294	23,093
Donated equipment from DHSC for COVID response (nor	4,394	
Cash donations for the purchase of capital assets - received from other bodies	609	-
Other (recognised in accordance with standards other than IFRS 15)	-	259
Rental revenue from operating leases	1,958	1,923
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	9,775	-
Total other operating income related to continuing operations	265,201	196,916
Total operating income	1,143,089	1,004,814

Analysis of other operating income: Other

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Car parking income	27	1,295
Estates recharges (external)	7,923	6,737
Pharmacy sales	23	73
Staff accommodation rental	726	993
Staff contribution to employee benefit schemes	1	1
Clinical tests	-	293
Clinical excellence awards	2,246	5,239
Grossing up consortium arrangements	8,348	8,462
Total	**19,294**	**23,093**

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

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Income recognised this year	436	488
Cash payments received in-year (relating to invoices raised in current and previous years)	122	417
receivables (relating to invoices raised in current and prior years)	11	284
Amounts written off in-year (relating to invoices raised in current and previous years)	0	252

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

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	13,995	14,992

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

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Revenue from contracts entered into as at by the period end expected to be recognised:		
- within one year	52,569	20,010

3. Operating expenses (by type)

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	38	4,008
Staff and executive directors costs	606,895	552,864
Non-executive directors	183	151
Supplies and services – clinical (excluding drugs costs)	176,782	157,269
Supplies and services - general	20,494	23,901
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	147,570	130,997
Consultancy	194	-
Establishment	13,529	11,902
Premises - business rates collected by local authorities	4,434	4,248
Premises - other	70,368	60,219
Transport (business travel only)	490	696
Transport - other (including patient travel)	1,825	1,744
Depreciation	18,470	17,552
Amortisation	4,366	4,236
Impairments net of (reversals)	19,056	3,195
Increase in impairment of receivables	348	2,699
Change in provisions discount rate	109	184
Audit services - statutory audit (net of VAT)	59	60
Other auditor remuneration (payable to external auditor only) for audit-related assurance services (net of VAT)	-	5
Internal audit	98	111
Clinical negligence - amounts payable to NHS Resolution (premium)	21,118	17,965
Legal fees	312	629
Insurance	392	288
Research and development	7	4
Education and training	1,780	3,040
Operating lease expenditure	7,955	10,328
Early retirements	102	308
Redundancy costs	-	4
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	739	1,378
Car parking and security	6,066	1,808
Hospitality	187	614
Other losses and special payments - staff costs	74	35
Other losses and special payments	88	202
Grossing up consortium arrangements	8,348	8,664
Grossing up apprenticeship Levy	1,462	-
Other operating expenses	12,677	5,573
Total operating expenses of continuing operations	1,146,615	1,026,881

In prior year comparative, there were reclassification of staff uniforms and disposable gowns costs of £0.647m from 'other operating expenditure' to 'supplies and services-Clinical (excluding drug costs)'.

4. Staff

4.1 Employee expenses

	Year ended 31 March 2021 Total £000	Year ended 31 March 2021 Permanent £000	Year ended 31 March 2021 Other £000
Salaries and wages	478,430	475,660	2,770
Social security costs	48,262	48,262	-
Apprenticeship levy	2,263	2,263	-
Pension cost - employer contributions to NHS pension scheme	52,408	52,408	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	22,853	22,853	
Temporary staff - agency/contract staff	2,980	-	2,980
Total gross staff costs	607,196	601,446	5,750
Staff and executive directors costs	606,821	601,071	5,750
Redundancy	199	199	-
Early retirements	102	102	-
Special payments	74	74	-
Total employee benefits	607,196	601,446	5,750

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.

However, during 2019/20 and 2020/21 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and expenditure has been uplifted to show these contributions to Trust 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 p	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

4.2 Average number of employees (WTE basis)

	Year ended 31 March 2021 Total Number	Year ended 31 March 2021 Permanent Number	Year ended 31 March 2021 Other Number
Medical and dental	1,526	614	912
Administration and estates	2,569	2,256	312
Healthcare assistants and other support staff	2,061	1,678	383
Nursing, midwifery and health visiting staff	3,600	3,186	414
Scientific, therapeutic and technical staff	864	765	99
Healthcare science staff	567	534	34
Other	-	-	-
Total average numbers	11,188	9,034	2,154

	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

4.2 Early retirements due to ill health

	Year ended 31 March 2021 Number	Year ended 31 March 2020 Number
Number of early retirements on the grounds of ill-health	5	4
	£000	**£000**
Value of early retirements on the grounds of ill-health	102	308

4.3 Reporting of other compensation schemes - exit packages

Compulsory redundancies	Year ended 31 March 2021 Number	Year ended 31 March 2021 £000
Exit package cost band (including any special payment element)		
£10,001 - £25,000	2	39
£150,001 - £200,000	1	160
Total	3	199

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

Other departures agreed	Year ended 31 March 2021 Number	Year ended 31 March 2021 £000
Exit package cost band (including any special payment element)		
<£10,000	8	74

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

Other (non-compulsory) departure payment	Year ended 31 March 2021 Number	Year ended 31 March 2021 £000
Contractual payments in lieu of notice	8	74

Other (non-compulsory) departure payment	Year ended 31 March 2020 Number	Year ended 31 March 2020 £000
Contractual payments in lieu of notice	2	35

5. Operating income and expenditure miscellaneous

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

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Minimum lease receipts	1,958	1,923

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

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
On land leases:		
- not later than one year;	1,027	956
- later than one year and not later than five years;	3,913	3,825
- later than five years.	13,584	14,228
	18,524	19,009
On buildings leases:		
- not later than one year;	931	966
- later than one year and not later than five years;	2,273	3,024
- later than five years.	2,984	3,392
Total buildings leases	6,188	7,382
Total leases	**24,712**	**26,391**

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

	Year ended 31 March 2021 Total £000	Year ended 31 March 2021 Buildings £000	Year ended 31 March 2021 Plant & machinery £000
Minimum lease payments	7,955	3,351	4,604

	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

5.4 Analysis of operating lease expenditure, future minimum payments

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
On buildings leases:		
- not later than one year;	3,353	3,279
- later than one year and not later than five years;	10,617	11,566
- later than five years.	20,102	22,196
Total buildings leases	34,072	37,041
On plant and machinery leases:		
- not later than one year;	3,753	4,595
- later than one year and not later than five years;	2,940	4,846
- later than five years.	21	11
Total plant and machinery leases	6,714	9,452
Total leases	40,786	46,493

5.5 Limitation on auditor's liability

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Limitation on auditor's liability	nil	nil

5.6 Other audit remuneration

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Other auditor remuneration paid to the external auditor is analysed as follows:		
Audit-related assurance services - Quality report (net of VAT)	0	9

6. Finance income and expense

6.1 Finance revenue

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Interest on bank accounts	1	257

6.2 Finance expenditure

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Interest on loans from the Department of Health and Social Care		
Capital loans	2,271	2,702
Revenue support / working capital loans	-	6,427
Finance costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	2,388	2,484
Contingent finance costs	2,041	2,011
Total interest expense	6,700	13,624
Unwinding of discount on provisions	50	94
Total finance expenditure	6,750	13,718

6.3 Gains/(losses) on disposal of assets

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Gains on disposal of other property, plant and equipment	69	107
Losses on disposal of other property, plant and equipment	(13)	(1,449)
Total	56	(1,342)

6.4 Impairments of assets

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Changes in market price	19,057	3,195
Total impairments charged to operating deficit	19,057	3,195
Revaluations charged to the revaluation reserve	2,934	808
Total impairments	21,991	4,003

7. Intangible assets

7.1 Intangible assets for the year ended 31 March 2021

	Software £000
Gross cost at 1 April 2020	47,425
Additions - purchased	1,153
Disposals	(140)
Gross cost at 31 March 2021	48,438
Amortisation at 1 April 2020	19,236
Provided during the year	4,366
Disposals	(140)
Amortisation at 31 March 2021	23,462
NBV total at 31 March 2021	24,976

7.2 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

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 2021

	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 2020	422,649	40,264	204,276	60,007	3,618	88,780	15	17,770	7,919
Additions - purchased	85,232		17,510	1,833	45,203	19,980		549	157
Additions - assets purchased from cash donations/grants	609		441		168				
Additions - equipment donated from DHSC for COVID response (non-cash)	4,394					4,394			
Downwards revaluations charged to the revaluation reserve	(4,532)		(14)	(4,518)					
Impairments charged to operating expenses	(27,226)		(27,226)	-					
Disposals	(6,391)					(3,484)	-	(2,086)	(821)
At 31 March 2021	474,735	40,264	194,987	57,322	48,989	109,670	15	16,233	7,255
Depreciation									
At 1 April 2020	78,412	-	7,907	-	-	50,067	15	13,337	7,086
Provided during the year	18,470	-	9,961	1,598	-	5,697	-	987	227
Downwards revaluations charged to the revaluation reserve	(1,598)	-		(1,598)					
Impairments charged to operating expenses	(8,169)	-	(8,169)		-	-	-	-	-
Disposals	(6,378)	-				(3,471)	-	(2,086)	(821)
At 31 March 2021	80,737	-	9,699	-	-	52,293	15	12,238	6,492
Net book value									
Owned	318,695	40,264	172,393		48,709	52,587	-	3,995	747
On-SoFP PFI contracts	57,322			57,322					
Government granted	24	-	-	-	-	24	-	-	-
Donated	17,957	-	12,895	-	280	4,766	-	-	16
At 31 March 2021	393,998	40,264	185,288	57,322	48,989	57,377	-	3,995	763

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.

	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
Additions - assets purchased from cash donations/grants	-	-	-	-	-	-	-	-	-
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
Revaluations	-								
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 ex	(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

9. Investments

9.1 Investments in joint ventures and associates (equity accounting)

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £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 2021

Carrying value	**Total £000**	**Drugs £000**	**Consumables £000**	**Energy £000**
At 1 April 2020	12,580	3,673	8,724	183
Additions	221,995	147,146	74,763	86
Additions (donated) - from DHSC	9,775		9,775	
Inventories consumed (recognised in expenses)	(233,386)	(147,570)	(85,779)	(37)
At 31 March 2021	10,964	3,249	7,483	232

10.2 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

11. Trade receivables

11.1 Trade receivables and other receivables

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Current		
Contract receivables (IFRS 15): invoiced	28,581	31,608
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	32,681	65,002
Allowance for impaired contract receivables / assets	(10,910)	(10,562)
Prepayments (non-PFI)	7,990	7,927
PDC dividend receivable	817	-
VAT receivable	382	2,177
Clinician pension tax provision reimbursement funding from NHSE	93	70
Other receivables	245	247
Total current receivables	59,879	96,469
Non-current		
Clinician pension tax provision reimbursement funding from NHSE	2,711	2,034
Total receivables	62,590	98,503

11.2 Allowances for credit losses (doubtful debts)

	Contract receivables and contract assets Year ended 31 March 2021 £000
At 1 April	10,562
New allowances arising	4,543
Reversals of allowances (where receivable is collected in-year)	(3,403)
Utilisation of allowances (where receivable is written off)	-
Changes arising following modification of contractual cash flows	(792)
At 31 March	10,910

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 2021 £000	Year ended 31 March 2020 £000
At 1 April	18,385	35,099
Net change in year	158,909	(16,714)
At 31 March	177,294	18,385

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 2021 £000	Year ended 31 March 2020 £000
Cash at commercial banks and in hand	1,404	2,250
Cash with the Government Banking Service	175,890	16,135
Total cash and cash equivalents as in SoFP	177,294	18,385

13. Trade Payables

13.1 Trade and other payables

Current	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Trade payables	10,431	21,114
Capital payables (including capital accruals)	32,351	4,412
Accruals (revenue costs only)	100,465	76,869
Social security costs	13,894	11,793
Other payables	8,424	7,598
Total current trade and other payables	165,565	121,786

13.2 Other liabilities

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Deferred income: contract liability (IFRS 15)	46,915	20,010
Deferred income: other (non-IFRS 15)	8,614	6,383
Deferred grants	32,567	266
Total other liabilities	88,096	26,659

14. Borrowings

Current	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Normal Course of Business Capital loans from the Department of Health and Social Care	7,138	7,216
Interim Capital loans from the Department of Health and Social Care	-	43,752
Revenue support / working capital loans from the Department of Health and Social Care	-	298,145
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,708	1,664
Total current borrowings	8,846	350,777
Non-current		
Normal Course of Business Capital loans from the Department of Health and Social Care	52,745	59,143
Obligations under PFI, LIFT or other service concession contracts	42,060	43,768
Total non-current borrowings	94,805	102,911
Total borrowings	103,651	453,688

Working capital loans and emergency capital loans have been refinanced in 2020/21 and replaced with Public Dividend Capital. This applied 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 reduced 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" remains.

14.1 Reconciliation of liabilities arising from financing activities

	DHSC loans 31 March 2021 £000	PFI, LIFT and other service concession obligations 31 March 2021 £000	DHSC loans 31 March 2020 £000	PFI, LIFT and other service concession obligations 31 March 2020 £000
Carrying value at 1 April 2020	408,256	45,432	340,825	47,249
Cash movements:				
Financing cash flows - principal	(346,595)	(1,664)	67,189	(1,817)
Financing cash flows - interest (for liabilities measured at amortised cost)	(4,048)	(2,388)	(8,887)	(2,484)
Non-cash movements:				
Interest charge arising in year (application of effective interest rate)	2,271	2,388	9,129	2,484
Carrying value at 31 March 2021	59,883	43,768	408,256	45,432

15. Provisions

15.1 Provisions for liabilities and charges

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Current		
Pensions relating to other staff	52	55
Pensions Injury benefits	138	135
Clinician pension tax reimbursement	93	70
Legal claims	64	10
Other	12,081	-
Total current	12,428	270
Non-current		
Pensions relating to other staff	428	459
Pensions Injury benefits	1,993	1,942
Clinician pension tax reimbursement	2,711	2,034
Legal claims	-	64
Other	-	700
Total non-current	5,132	5,199
Total provisions	17,560	5,469

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.

'Other' provisions are made up of amounts recognised as subject to clawback by the funder as conditions of funding have not been met as at 31 March 2021.

15.2 Provisions for liabilities and charges analysis

	Total £000	Pensions - Early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax reimbursement £000	Other £000
At 1 April 2020	5,469	514	2,077	74	2,104	700
Change in the discount rate	109	12	97			-
Arising during the year	12,121		13	27	700	11,381
Utilised during the year - cash	(152)	(43)	(109)		-	-
Reversed unused	(37)			(37)	-	-
Unwinding of discount	50	(3)	53		-	-
At 31 March 2021	17,560	480	2,131	64	2,804	12,081
Expected timing of cash flows:						
In one year or less	12,428	52	138	64	93	12,081
In more than one year but not more than two years	2,826	32	83		2,711	
In more than two years but not more than five years	469	129	340	-	-	
In more than five years	1,837	267	1,570	-	-	
Total	17,560	480	2,131	64	2,804	12,081

15.3 Clinical negligence liabilities

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Amount included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Cambridge University Hospitals NHS Foundation Trust	347,874	339,664

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.

The Department of Health and Social Care is regarded as a related party. During the year Cambridge University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department including NHSE, Health Education England and NHS Resolution.

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 2021 Revenue £000	Year ended 31 March 2021 Expenditure £000
Department of Health and Social Care	39,049	107
Other DHSC group bodies	1,068,752	30,247
Other Government bodies	2,893	131,252
University of Cambridge	9,797	12,190
	1,120,491	173,796

	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

16.2 Related party balances

	Year ended 31 March 2021 Receivables £000	Year ended 31 March 2021 Payables £000
Department of Health and Social Care	467	1,490
Other DHSC group bodies	120,112	105,171
Other Government bodies	12,340	21,545
University of Cambridge	4,258	2,243
	137,177	130,449

	Year ended 31 March 2020 Receivables £000	Year ended 31 March 2020 Payables £000
Department of Health and Social Care	1,490	125
Other NHS bodies	70,230	21,346
Other Government bodies	13,379	19,427
University of Cambridge	4,617	11,161
	89,716	52,059

17. Contractual capital commitments

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Property, plant and equipment	6,132	5,389
Total contractual capital commitments	6,132	5,389

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 2021 £000	Year ended 31 March 2020 £000
Gross PFI liabilities of which liabilities are due		
In one year or less	6,177	6,093
In more than one year but not more than two years	6,418	6,177
In more than two years but not more than five years	20,161	19,564
In more than five years	91,827	98,842
Gross Liabilities	124,583	130,676
Finance charges allocated to future periods	(80,815)	(85,244)
Net Liabilities	43,768	45,432
Net PFI obligation of which liabilities are due		
In one year or less	1,708	1,664
In more than one year but not more than two years	1,852	1,708
In more than two years but not more than five years	6,096	5,734
In more than five years	34,112	36,326
Total	43,768	45,432

18.2 Total On-SoFP PFI commitments

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Total future payments committed in respect of PFI arrangements		
In one year or less	10,508	10,252
In more than one year but not more than two years	10,771	10,508
In more than two years but not more than five years	33,955	33,127
In more than five years	146,498	158,097
Total	201,732	211,984

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 2021 £000	Year ended 31 March 2020 £000
Unitary payment payable to PFI operator consisting of:		
- Interest charge	2,388	2,484
- Repayment of finance lease liability	1,664	1,817
- Service element	739	1,378
- Capital lifecycle maintenance	1,828	1,420
- Contingent rent	2,041	2,011
Total amount paid to service concession operator	8,660	9,110

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 2021	Year ended 31 March 2020
	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	46,610	71,536
Receivables (excluding non financial assets) - with other bodies	3,987	14,759
Cash and cash equivalents	177,294	18,385
Total	227,891	104,680

19.2 Carrying value and fair value of financial liabilities

	Year ended 31 March 2021 Financial liabilities at amortised cost £000	Year ended 31 March 2020 Financial liabilities at amortised cost £000
Financial liabilities per the SoFP		
DHSC loans	59,883	408,256
Obligations under PFI, LIFT and other service concession contracts	43,768	45,432
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	13,201	15,418
Trade and other payables (excluding non financial liabilities) - with other bodies	130,951	87,679
IAS 37 provisions which are financial liabilities	17,560	5,469
Total	265,363	562,254

19.3 Maturity of financial liabilities

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000 Restated
In one year or less	171,226	462,878
In more than one year but not more than five years	60,782	55,587
In more than five years	124,467	132,854
Total	356,475	651,319

Prior year comparatives were restated to reflect the changes in the maturity analysis to be based on undiscounted future contractual cash flow (gross liabilities including finance charges) as required by IFRS 7, whereas in the past it was on book values.

Losses and special payments (approved cases only)

	Year ended 31 March 2021 Total number of cases Number	Year ended 31 March 2021 Total value of cases £000's	Year ended 31 March 2020 Total number of cases Number	Year ended 31 March 2020 Total value of cases £000's
Losses of cash due to				
theft, fraud etc	4	-	-	-
Other causes	11	4	26	2
Bad debts and claims abandoned in relation to				
Overseas visitors	-	-	5	252
Total losses	15	4	31	254
Special Payments, Ex gratia payments in respect of				
Compensation under court order or legally binding arbitration award	-	-	1	1
Loss of personal effects	36	21	45	14
Personal injury with advice	7	74	5	57
Other	1	1	1	2
Special severance payments	-	-	2	35
Total special payments	44	96	54	109
Total losses and special payments	59	100	85	363

Cambridge University Hospitals NHS Foundation Trust

Cambridge Biomedical Campus Hills Road
Cambridge
CB2 0QQ
United Kingdom

+44 (0) 1223 245151
www.cuh.nhs.uk