NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust

Annual Report and Accounts 2020-21

Pride in our care

A member of Cambridge University Health Partners

Cambridgeshire and Peterborough NHS Foundation Trust

Annual Report and Accounts 2020-21

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

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Contents

About this Report

Cambridgeshire and Peterborough NHS Foundation Trust's Annual Report 2020-21 and Annual Accounts have been prepared under a direction issued by NHS Improvement (NHSI) under the National Health Service Act 2006.

The report is divided into the following sections:

Introduction
Performance Report
Accountability Report
Auditors' Report and Certificate
Finance Report

The report is based on guidance issued by the Independent Regulator of NHS Foundation Trust's and was approved by the Board of Directors on the 25th June 2021. The Board of Directors considers the Annual Report and Accounts taken as a whole, to be fair, balanced, understandable and provides the information necessary for patients, regulators and other stakeholders to assess Cambridgeshire and Peterborough NHS Foundation Trust's performance, business model and strategy.

Tracy Dowling
Chief Executive

25th June 2021

Statement from the Trust Chair

Julie Spence Trust Chair

Being able to adapt and innovate has been the hallmark of our Trust for many years, and never have those traits been more at the forefront of our work than they have been over the last 12 months.

Coronavirus has dominated all of our lives and has had a huge impact on the way we operate. But while the challenges have been many and varied, thanks to the dedication of our teams and the understanding of our patients, service-users and carers, it has never beaten us.

While dealing with a pandemic may not have been high on anyone's agenda going into 2020, reacting to an emergency is what staff at our Trust, and those across the NHS – together with the frontline services across the public sector including my former colleagues at the police – trained for.

Day-in, day-out, they have run towards the fire, and while they might baulk at the word "heroes", they have certainly done everything they can to keep people safe. Our services have remained open with hundreds of staff being redeployed at the height of the response.

On our wards our staff had to quickly adapt to wearing PPE and scrubs which for our mental health teams and other departments such as those who work in our pharmacy service, for whom uniforms have not been commonplace for many decades was a radical change.

To provide scrubs to a significant number of our staff took an incredible effort and none of it would have been possible without our army of volunteers who delivered them to teams across our Trust.

Like all of us, our staff had many questions and concerns about how to keep their patients and themselves safe, and I must thank our Infection Prevention and Control Team for their expert advice throughout the last year.

At the height of the pandemic, we repurposed specialist wards to treat people for physical or mental health conditions who also had Covid. Again, our staff reacted rapidly to this ever-changing picture and with the upmost professionalism.

Our Community Teams - in physical or mental health - continued to visit people in their own homes to treat those who needed their support. Their vital work was brought into even sharper focus over the last year because they were often the only people those living alone or shielding at home may have seen. Not only were they performing their specialist clinical duties, they were often there to provide a listening ear and a reassuring presence during an uncertain time.

For those patients or service-users we could not see in person due to social distancing guidelines, we turned to technology.

The use of video technology for services as diverse as mental health counselling, physical health nursing for people with conditions such as respiratory problems and diabetes, and art therapy, came several years sooner than anyone could have anticipated. But staff and most importantly, service-users, embraced it and CPFT led the way, with many more appointments per day being carried out.

Our frontline colleagues are supported by hundreds of staff from HR to finance, estates

to administration. To reduce footfall and rates of transmission, many of them began working from home and they too turned to the online services put in place by our Business Technology Team to carry out their daily tasks. In March this year alone, 32,000 meetings took place on Microsoft Teams across our Trust.

Likewise, the Board and Council of Governors moved to shorter more focussed virtual meetings and even conducted successful virtual visits to teams across the Trust to check how they were managing - everyone's flexibility and adaptability was impressive allowing us to carry out our statutory responsibilities while keeping patients and staff safe. Of course, none of the incredible work of the past year has been easy. It has led to already under-pressured staff being placed under even more strain.

Caring for those who are in caring roles has been paramount and that work has been led by our Staff Wellbeing Service and our staff have also been able to turn to our Psychological Wellbeing Service, our Wellbeing Hub, and the Staff Mental Health Service.

We have also opened up those services to colleagues working for our health partners, with our specialist staff volunteering to provide mental health support and counselling.

Giving colleagues somewhere to turn to and someone to talk to has been vital. Many staff across our Trust were deeply saddened by the death of Jenny Esson, Training and Development Co-Ordinator with our Recovery College. Jenny, who had underlying health conditions, was working from home when she was taken ill. She had tested positive for coronavirus. As well as Jenny, many staff lost friends and family to Covid, while due to lockdown many others simply lost contact with those they held dear.

The vaccination programme has offered us all hope out of the pandemic and our Windsor Research Team – together with staff who took part in trials – were at the forefront of developing the Oxford AstraZeneca vaccine.

Once the vaccines were approved, giving them to those in the community and to NHS staff became a team effort involving all local health providers. Again, CPFT colleagues played a full part, from joining the vaccination hubs at our local hospitals to vaccinating house-bound patients in their homes.

Throughout the last year, the support from the general public has been incredible and the donations to our Head-to-Toe Charity received from individuals, groups and NHS Charities Together were gratefully received and will continue to be used to benefit our staff, our service-users and our carers.

The work of our teams continued to be recognised on a wider level as well. In March, our Springbank Ward, at our Fulbourn Hospital site in Cambridge, who operate the ground-breaking facility for women with borderline personality disorder, won the Patient Safety Award at the Health Service Journal Awards for their continued work to abolish restrictive practices. Our Freedom to Speak Up Team was also a finalist at the same award ceremony.

Meanwhile, our Community Respiratory Team has been shortlisted in the Respiratory Care Initiative of the Year category in the Health Service Journal Value Awards, while our First Response Service has been named as a finalist in the Laing Buisson Awards in the Outstanding Response to Covid in Healthcare category.

While at the time of writing, the signs are heading in the right direction, the pandemic is far from over, and there will undoubtedly be more changes and challenges to come.

While the introduction of technology has been rapid and welcome, we will seek a balance between using online appointments and seeing service-users face-to-face. The same will go for staff working from home. While some have liked it, others have found it isolating. Work can and should be a "safe-place" and we will look to offer our teams a greater mix in the future.

While everyone at our Trust should be proud of their work over the last year, there will be – and should be – lessons to be learned from

our response and it is vital that teams reflect on the previous 12 months and use their experience to shape how our services will continue to provide support.

Overall, we will face the future with the continued knowledge that all of our teams will continue to use those hallmarks of adaptation and innovation to meet the needs of the people who require our care.

The Trust Chair's Statement has been signed by the Trust Chair:

Julie Spence
Trust Chair

25th June 2021

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Section 1: Performance Report

This section provides information on Cambridgeshire and Peterborough NHS Foundation Trust, its main objectives and strategies, and the principal risks that it faces. It covers the requirements of a Strategic Report as set out in the *Companies Act 2006* and NHS Improvement guidance.

It includes:

Overview
Overview of Going Concern

Overview

Tracy Dowling Chief Executive

Statement from the Chief Executive

This is my fourth performance report since becoming Chief Executive Officer, however 2020-21 has been a year like no other.

I would like to extend my sincere thanks to all our staff who have shown incredible bravery, professionalism and dedication over this last year as we responded to the Covid-19 pandemic and continued to deliver as many of our services as possible, as well as delivering additional services to ensure a full system wide response to the pandemic and the delivery of the vaccination programme.
I would also like to thank the families of our staff for the support they provided as we all adapted to working from home; providing homeschooling and coping with the impact the pandemic had on our personal and our professional lives.

I would like to offer my condolences to the families of all those in our care who sadly lost their lives to Covid over the last year. I would also like to offer again my condolences to the family of Jenny Esson, Recovery College Training and Development Co-ordinator who passed away due to Covid-19 in April 2020. She is still greatly missed.

Over this year we have continued to focus on our four strategic goals, but with the need to respond to the pandemic at the forefront of how we have continued to provide care safely; prioritised to those with greatest need and delivered in ways that adapt as we have experienced the different phases of the pandemic and learned more about the virus and its impacts on both our physical and our mental health. The health inequalities that exist across our communities have been exposed by this pandemic and we commit to addressing these, both in terms of access, experience and outcomes from our services; and internally focusing on our commitment to make CPFT an equal, diverse and inclusive place where all of our staff can thrive.

Our strategic goals of delivering the best care; being a leading innovator and research Trust; delivering best value and being a great place to work have been a strong guide this year.

Our PRIDE values have been central to our Covid response and we have continued to seek to be a fair and supportive place to work. We have continued to engage and co-produce with patients and carers, and we have embraced the opportunities that technology has offered to us over this last year. Many of the new ways of working will remain long after the pandemic because we have found many of them to be effective and more efficient. However, we have also continued to deliver face to face care where necessary and where the benefits outweigh the risks throughout the pandemic, and we look forward to increasing this as the vaccination programme progresses and it becomes safer to deliver more of our activity in traditional ways too.

Delivering the best care

We rapidly implemented a Gold, Silver, Bronze command and control system to manage the pandemic. This continues to be a major incident and we continue to respond accordingly.

We have enhanced and improved our Infection Prevention and Control (IPC) over the last year and have managed each Covid outbreak to conclusion with expert support from our internal IPC team and with support from our colleagues in the CCG. We have also achieved over 90% vaccination rates among our staff and continue to ensure our patients are prioritised for vaccination.

We have seen some waiting times increase during the pandemic as we redeployed staff to focus on discharge from hospital; on delivering

vaccination and on treating those who were urgent and high priority. There are also some services where the risks of virus transmission were so high that we have had to delay face to face assessment and therefore treatment and wait times have extended. We are again, as we did between the two waves of pandemic peaks, beginning to address these backlogs and we plan to recover all services over 2021-22.

We have worked in really close partnership with colleagues in the local authorities and in the acute sector to deliver rapid discharge from hospital during the pandemic. This work has built our partnerships and we will build on this in 2021 with some dedicated transformation work to develop sustainable approaches to ensure that no one stays in hospital longer than they need to, and that wherever possible, people are discharged back to their homes.

Leading innovator in healthcare and Research

In the summer of 2020, our Windsor Research Unit led the local research trial of the Astra Zeneca Covid-19 vaccine through a partnership with System colleagues at Cambridge University Hospitals and Royal Papworth Hospital. We have also actively engaged with NHS Check and many other research studies seeking to learn from the pandemic. We have undertaken research in CAMHS comparing face to face and virtual consultations; and throughout 2020-21 we have sought to adopt innovation and to use technology such as the Attend Anywhere platform for virtual consultations and MS Teams for MDTs and team meetings.

I would like to thank our IT support services for incredible work over this last year. Without them and their 'can-do' approach we would have seen far greater service disruption and much more challenge adapting to safe working practices.

We continue to innovate and to learn, and we have developed strong partnerships for innovation with Cambridge University Health Partners, the Eastern Academic Health Science Network, and the NIHR Applied Research Collaboration (ARC) East of England which we host.

Through these partnerships we are discovering new learning and developing new ways of working to apply research in practice to improve care and outcomes. We are especially focused on doing this to address health inequalities. An example of this is our Exemplar community mental health project which we have focused in Peterborough because of the significant health inequalities that exist in this area. We are formally evaluating this through the ARC to understand how, through working with the community, we can improve the population's mental health. We hope to apply this population health informed model to our other 'places' across the County as we roll out community mental health investment over future years.

Demonstrating best value

In our response to the pandemic we have had clear processes in place through incident coordination to ensure an organisation wide system of command and control. This has also ensured that we have made efficient and effective use of the additional resource necessary to meet the challenges posed by the pandemic. This has included corporate services; and direct oversight by Non-Executive Directors at Trust Gold Command Meetings to ensure Board assurance in near real time.

Collaboration and partnership continue to be key to ensure we are providing the best and most cost-effective care. This has been instrumental throughout the pandemic and we have been a strong part of the Health and Care System, led through the CCG Health Gold coordination cell.

The financial systems have supported the pandemic response across the NHS, but now as we emerge from the latest wave, we are focussed on reassessing the effectiveness and the efficiency of how we use the resources we have to maximise the population health gain and address the underlying financial deficit which remains.

We continue to use data to inform our decisions and will increase the focus on using data regarding inequalities to shape how we invest in and develop services to ensure equality of access, experience and outcomes. The exemplar project is an example of this in Peterborough; developing crisis services for children's mental health is another example of where we have addressed inequalities in 2020. We are also focussed on older people's access to services and are increasing psychological wellbeing services for older people in 2021 to ensure we do not have discrimination on the basis of age. These are also examples of how we are meeting the Public Sector Equality Duty.

We continue to work with our partners on long term projects such as the Cambridge Children's Hospital, the urgent and emergency care collaborative and through the North and South Alliances to integrate care in local neighbourhoods. Joining up care in partnership with others working with the same people in their communities is vital for delivering true value.

Financial performance has been strong with delivery of the agreed control total; however, there is further work to do to address the underlying deficit position and our historic high reference costs. We have a programme of Continuous Service Improvement (CSI) to redesign and develop our service delivery models and our effective and efficient use of resources to support delivering best value.

Improve the experience of working at CPFT

During 2020-21 our staff have been incredible. This has been a hugely challenging year, yet we have had low rates of turnover, low vacancy rates and sickness rates have been surprisingly stable given the context of the pandemic.

Looking after our colleagues and listening and responding to their needs is vital. The Staff Survey 2020 showed many significant improvements and clearly evidenced reductions in bullying and harassment, and improvements in many areas of staff satisfaction. However, the survey also identified high levels of musculo-skeletal concerns among staff (thought to be linked to changes in ways of working as a result of the pandemic), and also indicated that we still have more to do to be a workplace where there is true and evidenced equality of opportunity and equal treatment for all.

We continue to exercise our duties to comply with the Public Sector Equality Duty and the Equality Delivery System 2. The CPFT Equality, Diversity and Inclusion Annual Report 2020-21 is included in this Annual Report and sets out the many ways we are continuing to make progress to be an equal, diverse, and inclusive organisation where everyone can thrive.

Throughout the pandemic we have supported the physical and mental health of our staff. The Staff Wellbeing Service has been a vital part of our pandemic response, frequently joining me on the weekly 'Talk To Tracy' broadcast to pass on their wellbeing advice and to promote the support they can provide for staff. We have also developed the Staff Mental Health Service for staff across the Health and Care System who have had a significant impact on their mental health because of the pandemic.

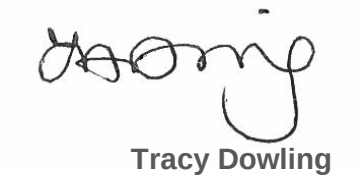
We recognise that collaboration across the System around workforce will be part of the future ways of working. Many of our staff have been redeployed to different areas during the pandemic and we thank them for showing such adaptability and for doing what was needed, in often very challenging circumstances.

Our staff continue to be our greatest asset and therefore whilst not underestimating the challenges facing the NHS over 2021-22, I remain confident of our ability to continue to provide really good care – in ways that fit with our values, and in ways which adapt and respond to peoples differing needs as the

pandemic progresses and we recover our service levels.

The Covid-19 pandemic has taken its toll on many staff, and whilst turnover rates have been low through 2020-21 we do anticipate that this may change in 2021 as the pandemic eases. We have adopted the Kings Fund ABC (Autonomy, Belonging and Contribution) Model to recovery from the pandemic. It is vital that staff have a chance to reflect, to recharge and then to develop themselves and their services as we emerge from the pandemic.

We remain committed to supporting the development and career progression of all our staff; we commit to becoming an anti-racist organisation and one that is truly equal, diverse and inclusive, and one where everyone is treated in a just and fair way. In these ways we will continue to be a great place to work, and to receive care and support.



Tracy Dowling
Chief Executive

25th June 2021

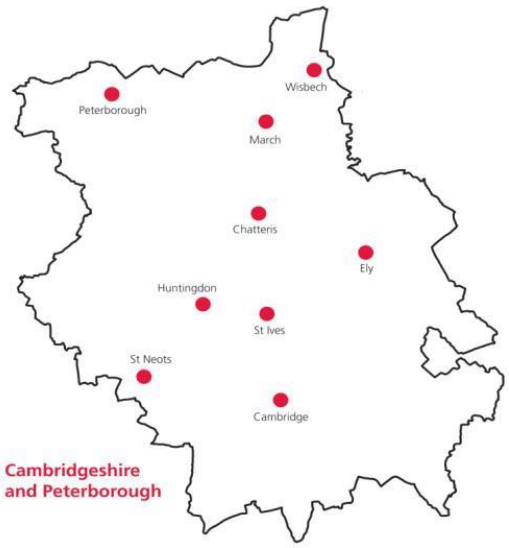
History and Purpose

Cambridgeshire and Peterborough NHS Foundation Trust was formed on 1st June 2008 under the Health and Social Care (Community Health and Standards) Act 2003, succeeding Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

We provide a wide range of mental health, physical health, specialist, learning disability and neuro-rehabilitation community and hospital services to a population of around 950,000 people in the east of England. CPFT is a health and social care organisation, providing:

- integrated older adult physical and mental health services,
- adult mental health and learning disability services (including specialist services such as low secure services and adult eating disorder in-patient services)
- children's mental health services (including specialist services such as child and adolescent in-patient services, and adolescent in-patient eating disorder services), across Cambridgeshire and Peterborough, and
- children's community physical health services in Peterborough.

Our staff operated from more than 50 locations across the County, with main hubs of activity in Cambridge, Huntingdon, Peterborough and Fenland.



CPFT is a designated Cambridge University Teaching Trust and a member of Cambridge University Health Partners; one of only eight Academic Health Science Centres in the UK.

Strategic Ambitions

Our Three-Year Strategy for 2018-2021 sets out our **Statement of Purpose:**
'CPFT strives to improve the health and wellbeing of the people we care for, our staff and members, to support and empower them to lead a fulfilling life.'

We have set ourselves four strategic goals to achieve this purpose, each delivered through a series of strategic objectives setting out what we need to do to work effectively with partners to improve the health and wellbeing of the people we care for, and how success will be measured. Our goals are to:

- Deliver the best care,
- Be a leading innovator in healthcare and research – nationally and internationally.
- Demonstrate best value, and
- Improve the experience of working in CPFT.

The full plan is available to view via this link to our website, with updates on progress submitted regularly to our Board of Directors.

A number of enabling strategies have been developed and are in place to support the delivery of the three-year strategy, around:

- - Workforce and organisational development
- - Information management, technology and
- estates
- - Clinical strategies
- - Research and development
- - Patient experience and involvement
- - Communications and engagement
- - Nursing and Allied Health Professionals.

Further details are available from the Trust Secretariat:

Cambridge and Peterborough NHS
Foundation Trust (CPFT)
Elizabeth House
Fulbourn Hospital
Fulbourn
Cambridge, CB21 5EF
corporateoffice@cpft.nhs.uk

Values and Behaviours

Professionalism – We will maintain the highest standards and develop ourselves
Respect – We will create positive relationships
Innovation – We are forward thinking, research-focused, and effective
Dignity – We will treat you as an individual
Empowerment– We will support you

Head to Toe Charity

As Cambridgeshire and Peterborough NHS Foundation Trust's dedicated Charity, Head to Toe exists to help staff provide the very best care and experience for patients. The Charity supports Trust staff to focus on improving services provided, with a mission to:

- Empower all members of our community to live fulfilling lives.
- Provide hope and support to those who need the specialist care of our NHS services.
- Raise awareness and understanding of physical and mental health conditions.

Head to Toe focuses on improving the wellbeing and resilience of our local communities, ensuring that people have the tools, resources, and support to live well, regardless of their physical or mental health diagnosis.

Over the last 12 months, Head to Toe has played a significant part in CPFT's response to the Covid-19 pandemic.

Thanks to the generosity of Head to Toe supporters and fundraisers, and funding received from NHS Charities Together and Cambridgeshire Community Foundation, the Charity has been able to support patients, service users and staff throughout 2020-21.

Head to Toe has delivered over 200 projects as part of its Covid-19 Emergency Wellbeing Funding Programme, focused on improving the wellbeing of our staff, service users and carers to lessen the impact of the pandemic on our mental and physical health. From providing personalised therapeutic boxes to support patients through isolation, to funding activities on in-patient wards and creating wellbeing 'wobble' rooms for staff to reflect and seek respite during these challenging times.

Working alongside colleagues from CPFT Networks, which support staff from Ethnic Minorites and those with a disability or long-term condition, Head to Toe successfully secured £50,000 worth of funding for communities who have been disproportionately affected by Covid-19. This funding has enabled us to develop a wide-reaching agenda of training, events and continuing professional development opportunities for under-represented staff.

The funding has also included facilitating a wide and inclusive programme of events for CPFT Black History Month celebrations, and the creation of a culturally diverse 'global food bank', to support our staff to access food and resources out of hours.

Head to Toe collaborates with a wide network of non-profit organisations and businesses

across the county, strengthening our wellbeing offer to the local community, and increasing joint fundraising opportunities. Collaborations this year have included working with the Samaritans, Dreamdrops Children's Charity, HomeStart Cambridgeshire and The Edge Social Enterprise Café.

The Charity continues to partner with Addenbrookes Charitable Trust (ACT) and the University of Cambridge, with the philanthropic campaign to raise £100 million for the ground-breaking new Cambridge Children's Hospital, planned for the Cambridge Biomedical Campus. Key milestones from the campaign this year include the development of the campaign brand and materials, and the campaign launch at a high-profile event in Spring 2021.

Head to Toe works alongside local event providers throughout the year, to offer a programme of local fundraising events for CPFT staff and supporters; these include the Cambridge Half Marathon, the London to Cambridge Bike Ride and the Fulbourn Park Run (recently launched on the Fulbourn Hospital Site).

The Charity continues to strive to find new and innovative ways for fundraisers to get involved and show support, with additional fundraising completed through virtual events throughout the year, including through the inaugural 'Head, Shoulders, Knees and Toes' multi-challenge event.

Looking forward to 2021/22 Head to Toe will continue to grow the Charity's profile across the region, working closely with CPFT's Voluntary Services, focusing on developing local networks, growing our database of regular donors, supporting a diverse range of wellbeing programmes and initiatives, and continuing to develop the fundraising campaign to support the new pioneering Children's Hospital.

Head to Toe will also continue to fundraise to support CPFT's response to Covid-19, with the next stage of the funding programme focusing on delivering respite and supporting recovery across the Trust. The Charity will continue to prioritise the wellbeing of staff and patients, encouraging better access to services (both physically and virtually) and will continue to address our regional health inequalities.

You can find out more about the Charity's work and how you can help by visiting: www.cpft.nhs.uk/ourcharity or by calling 01223 219708.

Head to Toe charity

Supporting NHS Cambridgeshire and Peterborough NHS Foundation Trust

Business and Overseas Development

The Trust continues to scan the market to provide the directorates and Executive Team with the necessary commercial opportunities in line with our Trust Strategy 2018-21:

- to demonstrate best value; and
- to enhance our ability to improve health outcomes through current and future business development opportunities.

We have a dedicated Business Development Team with the necessary systems in place enabling us to respond to commercial developments locally, regionally and internationally.

During 2020 we progressed the delivery of our first international business venture supporting the development of psychology services overseas, as part of a three-year contract.

Throughout the last year we continued to progress our work in support of New Care Models. We are one of six partner Provider organisations in the East of England Collaborative supporting this national programme of work which aims to enhance Tier 4 care delivery closer to home through devolved commissioning arrangements.

We continue to have an interest in potential European and international opportunities where we could offer research expertise, mentorship, training and service and strategy development.

Service: Key Risks and Issues

In line with our risk reporting cycle of business, the Board Assurance Framework (BAF) and Operational Risk Register (ORR) content is reviewed by the Trust Leadership Team each month, and subsequently by the Board and Board Sub-Committees at each meeting.

The BAF reflects the top organisational risks that have the greatest impact on the delivery of the Trust's strategic objectives and have a mitigated risk score of 15+.

The ORR reflects risks that threaten delivery of operational goals and risks with a mitigated risk score 12+ and that have been scrutinised and escalated from Directorate level.

Board Assurance Framework (BAF)

At time of writing, the top risks recorded on the BAF are:

Risk Ref: 4655 - Sustainable Discharge to Assess Model *(Risk Score: 16)*
1) Lack of clear commissioning for Discharge to Assess (D2A)/Intermediate Care Model. 2) Lack of clear governance structure for care support and provision. CPFT undertook to establish a D2A model as part of the Sustainability and Transformation Partnership (STP). Responsibility for funding of this scheme for 2018/19 and beyond was passed to the CCG. Private provision of care was transferred to the CCG from CPFT and CPFT continues to run co-ordination and professional input.

Risk Ref: 5553 - Vacating Ida Darwin Site *(Risk Score: 16)*
Not able to vacate Tier 4 Children's Wards by April 2023. There is no scope to extend the lease on the Ida Darwin site and an interim accommodation solution is needed for the Tier 4 wards. There is a risk to the Tier 4 service if this is not in place by March 2023. Potentially could lead to loss of service and loss of income. Possible legal challenge if we cannot vacate the site. Cost and reputational impact.

Risk Ref: 6197 - Recurring Efficiencies *(Risk Score: 16)*
There is a risk that the lack of a detailed and delivered plan for recurring efficiencies will result in the Trust being unable to operate effectively and 'live within its means'. As a result, more formal measures may be brought to bear on the Trust, thus limiting the freedom to focus resources and sustain services in a manner that the Trust Board may prefer.

Operational Risk Register (ORR)

The top risks recorded on the ORR at time of writing, are:

Risk Ref: 3177 – Unacceptable Psychology Waiting Lists *(Risk Score: 20).*

Risk Ref: 4291 – Tier 4 Financial Risk *(Risk Score: 16).*

Risk Ref: 4465 – Approved Mental Health Professionals *(Risk Score: 16)*

Risk Ref: 5693 – Child and Adolescent Mental Health Service Assessment and Treatment Waiting Time *(Risk Score: 16).*

Overview of Going Concern

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

Use of Resources Rating

The financial health of NHS Trusts is ordinarily measured using the Use of Resources Metric outlined in the NHS England and NHS Improvement's Oversight Framework. The rating is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score.

Due to the temporary funding arrangements in place during Covid-19, NHS England and NHS Improvement paused the requirement to measure against the Use of Resources Metric for 2020-21. This was last reported in 2019-20 and the Trust achieved a rating of 1.

Capital Investment

The Trust continued to invest in infrastructure improvements, with Capital expenditure in 2020-21 of £7.7m.
Improvements in the year included continuing investment in technology to implement our new Clinical Records System, and to improve IT resilience and performance. The Trust also continued to invest in mobile working technology to support staff to work in a more agile way.

Estates and facilities investments were made to address areas of risk, relocate Teams and support improvements to enhance the clinical environment. The capital programme was funded through a combination of internally generated funds and National Monies made available by NHSE/I for Health System Led Investment programmes.

Environmental Impact and The Green Plan

By encouraging sustainable development in all its forms, the Trust will continue to take positive steps to mitigate the effects of its activities on the environment. We already incorporate sustainability into some aspects of our activities but recognise that more needs to be done.

The NHS has changed the terms of engagement on issues of sustainability at a national scale, launching their Net Zero strategy, setting long term targets and rebranding the old Sustainable Development Unit as The Greener NHS. This change will see The Trust develop it's Green Plan, which will replace old Sustainability policies, and re-invigorate a Sustainable Development Management Plan (SDMP) within the new Green Plan framework.

The Trust can play a significant role in reducing our carbon footprint and contributing to the NHS Net Zero strategy, limiting our impact on the environment and making a significant difference to the public's health.

The huge challenge presented by Covid-19 is also an opportunity for us to rethink the way we deliver care, bringing sustainability benefits which we can recognise and contribute to our own targets within our Green Plan.

Many of these positive changes are also taking place around us, with actions being taken both professionally and personally as people opt to reduce their environmental impact. The range of actions that we take together can cover everything from energy efficiency, recycling and plastic reduction, to reducing emissions from travel, creating flexible work environments and ways of working, supplementing green spaces or improving logistics.

Despite the difficult year of Covid, the Trust has continued with key work streams for estate rationalization, rolling out LED lighting schemes and replacing ageing assets through lifecycle replacement and refurbishment opportunities.

Social, Community and Human Rights

The Trust has continued to work with its local authority partners through the Social Work Partnership Agreements under Section 75 of the National Health Service Act (2006), to deliver Care Act (2014) compliant delegated responsibility for the delivery of adult social work services, and specified duties, for people aged 18 years and over with needs associated with their mental health, This year has seen the progression of work to ensure that social work staff, based within the Trust under these agreements, are line managed and professionally supervised by registered Social Work Managers.

Freedom to Speak Up

The Trust appointed its first Freedom to Speak Up Guardian in 2017 following the recommendations from the Freedom to Speak Up Review Report (2015). The Freedom to Speak Up Guardian (FTSUG) resource was increased in February 2020 from 0.50 WTE to 1.20 WTE with two FTSUGS covering the service.

During the past year, there has been significant and demonstrable evidence of continued developments of the Freedom to Speak Up service both internally in the Trust and externally at local, regional and national levels.

Internally, the Freedom to Speak Up Guardian has continued to work extremely closely with senior leaders and other Trust services such as HR, Equality, Diversity and Inclusion, Staff Well-being, Staff Side and Union Representatives. This collaborative work has led to a number of key tangible outputs across the Trust. Examples include the design and delivery of a joint Trust-wide conference on tackling racism, delivery of multiple workshops and content development for the Trust's Respect mandatory training module and enhanced triangulation of Trust data to help make improvements.

In particular, the Freedom to Speak Up Guardian has continued to build on the learning from Freedom to Speak Up and worked collaboratively with HR to make improvements in the Trust as part of embedding the Restorative Just Culture framework. This has directly led to the review and enhancement of the Trust's mediation service, development of a Trust Charter and the review and relaunch of the Trust's Early resolution, dignity at work and grievance policy.

Externally, the Trust has continued to establish a strong Freedom to Speak Up profile through active engagement at local, regional and national levels over the past year. In addition to the System work locally, the Trust's Lead Freedom to Speak Up Guardian took on the role of the Regional Network Chair and a number of articles of and promotional films were published nationally in different forums to share excellence and best practice.

The 2020 National Guardian Office Annual report laid before parliament in March 2021 showcases an example of Freedom to Speak Up work from CPFT. The Trust is extremely proud to be a finalist in the Health Service Journal 2020 award for

Freedom to Speak Up Organisation of the year.

Counter-Fraud, Bribery and Corruption

The Trust has in place a Counter-Fraud, Bribery and Corruption Policy that follows the NHS Counter-Fraud Authority's strategic guidance. This policy helps to ensure staff are aware of the correct reporting requirements in this area, and of the actions that the Trust will take to counter fraud, bribery and corruption. The Local Counter-Fraud Specialist delivers specific anti-bribery guidance to staff on a regular basis.

Significant Events Since Statement of Financial Position

The outbreak of Covid-19 continues to have a significant impact on NHS resources, which has led to the current suspension of the long-term planning regime being extended into 2021/22. As a result, and following national guidance, the Trust has only agreed a budget for the first six months of 2021/22. However, a capital programme for 2021/22 has been agreed for a full year.

Performance Analysis

The financial year of 2020-21 delivered unprecedented challenges for the NHS, as focus was placed on the response to the Covid-19 global pandemic. The impact on the Trust was significant, as numerous and rapid service adjustments were required to support the response. Working ever closer with partners across the local health economy, the emphasis on core performance was refocused onto a range of new metrics and urgent requirements.

From very early in 2020-21, it became apparent that clinical services would need to adjust and prioritise requirements for the Covid response. To support capacity, the usual performance framework arrangement for statutory and contractual key performance indicators was streamlined. Monitoring and reporting continued to take place centrally, with attention maintained on key patient safety indicators, but through each wave and lockdown, priorities for clinical services was the immediate response.

That said, information management and performance analysis techniques continued to follow best practice, whilst performance management was scaled back. Enhancements to the Trust data warehouse progressed, notably with the delivery of a strategic aim to consolidate community and mental health data onto one source system.

Furthermore, the Trust embraced cloud-based technologies, updating legacy data processing infrastructure to embrace capabilities offered in Microsoft Azure and complementary Office 365. This development lays the foundations for future performance analysis, using Artificial Intelligence, process automation and more holistic use of 'big data' in a secure and robust environment. Data processing and performance analysis continued to undergo internal audit practices, resulting in an increased confidence in data assurance.

As the Trust begins 2021-22, and continues the recovery of service provision, performance analysis capabilities to support this are prepared. This context should be considered when reviewing the Trust's KPI results below.

Performance measures within the Trust are monitored through a robust governance structure. An active and effective performance management framework hierarchy exists, from service line reporting within individual teams, through to monthly Performance and Risk Executive meetings, the Board subcommittees (People, Safety and Quality and Business and Performance Committees) and then to the Trust Board.

At each stage of this cycle, data-driven performance discussion and challenge is undertaken to ensure established and effective processes are in place, and that any performance issues are identified and addressed in a timely manner.

The People, Safety and Quality Committee has Board-delegated responsibility for receiving and scrutinising data and information relating to the quality and safety of our services. At Directorate level, data is reported and discussed at the Directorate Management Team (DMT) meetings, who are then held to account through the monthly Performance and Risk Executive (PRE) meetings.

The Trust has in place a range of processes to monitor compliance against Trust policy, as well as progress in meeting targets and objectives. These include:

- patient, carer and staff surveys and feedback
- incidents
- complaints
- clinical audit
- other service evaluations.

The following table shows the performance of the Trust against the mandated NHS Improvement indicators, as defined in the Single Oversight Framework. Additionally, for completeness legacy indicators are reported.

Quality Assurance dashboard

Measure		Type	Measure Source	2016/17 Full year	2017/18 Full year	2018/19 Full year	2019/20 Full year	2020/21 Target	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	YTD Full year
Staff Friends and Family Test % recommended - care *(% of those categorised as extremely likely or likely to recommend)*		Caring	NHS England	69.5%	72.5%	71.0%	74.6%	↑	N/A	N/A	77.3%	79.8%	78.6%
Community scores from Friends and Family Test – % positive (% of those categorised as extremely likely or likely to recommend)		Caring	NHS England	52.7%	76.9%	87.7%	88.9%	↑	86.5%	87.7%	89.1%	92.5%	89.3%
Finance - Use of Resources		Effective	CQC	2	2	2	2	<=2	N/A	N/A	N/A	N/A	Not Available
Written complaints - rate		Caring	NHS Digital	174	214	205	170	-	39	30	26	25	120
Inpatient scores from Friends and Family Test - % positive		Caring	NHS England	92.9%	93.2%	81.8%	84.3%	>60%	80.1%	82.6%	81.8%	86.9%	83.0%
Mixed Sex Accommodation breaches *(Count of number of occasions sexes were mixed on same-sex wards)*		Caring	NHS England	0	0	0	5	0	0	0	0	0	0
% clients in employment (on CPA, aged 18-69)		Effective	NHS Digital	Measured differently	13.0%	14.6%	11.5%	4.50%	12.3%	12.0%	12.4%	11.5%	11.5%
% clients in settled accommodation (On CPA, aged 18-69)		Effective	NHS Digital	79.6%	80.0%	79.9%	82.2%	75%	82.8%	80.6%	80.9%	80.4%	80.4%
Admissions gate kept by CRHT		Effective	CPFT	99.4%	99.8%	99.8%	99.7%	95%	98.7%	99.5%	98.9%	100.0%	99.3%
Care programme approach (CPA) follow-up - proportion of discharges from hospital followed up within 7 days		Effective	NHS Digital	96.0%	95.8%	95.7%	96.4%	95%	95.9%	93.1%	94.2%	91.7%	93.8%
Inappropriate out-of-area placements for adult mental health services *(defined as - The total number of bed days patients have spent out of area, where bed stock exists locally)*		Effective	NHS Digital	1554	977	554	67	↓	0	0	13	0	13
Appropriate out-of-area placements for adult mental health services *(defined as - The total number of bed days patients have spent out of*		Effective	NHS Digital	1113	2317	1149	828		272	207	238	72	789
Minimising delayed transfers of care		Effective	CPFT	2.9%	2.3%	1.9%	1.1%	<=3.5%	0.2%	0.4%	0.0%	0.4%	0.3%
CQC community mental health survey *(Findings from the CQC survey which gathered information from people who received community mental*		Organisational health	CQC	Compliant	Compliant	Compliant	Compliant	-	Compliant	Compliant	Compliant	Compliant	Compliant
Proportion of temporary staff -Agency staff (accumulative)		Organisational health	Provider return	7.8%	7.9%	4.6%	3.9%	<=4%	3.7%	3.8%	4.0%	3.4%	4.0%
Proportion of temporary staff - Bank Staff (accumulative)		Organisational health	Provider return			4.7%	4.9%	<=4.6%	4.6%	5.3%	5.4%	8.5%	5.4%
Staff sickness		Organisational health	NHS Digital	4.9%	4.1%	4.6%	4.3%	<4.35%	4.1%	3.9%	4.4%	4.4%	4.2%
Staff turnover *(cumulative 12 month rolling)*		Organisational health	NHS Digital	14.8%	12.2%	11.3%	12.5%	<10.5%	11.6%	10.0%	9.9%	10.0%	10.0%
Occurrence of any Never Event *(Count of Never Events in rolling six- month period)*		Safe	STEIS/NHS Improvement	0	0	0	0	0	0	0	1	0	1
Patient Safety Alerts not completed by deadline *(Improvement patient safety alerts outstanding in most recent monthly snapshot)*		Safe	MHRA/NHS Improvement	-	0	0	8	0	0	0	0	0	0
Admissions to adult facilities of patients who are under 16 years old		Safe	NHS Digital	-	0	0	0	0	0	0	0	0	0
Clostridium difficile - Infection rate		Safe	PHE	0	2	0	0	0	0	0	0	0	0
MRSA bacteraemias		Safe	PHE	0	1	0	0	0	0	0	0	0	0
People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral			NHS Digital	N/A	100.20%	91.89%	93.84%	60%	90.3%	94.6%	69.7%	64.5%	80.3%
% Compliance Overall Mandatory Training (core modules)			CPFT	N/A	99.10%	93.84%	94.93%	90%	89.6%	89.7%	88.6%	86.4%	89.6%
Safe Staffing Levels (Registered and Unregistered)		Safe	CPFT	100.9%	88.2%	101.7%	103.5%	80%	103.6%	102.5%	105.4%	102.6%	103.5%

New Measures added 2020-21					Target	Q1	Q2	Q3	Q4	Full Year
Number of New Complaints - Rate of written complaints per WTE		Caring	NHS Digital			0.35%	0.27%	0.23%	0.22%	0.27%
Count of Never Events in rolling six-month period		Safe	NHS Improvement		0	0	0	1	1	1
Incidents:	Harm:									
Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	No	Safe	NHS Improvement			76.86	285.44	469.83	669.89	669.89
	Low					61.56	240.95	370.02	476.78	476.78
	Moderate					5.82	22.07	33.28	43.88	43.88
	Servere					0.26	1.30	1.48	1.65	1.65
	Death					0	0	0	0	0
Data Quality:										
Data Quality Maturity Index (DQMI) - National figures release 3 months after submission		Well Led	NHS Digital		95%	97.1%	97.1%	96.6%	96.3%	96.3%
Mental Health Services Data Set (MHSDS) - National figures release 3 months after submission					95%	98.5%	98.0%	97.5%	97.2%	97.2%
Community Services Data Set (CSDS) - National figures release 3 months after submission					95%	93.0%	94.0%	94.3%	94.3%	94.3%
Improving Access to Psychological Therapies (IAPT) - National figures release 3 months after submission					95%	98.5%	98.4%	97.5%	97.2%	97.2%
IAPT										
Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)		Effective	NHS Digital		50%	48.3%	49.0%	50.4%	49.3%	49.2%
Waiting time to begin treatment (from IAPT minimum dataset): **I) within 6 weeks**		Responsive	NHS England		75%	73.4%	85.3%	90.0%	92.3%	85.3%
Waiting time to begin treatment (from IAPT minimum dataset): **II) within 18 weeks**			Service Standards		95%	96.1%	98.5%	98.3%	98.5%	97.8%

Research Activity and Performance

Approaching the end of a successful year in March 2020, many studies paused due to the coronavirus pandemic and research staff were urgently redeployed to clinical services to support the Trust's incident response. Research efforts were refocused on urgent Covid-19 Public Health studies and research staff helped to deliver antibody testing and flu vaccination clinics. In 2021, CPFT is restarting other studies in intellectual disabilities, physical and mental health, following National Institute for Health Research (NIHR) guidance as restrictions ease.

Online survey studies attracted record participation during the peak lockdown period in 2020, with the national health data survey contributing to an incredible 7,634 people taking part in research with CPFT this year in 29 studies, more than doubling our final annual total of 3,290 for 2019-20. CPFT is the second highest recruiting NHS Trust in the eastern region and the UK's second highest performing NHS Trust for mental health research.

Urgent Covid-19 Research

Research at CPFT is a vital part of our response to the pandemic, and the Trust's specialist expertise and facilities are a major asset to regional, national and international studies developing effective vaccines, finding treatments and understanding the impact of Covid-19 on physical and mental health.

Our researchers contribute to national and regional research prioritisation panels, and have published findings to guide strategies for mental health science research on the impact of coronavirus, and provided clinical academic leadership for the national survey of children and young people's mental health. Researchers at the NIHR Applied Research Collaboration (ARC) East of England hosted by CPFT developed top tips for care home staff during the pandemic, and guidance on palliative and end of life care as well as a series of policy briefings on the impact of Covid-19 on food and eating in the East of England.

Covid-19 Vaccine Trial

CPFT was the only integrated physical, mental health and social care NHS Trust in the UK to join the Covid-19 vaccine trial with Oxford University. This study was made possible through a landmark partnership with neighbouring Royal Papworth and Cambridge University Hospitals NHS Foundation Trusts, working with CPFT's specialist Windsor Research Unit staff.

Over 300 professionals from primary care, community and emergency services joined acute staff to take part and attend follow up clinics at the Windsor Research Unit, with many participants sharing positive feedback and gratitude for their experiences and the care they received throughout.

CPFT continues to support the NIHR with Covid-19 clinical trials and research. The national vaccine trial registry is helping to speed up recruitment and find people from all backgrounds to test new vaccines. Visit nhs.uk/researchcontact to find out more and register.

Covid-19 Surveys

A number of urgent public heath surveys were set up to investigate the impact of Covid-19 on general health and wellbeing during lockdown, as well as assessing the impact on NHS staff. CPFT staff, patients, partners and the public helped to share these opportunities to participate:

- CPFT ran the global survey with Southern Health NHS Foundation Trust to understand the psychological impact of Covid-19, with over 1249 CPFT respondents contributing their views. This is one of the Trust's best performing research surveys to date, and CPFT was one of the top national recruiters for this study.

- The NHS Check study with King's College London is assessing the impact of Covid-19 on NHS staff to help improve support for them during and after the pandemic. Following invitations and reminders to take part, over 30% of the CPFT workforce completed the survey.

CPFT Data Study Impact of Covid-19 on Local Health Services and Mortality

Early results from Cambridgeshire and Peterborough show use of mental health services reduced during the pandemic peak and indicate that mortality risk increased for people with serious mental illness. Lead author and CPFT Consultant Psychiatrist, Dr Rudolf Cardinal, led the research team reviewing anonymous data from CPFT's Research Database and clinical records systems, to find key patterns. They examined changes in referrals and activity in mental health and community health services during lockdown, alongside shifts in mortality rates. Their findings are published in the international Journal of Psychiatric Research, reporting from one of the first UK health data studies investigating the early effects of Covid on NHS community and mental health services.

Optimising Use of Data, Medtech and Clinical Informatics

The urgent Public Health research study described above shows how NHS trust health data and clinical information systems can be used to rapidly track and identify the impact of coronavirus and other diseases on populations at scale, over the course of a few months. A number of other studies published this year used CPFT's Research Database (CRATE) to look at recovery pathways for CAMEO early intervention service users, mental health and dementia care outcomes. CPFT's Research Database lead Dr Rudolf Cardinal is a co-investigator in the national team developing a mental health data research hub in partnership with Health Data Research UK.

CPFT is one of the Cambridge Biomedical Campus partners, exploring innovations, medtech and implementation of novel solutions to improve care. Major projects across the campus such as the Cambridge Children's hospital are harnessing health data and technical expertise to drive integration of mental and physical health services, improve clinical information systems and data sharing between NHS Trusts to transform the patient experience and care pathways.

Growing research portfolios and partnerships

CPFT continues to increase participation in research running National Institute for Health Research (NIHR) portfolio studies at the specialist Windsor Research Unit at the Trust's

Fulbourn headquarters and exploring opportunities for sites in Peterborough to increase access to research. The Trust is forging new research partnerships with NHS Trusts across the UK and international institutions. During 2020 – 21, CPFT's mental health research has attracted unprecedented funding over $4 million from US National Institutes of Health, in two landmark projects as UK partner. CPFT will also be a key partner in the Cambridge Biomedical Research Centre (BRC) and their new mental health research programmes, working with organisations across the Cambridge Biomedical Campus, regional and national research networks.

The Cambridge Children's Research Institute is a major part of the Cambridge Children's hospital project integrating physical and mental health care for children. This project is working to ensure that children and young people benefit from the latest research and treatments, building an expert multidisciplinary team to embed research with care, and develop a world-class facility in the East of England. Dr Cathy Walsh, Professor Ed Bullmore and Professor Tamsin Ford have been leading for mental health in the planning of this important new hospital and research institute, focusing on long term health trajectories and prevention of poor outcomes, and using digital technologies to deliver enhanced mental healthcare for children across the region.

Developing research capacity and skills for all CPFT staff

Research and development leads are currently investigating options to provide CPFT research facilities in Peterborough, to increase access to resources and opportunities to participate for people in this area, which is also a population in focus for the NIHR ARC East of England.

Following a successful application in 2019, the Trust was awarded nearly £15,000 funding by the NIHR ARC East of England to build CPFT's research capacity, focusing on nurses and allied health professionals. Staff from all directorates have benefitted from attending the Research and Development Forum's national training courses on research leadership and essential skills and two places at the UK Dementia Congress in 2019. Three places have also been booked for the Research and Development Forum's annual flagship conference, postponed until 2021.

CPFT's first dedicated research skills day workshop for nurses took place in March via Microsoft Teams, as part of the LEAD training programme developing our nursing workforce. This pilot will be further developed for other CPFT staff groups to introduce them to research at the Trust and some foundation skills. Clinical research skills training days continue to run online via Zoom with the University of Cambridge Department of Psychiatry. The workshops are open to anyone running or is about to start a clinical study; particularly PHD students, postdoctoral scientists and other clinical researchers working in CPFT.

Building research resources

Research talks running online via Zoom and Microsoft Teams with the University of Cambridge Department of Psychiatry during the pandemic have increased access to learning for CPFT staff, with over 100 people attending some of the lunchtime seminars. Research talks are also published on CPFT Research YouTube for everyone to view.

Our new CPFT Research website www.cpft.nhs.uk/research launched in February 2021 with over 20 pages of resources and information for health staff and researchers, patients and the public.

This website will continue to develop over 2021, growing the library of case studies and films

with research participants and staff sharing their experiences.

Involving experts by experience in research

Involvement of people with lived experience of mental health issues in research is a key priority area within our R&D programme, and CPFT has over 15 years of experience and expertise in this area. We aim to support, enable and empower service users, carers, researchers and clinicians to work together to develop high quality research which is relevant to people's needs.

CPFT Service User and Carer Research Group (SUCRG)

This is a virtual group where people with lived experience of mental health issues or dementia are supported to be involved in the development, delivery and dissemination of research, and to facilitate learning.

During 2020-21:

- **31** Experts by Experience (EbEs) were supported to be involved in **27** research or research related activities
- PPI advice and support was provided to **29** researchers

Key achievements in 2020-21 include:

- **Increased number of research projects involving EbEs**

CPFT's research and development team continued to support and encourage involvement of experts by experience in CPFT research studies from the beginning of the pandemic and throughout the year.

The commitment of SUCRG members and researchers to continue working collaboratively and learn from each other despite the circumstances, is demonstrated by the increased number of research studies EbEs had the opportunity to be involved in (19 during 2020/2021 compared to 16 in 2019/2020). Having an established PPI process in place and a very active group has been crucial to ensure that involvement of EbEs remained a core part of all CPFT sponsored studies, as well as many funding applications and student research studies.

- **Involvement in Covid-19 research during the pandemic**

Members of the SUCRG worked closely with researchers, clinicians and managers to set up a study exploring the reasons for inpatient admissions during the first lockdown. Building and sustaining collaborative relationships can take time. Switching to remote working and setting up Lived Experience Advisory Groups to provide rapid, meaningful input can be challenging. Our links with a very motivated and experienced group of EbEs and the commitment of researchers ensured meaningful involvement throughout the project, without delaying the project initiation and delivery.

- **Shifting to virtual involvement activities**

Following Covid-19 restrictions and guidance, all face-to-face meetings were changed to virtual meetings. This also included conferences and other learning and development activities.

The Social Power and Mental Health steering group, which consists of researchers from the Department of Geography (University of Cambridge), members of the SUCRG and other experts by experience, worked continuously to reshape the Social Power and Mental Health: Evolving Research Through Lived Experience conference into a festival of virtual events hosted by the Centre for Research in the Arts, Social Sciences and Humanities (CRASSH) during the week 19 – 23 April 2021. This annual event aims to foster better dialogue between researchers and those with lived experience of mental health issues.

Other learning and development activities that evolved into virtual sessions include the PPI sessions delivered for CPFT researchers and nurses and the *Conversations with Experts by Experience (CEbE)* teaching programme.

Research Case Studies

NHS Trusts collaborate on UK's first home-grown Covid-19 Vaccine

When the pandemic hit UK shores, research teams at CPFT, Cambridge University Hospitals (CUH) and Royal Papworth Hospital (RPH) NHS Foundation Trusts joined colleagues across the country to tackle coronavirus and develop a safe, effective vaccine.

Finding a vaccine for Covid-19 quickly became a prime focus for many scientists the world over, with one early candidate originating in Oxford, funded and supported by the NIHR. In England, the unique NIHR network of staff embedded in the NHS were able to hit the ground running when the call went out, to begin recruiting volunteers to help test the Oxford vaccine, which was approved for use in 2020 and is now protecting people.

This partnership has now set a standard for cross-working to deliver these kinds of trials. The Cambridgeshire collaborative has now taken on a further vaccine study in recruiting to the Janssen vaccine trial and is ready to open further research to make sure the most effective vaccines and treatments can be found for as many people as possible.

Major research award to boost treatment for Alzheimer's disease in adults with Down's syndrome

The Cambridge Intellectual and Developmental Disabilities Research Group (CIDDRG), led by CPFT consultant psychiatrist and researcher Dr Shahid Zaman (left), has been awarded $3.4 million by the US National Institutes of Health to expand research investigating biomarkers and brain changes in Alzheimer's disease, and progress treatments for adults with Down's syndrome who are most at risk.

Their ongoing research programme published results in The Lancet this summer, revealing that the cognitive and biochemical changes in Alzheimer's disease start more than 20 years before clinical symptoms present in people with Down's syndrome. Imaging biomarkers show that a long preclinical phase follows a predictable sequence, similar to the development of Alzheimer's disease in the general population.

Early care for people with psychosis supports recovery

A study with early intervention mental health service CAMEO at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) has found that sixty percent of people cared for in their first episode of psychosis recovered well. The research team led by consultant psychiatrist and Wellcome Trust Fellow Dr Golam Khandaker used CPFT's Research Database to review blood markers and health outcomes for CAMEO service users, in a longitudinal study of anonymous patient records between January 2013 and November 2019. The study results were published in Brain, Behaviour and Immunity. This is one of the first studies in the UK to measure these associations in a large group of people, using a broad set of blood tests for biomarkers which can signal physical health issues underlying mental health conditions.

CPFT joins international research partnership to find new schizophrenia treatments

CPFT's early intervention mental health service CAMEO will lead a major global study as UK partner, to investigate the causes and impact of schizophrenia on high risk adolescents and young adults, and to try to find effective early treatments.

An international consortium has been awarded one of the largest ever grants for research into psychosis and serious mental illness, securing $52 million from the National Institutes of Health in the United States for the project achieving unprecedented scale and partnerships in this field.

Following their successful bid led by Professor Jesus Perez (pictured), CAMEO will directly receive $1.3 million to run this research, as one of 26 centres of excellence around the world. Investigators will recruit over 1,000 people worldwide at high risk of developing psychosis for an in-depth study assessing brain structure and function, psychopathology and cognition, genetics, behaviour, and speech and language, over two years.

ARC East of England to address national health and care research priorities

People across the country will benefit from targeted research projects to improve health and care, led and supported by the National Institute for Health Research (NIHR) Applied Research Collaboration (ARC) East of England, hosted by CPFT. Working together on successful bids in 2019, the national network of 15 Applied Research Collaborations (NIHR ARCs) has secured over £13 million to develop additional research programmes over the next three years, to tackle the most pressing challenges for the health and care system.

The NIHR ARC East of England will co-lead national work to improve mental health for adults, children and young people, driven by the Mental Health Priority Network in partnership with ARC South London, and will also be a key collaborator in projects to address health and care inequalities, prevention – including behavioural risk factors, and improve adult social care and social work.

Study shows cardiac changes in schizophrenia raise heart disease risk

Research with CPFT has uncovered changes to heart structure and function in people with schizophrenia, that could increase the risk of heart disease and mortality. The research team's findings are published in The British Journal of Psychiatry and they won the Royal College of Psychiatry's Article of the Month in August for vital work investigating physical health issues in schizophrenia, a severe long term mental health condition.

Lead author Dr Emanuele Osimo (pictured), Specialty Registrar in Psychiatry at CPFT and National Institute for Health Research Academic Clinical Fellow, organised a multidisciplinary research team at the University of Cambridge and Imperial College London.

Working with the research team, the study was made possible by 40 patients with schizophrenia who volunteered to take part, matched by an equal number of healthy controls from the general population. Their hearts were expertly scanned with cutting edge technology at the Robert Steiner MRI Unit.

Urgent call to tackle impact of Covid-19 on mental health

In a paper published in The Lancet Psychiatry, CPFT research leads joined 22 global experts to call for studies to address the mental health impact of Covid-19. Two online surveys were completed in late March 2020 (when lockdown measures were announced) to enable the public and people with lived experience of mental health conditions to inform this paper. They showed that people had specific concerns related to Covid-19 including increased anxiety, fear of becoming mentally unwell, access to mental health services and the impact on mental wellbeing.

Co-authored with CPFT honorary consultant psychiatrists Professor Ed Bullmore, CPFT's Director of Research and Development and Professor Tamsin Ford at the University of Cambridge, their paper highlighted the urgent need to improve monitoring, protection and treatment for mental health, and understand how coronavirus affects the brain.

Adult and Specialist Mental Health Directorate

Accreditations: Accreditation for Impatient Mental Health Services (AIMS). Quality Network for PICU (QNPICU). College Centre for Quality Improvement for Forensic Inpatient Services (CCQI). Quality Network for Eating Disorder Services. Enabling Environments Accreditation. Home Treatment Accreditation Schemes (HTAS). Psychiatric Liaison Accreditation Network (PLAN). ECT Accreditation Scheme (ECTAS).

The Adult and Specialist Mental Health Directorate was created five years ago which oversees the adult mental health and learning disability services in Cambridgeshire and Peterborough within primary care, secondary care acute care and criminal justice settings.

The Senior leadership team comprises the Associate Director of Nursing and Quality (and Deputy), Clinical Director (and Associate Clinical Directors), Service Director, General Managers, Head of Social Work and Business Manager.

The Community and Inpatient Teams are led by Service managers, Team Managers and Clinical Specialists (Doctors, Nurses and/or AHPs as appropriate). This promotes collective and collaborative working ensuring teams and services are empowered to make appropriate decisions at each level to facilitate continuously improving, high quality patient care; staff and patient wellbeing, and the overall performance of the directorate**.**

The last 12 months has seen the Adult and Specialist Mental Health Directorate significantly impacted by the Covid-19 pandemic. The Directorate has supported the System response through redeployment of staff to physical health services and the national vaccination programme.

In line with Public Health modelling, the directorate are witnessing the impact of the pandemic on the mental health of NHS and Social care staff, including those within the directorate. As the System Leader in Mental Health, we have mobilised a staff mental health service supporting all staff within the Cambridgeshire and Peterborough System.

The pandemic has impacted the local population which has resulted in a marked increase in acuity of presentation. This has caused pressures on the complexity of issues that our staff are having to treat.

National guidance for managing the pandemic has created significant challenges for our service delivery and whilst our services have adapted to respond to this, we have had to mitigate a number of clinical and quality risks. However, there have been some key improvements and opportunities that have arisen during the pandemic, namely the joint mental health response car delivered in partnership with East.

Despite encountering significant challenges the directorate has continued to develop, expand and improve services and has demonstrated many examples of excellence in

practice, including:

- the introduction of Exemplar Services in Peterborough;
- leading regionally on significant developments in eating disorder services;
- securing expansion of CAMEO service alongside involvement in a multi-site, multinational research project; and
- the success of the first year of the Individual Placement and Support (IPS) service, the development of a new Cambridge Psychosis Centre and the Long Covid Clinics.

Exemplar Services

The Exemplar initiative has worked closely with services such as adult locality teams (ALT), personality disorder services (PDCS), the primary care mental health service (PCMHS) and learning disability services (LDS) to identify and bridge gaps in service provision. Initially in the Peterborough locality, this has led to the introduction of new staff in PCMHS, PDCS and also the development of a Psychological Skills Service (PSS) to provide psychological treatment for some patients for whom there has historically been limited availability of treatment options.

Eating Disorder Services

CPFTs Eating Disorder Services (AEDS) are leading on the regional implementation of significant developments in eating disorder services aligned with the NHS Long Term Plan and New Care Models to improve patient care and outcomes. The teams are implementing 3 new clinical pathways: a stability and support pathway for those with severe and enduring eating disorders; a high-risk pathway for those who are medically unstable, and an early intervention pathway. This is in addition to the continuation of the existing community

CAMEO

CAMEO has secured their involvement in a multi-site, multinational research study that will support the development if profiling and identifying people at risk of developing psychosis.

Staff Wellbeing

In addition to the development of the new Staff Mental Health Service (SMHS) the directorate has seen many initiatives within teams, such as PWS and PCMHS joining forces to offer their staff a regular “midweek mindfulness” session, and a weekly Tuesday morning yoga session for all staff based at the Newtown Centre, introduced by Huntingdon ALT.

Prizes, Awards and Excellence

The First Response Service (FRS) were finalists in the national LaingBuisson Awards for outstanding response to Covid in healthcare. FRS have also seen good outcomes from the Mental Health Ambulance Car initiative to reduce
inappropriate conveyance to A&E. Early indications have demonstrated an 80% reduction in those metrics.

Springbank Ward won the 2021 Health Service Journal Patient Safety Award for their innovative work with individuals with risk taking behaviours.

New Developments

The Cambridge Psychosis Centre, led by Dr. Emilio Fernandez Egea is a national advice, guidance and 2nd opinion centre for patients with schizophrenia and those treating them.

The Long Covid Clinic, assessing and treating psychological needs in those with long covid is a local initiative that will inform national future best practice and service development.

2020/21 has been a challenging and difficult year for staff across the Older People's and Adult Community Services (OPAC) directorate due to the Covid-19 pandemic.

OPAC has focused on leadership and engagement with staff, driving forward a supportive collaborative approach to deliver the demands during the pandemic. Alongside this we have continued to deliver our commitment to deliver the quadruple aim whilst being flexible to the needs of the pandemic.

Staff within our services have responded to the demands of the pandemic supporting the systemwide pressures exceptionally well with remarkable courage and resilience.

Performance Headlines in 2020/21 include:

- OPAC services ended 2020/2021 with a caseload of 34,000 active referrals, a reduction of 4% in the year, reflecting the disruption to business as usual throughout the period.
- OPAC services delivered 721,000 community contacts throughout this period, which was down by 133,000 in year (-15%), stemming from suspension of routine care pathways during two Covid waves, and the impact of staff re-deployment and absence from working in their normal roles due to Covid (including staff shielding & working at home).
- Minor Injury Unit attendances reduced significantly (-59%) from the previous year, down by 26,000 attendances, following necessary closures to both Wisbech and Doddington sites, resulting from re-deployment of these skilled staff to other services.
- OPAC inpatient units delivered 36,400 inpatient bed days across our community physical health and older people's mental health wards, a 27% reduction of 13,500 bed days, necessary to apply national Covid guidance on safety at work in an inpatient environment for staff and patients alike. Two temporary wards were mobilised in Q4 2020/21 to assist with timely patient discharges from acute hospitals.
- 95.8% of referrals were seen within 18 weeks, down from 98,1% in 2020/21, noting that the Directorate ended the year with increased numbers waiting for community services.
- There were no 'Never Events' incidents reported in year.
- OPAC reported 12 Serious Incidents, compared with 4 in 2019/20.
- 'Stop the Line' processes were suspended within the year, replaced by Incident Command & Control and extensive communications with all staff.
- The directorate received 44 formal complaints in 2020/21, down from a total of 53 in 2019/20.

The NHS Long Term Plan published in January 2020 identified clear goals and ambitions to address major national, organisational and workforce issues across the Health and Care System. The People plan was published in July 2020. During 20/21. The directorates main focus was on the challenges of the pandemic by incorporating the principles of the people plan.

Vaccination Programme

Throughout 2020/21, OPAC delivered 5,242 flu vaccinations to our housebound patients and carers, which was double compared to what was delivered in 2019/20 (2,698).

The Directorate continues to deliver the second round of the housebound vaccinations. Since April 2021 OPAC have delivered 2,842 first dose. The second will be completed by July 2021.
Delivery of the Covid-19 Vaccination Programme will be delivered via the Vaccination Hubs, by releasing staff as required.

CPFT put together an immunisation and vaccination education package and trained over 400 staff. This package has been agreed to be accredited by The Royal College of Nursing.

Working with Integrated Community and Primary Care

Throughout the year the Directorate has worked closely with our partner organisations in response to the pandemic, including Primary Care Networks (PCNs), Social Care, Local Acute Trusts, the Voluntary Sector, the County Council, North and South Alliances, the CCG and Primary Care.

Quality and Patient Safety

The Directorate has maintained a focus on patient quality and safety throughout 2020/21.

In the absence of formal CQINs and KPI's OPAC have continued to be vigilant. Falls prevention and pressure area care remains a priority and there has been a clear reduction in the total number of Falls incidents, which we continue to monitor.

During 2020/21 we have ensured Directorate risks are reviewed and lessons learnt are shared and discussed at directorate wider leadership events and patient safety and quality meetings.

Investing in Digital and Clinical Systems

The Directorate has engaged with the trust wide roll out of OneVision and Community Hospital (COHO) for our inpatient physical health wards as we continue to modernise our clinical systems. Large numbers of clinician teams have been trained in these new clinical IT systems in order to enhance patient care.

Within 2020/21 OPAC has embraced the virtual world by supporting and rolling out the attend anywhere virtual clinics. We have also conducted our day-to-day business via Microsoft TEAMs, along with other virtual platform apps to ensure ongoing use of digital technology.

Transformation and Financial Balance

Ensuring we work in the most effective and efficient way remains an ongoing challenge for OPAC staff, with several initiatives and projects underway in 2020/21 that will continue as we move into the new financial year.

Our Staff, Workforce, Planning and Development

Ensuring we have a *highly skilled, well trained and developed workforce*, who feel engaged, listened to and supported across all teams is recognised as fundamentally important to OPAC.

Throughout the year we have increased wider leadership, weekly staff engagement sessions, supported Service Line Reporting, and successfully redeployment of over 100 staff. In addition, we have also developed virtual Schwartz rounds as we embed a Just culture and strive to live by the PRIDE Trust values.

The Directorate continues its commitment and focused approach on strong leadership and high engagement with our staff, driving forward a co-creation approach to delivering local service improvements.

Use of feedback from local questionnaires along with the national staff survey results continues to assist us to shape our future model for staff engagement, ensuring our staff feel valued and supported to do the basics well, empowering them to make decisions and ensuring communication channels are efficient, effective and supportive.

Older people's and adult community

- Neighbourhood Teams
- Joint Emergency Teams (JET)
- Older people's inpatient wards
- Rehabilitation services and long-term condition specialist services.
- Inpatient and community mental health services for people over 65.

Tier 4 Inpatient Units

The Darwin Centre for Young People (DCYP) is engaged in a project to deliver 72hr admissions from June with the arrival of the new Consultant Psychiatrist – these will increase patient flow and reduce the iatrogenic effects of extended admissions on attachment disordered young people. The project will be bolstered by the arrival of another Consultant Psychiatrist in the new Home Treatment Team and close working between the two services should have a significant positive effect on patient flow.

Red to Green principles are now embedded within the Patient Flow meetings on the ward which aim to remove blockages to discharge. In addition, the Section 85 three-monthly statutory notification to social care is now made on admission where the admission is expected to meet or exceed three months which engages the Local Authority ahead of time.

The SafeCare Healthroster module is now in place and expected to replace the Safer Staffing process shortly – it allows for measures including acuity and which identify tasks which do not fit within business-as-usual to be recorded and by June 29 we will have sufficient data with which to review the establishment – this is in fact in use on all three units so all three plans to review at this point.

The Croft Children and Family Unit has increased to a seven-day service and now provides 8 beds with the additional ability to accept crisis admissions following negotiation with NHSE. There will be further developments including the establishment of a High-Dependency Unit. The unit is already fully recruited in line with the planned rollout which took place on April 1st.

The plan for the next 12 months will include embedding the 'Red to Green' process within the weekly Transition Meeting which will allow for focus on some of the young people the unit has been seeing in the community for the longest time to be RAG-rated and for plans to be made to increase flow. This will be reviewed however as crisis admissions and the increased number of admissions with disordered eating may mean a move away from the 8-week standard for admissions to the Croft.

The Phoenix Centre

There have been multiple challenges for the team in the past 12 months with significantly increased acuity amongst young people with disordered eating in the context of the Coronavirus outbreak. The staffing establishment will be reviewed at the end of June as stated and there is a significant focus on recruitment as well as retention. Supervision is being closely monitored with a QI plan in place specifically around increasing uptake and process.

Twice weekly Bed Management/Patient Flow meetings are in place to improve communication and planning with community colleagues during the crisis. The Red to Green approach is encouraged within this meeting so that the degree of acuity amongst referrals and inpatients can be balanced to improve patient flow. This is complicated by the need to weight restore in order to improve long term outcomes, so consideration is being given to having separate clinical pathways.

All three units are engaged with the plans for the new Cambridge Children's Hospital with monthly staff reference groups starting on 28th April.

Child and Adolescent Mental Health Community Services (CAMHS)

CASUS have combined their service provision with YOS substance misuse workforce to ensure a robust consistent offer to children countywide.

There will be a continued focus on delivering timely access to Eating Disorder Assessments and evidence-based treatment at clinics across the County for children and young people with anorexia, moderate-severe bulimia and binge eating disorder. Referrals have remained high over the last year and work continues to develop a Home Treatment Service to support children in the community and reduce the need for hospital admission.

A new partnership has been commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire County Council, and Peterborough City Council, to bring together mental health and emotional wellbeing services for children and young people aged 0-25.

The new partnership includes:

- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services NHS Trust (CCS)
- Centre 33
- Ormiston Families.

Together these organisations will bring their expertise to help build relationships across our Mental Health and Care System to ensure clinical services, voluntary organisations and local authority services work closer together to support children and young people with their mental health and wellbeing.

The new 'whole System approach' will improve current pathways and improve efficiency by providing a single referral point for accessing mental health and wellbeing services. Initially, the referral point will only be available to professionals with referral forms available on partner websites. This single point of referral will make it easier for young people to navigate and access the right support when they need it.

Joint working with local Paediatric Teams within the Neurodevelopmental pathway is fully underway, with joint working now established across Cambridgeshire, for children receiving a new diagnosis of ADHD.

The CAMHS Crisis Assessment Team launched on the 6th April, providing assessment and support for children and young people in Crisis. We are assessing children and young people in hospitals and in their homes aiming to reduce hospital admissions and facilitating access to the appropriate support. We will further develop a home treatment service to support those children's young people and families when needed building on the excellent work already being done by CAMHS Intensive Support Team (IST).

The 'Outcomes Section' continues to collect and analyse outcome data to evidence effectiveness and contribute to national best practice research such as CASUS AMBIT Approach Outcomes. The paper is published at: https://doi.org/10.1177/1359104521994875

East of England Community FCAMHS

FCAMHS has been fully operational across the East of England region since April 2019. This Tier 4 community service offers advice, consultation, multiagency liaison, and direct assessment, where indicated. The service is available to all partner agencies that work directly with children and it takes referrals (from professionals only) in relation to children to present with both mental health concerns and a risk to others.

The service has successfully engaged with and built working relationships with relevant stakeholders across the region and continues to do so. In 2020, the service started to roll out training (all virtual in light of the pandemic), which will be available for booking by all partner agencies and stakeholders across the region and which covers a broad range of topics.

This training offer is currently on hold due to CPFT Covid-19 restrictions.

Clare Lodge Health Team

Within the last year, CPFT were successful in their bid to continue to provide the In Reach Health Service for Clare Lodge for the next 5 years; this includes providing mental and physical health care planning and interventions. The Secure Stairs framework, a model for developing trauma-focussed integrated formulations and care plans for young people in the Secure Estate, continues to be used to support the setting. The expansion of the health service to a seven-day service is currently being implemented.

Complex Case Management Service

CCM has had a year of change, establishing a Peer Support role within the service model and broadening the referral pathway to include Pupil Referral Units across Cambridgeshire & Peterborough and maximise opportunities for children and young people who traditionally struggle to access mainstream services. This work is ongoing. We have continued to engage with our young people and parent/carer. We also sent out a letter at the peak of the COVID crisis to our stakeholders with advice and support for young people to help maintain a healthy mental state.

Paediatric Therapies

Over the past 1-2 months, staff in the Therapies Teams have been working hard to improve the service received by CYPF. This has been especially true for the Occupational Therapy (OT) Service who have been working hard to try and maintain patient waits to below 18 weeks despite staffing changes and reduction (e.g., due to maternity leave). At the end of the financial year the draft specification for OT was released for discussion between the Local Authority, Commissioners, CCS and CPFT, along with an initial investment from the local authority. Discussions around the Physiotherapy specification have been put on hold indefinitely. We have been particularly excited to have been able to support our first OT Assistant Practitioner to successfully enrol on the OT Apprenticeship scheme.

In Speech and Language Therapy the team has benefited from the speedy implementation of virtual platforms for therapy where we previously knew this could be successful but has been catalysed due to the Covid-19 situation.

The Directorate has worked especially hard on providing a virtual offer to meet the needs of the school aged workforce in supporting children and young people with SLCN. Due to the pandemic the service is managing increased waiting lists and therefore the coming year will be focused on managing these along with setting new KPIs with our commissioners.

A key focus of work during the year was the joint transformation work with Cambridgeshire Community Services NHS Trust to bring together children's services across Cambridgeshire and Peterborough. The 0-19 services have progressed with a joined-up service model and single clinical leads across services. Occupational therapy and physiotherapy services now share a clinical lead across the 2 organisations leading to a more joined up and consistent service offer for families.

Cambridge Children's Hospital

Cambridge Children's aspires to be more than a hospital. We are seeking a visionary new approach to healthcare for young people.

We will treat the whole child, not just illnesses or conditions, using all the talent that Cambridge and our region has to offer.

Delivering the right care for young people, in the right place at the right time, will vastly improve outcomes over their whole lifetime. Together we will build a new model of paediatric care in the East of England that will set the standard nationally and internationally. By combining government support and philanthropy we can deliver an ambitious vision that transforms child health care, benefiting children and young people, today and long into the future.

A unique combination of ground-breaking research with mental and physical health expertise, Cambridge Children's Hospital will focus on prevention and early detection of childhood diseases, supported by world-leading genomics, brain imaging and clinical research facilities.

The specialist Hospital will deliver state-of-the-art care, and work in close partnership with local acute providers, community services, GPs and social care to ensure children are treated at home or in their communities wherever possible. We will make care pathways seamless by working hand-in-hand with young people and families, using the latest medical technology to improve remote monitoring and communications.

We will engage actively with children, young people and their families to co-design a unique building with an emphasis on usability, play and maintaining a normal childhood.

Developing a psychologically literate workforce, with staff who can assess both the psychological and physical needs of their patients, is a key ambition of Cambridge Children's. The integration of physical and mental health care will lead to better outcomes and transform how children, young people and their families experience care.

Significant progress has been made over the past year in preparing the Outline Business Case, particularly since the appointment of the design team. There has been ongoing work with stakeholders at CUH, the University and across the System to develop the proposals for integration and transformation across all the different project workstreams. There has also been increasing focus on co-production, supported by the launch of the Children's Network. Engagement and development work will continue at pace through the coming year, in the run up to the submission of the OBC in the autumn.

Children and young people

- Child and adolescent mental health community services in Cambridgeshire and Peterborough
- Children's community services in Peterborough
- Adolescent intensive support team
- Young people's drug and alcohol service and Specialist inpatient services for children, young people and their families

End of Section 1: Performance Report

The Performance Report is judged to be a fair, balanced and understandable analysis of Cambridgeshire and Peterborough NHS Foundation Trust's performance in line with the overarching requirement for the Annual Report and Accounts as a whole.

The Trust's Auditors have reviewed the Performance Report for consistency with the Financial Statements.

Tracy Dowling
Chief Executive

25th June 2021

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Section 2: Accountability Report

The Accountability Report comprises:

Director's Report
Remuneration Report
Staff Report
Disclosures set out in the NHS Foundation Trust Code of Governance
NHS Improvement's Single Oversight Framework
Statement of Accounting Officer's Responsibility
Annual Governance Statement

Statement of Chief Executive's Responsibilities as the Accounting Officer of Cambridgeshire and Peterborough 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 Cambridgeshire and Peterborough NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Cambridgeshire and Peterborough NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

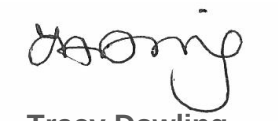
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- 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 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 Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable her to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the 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 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.



Tracy Dowling
Chief Executive

25th June 2021

Directors' Report

Board of Directors

The Trust's Board of Directors is accountable for organisational performance and stewardship. Its key responsibilities are to:

- Set the overall strategic direction.
- Ensure provision of consistent high-quality, safe and effective services.
- Maintain effective dialogue with the communities which the Trust serves.
- Ensure high standards of governance across all organisational activities.
- Approve the Annual Report and Accounts.
- Manage resources to maintain financial sustainability.

Day-to-day responsibility for overseeing and directing the delivery of services is held by the Trust Leadership Team acting under delegated authority from the Board of Directors.

The Board currently comprises eight Executive Directors, less the two who left in March (as outlined on pages 50 and 52), and eight independent Non-Executive Directors (NEDs), including one Non-Voting Advisory NED. The Non-Executive Chair maintains a casting vote. Seven formal Board meetings were held during the financial year 2020–2021.

During the year, the Trust has reviewed and holds in place a detailed Board of Director's skills matrix, which is reviewed by the Nominations and Remuneration Committees, to ensure that the Board has an appropriate balance of skills and experience. The Board of Directors also evaluates its own effectiveness on an annual basis, with the results presented to the Private Board meeting.

During 2020-21, the Trust continued to develop governance systems and processes in line with the Well Led review previously undertaken and supported by Grant Thornton.

Appointment of the Trust Chair, Non-Executive Directors and Executive Directors

The table below outlines responsibility for the appointment of members of the Board:

POSITION	APPOINTMENT RESPONSIBLITY
Trust Chair	Council of Governors
Non-Executive Directors	Council of Governors
Chief Executive	Trust Chair, Remuneration Committee, and the Council of Governors
Executive Directors	Trust Chair and Chief Executive Officer

Details of remuneration paid to the Trust Chair, NEDs and Executive Directors are outlined in the Annual Remuneration Report. NEDs are appointed for a term of three years and are subject to an annual performance appraisal.

NEDs may be re-appointed for a second three-year term providing they continue to be effective and demonstrate commitment to the role. In line with the Trust's constitution, a third term may be considered subject to any reappointment being reviewed on an annual basis.

Removal of NEDs, including the Trust Chair, requires the approval of no less than 75 percent of the Council of Governors.

Register of Interests

The Trust Register of Interests details any (potential) conflicts of interest of Board members. The register is maintained by the Trust Secretary, and all Board members are given the opportunity to declare any new interests at the beginning of each Board and Sub-Committee meeting.

The Trust Register of Interests is available for public inspection via the website and also upon written request to the following address:

Trust Secretary
Cambridge and Peterborough NHS
Foundation Trust (CPFT)
Elizabeth House
Fulbourn Hospital
Fulbourn
Cambridge, CB21 5EF
corporateoffice@cpft.nhs.uk

Non-Executive Directors 2020-21

Julie Spence OBE
Trust Chair

Chair of:
Board of Directors
Council of Governors
Nomination Committee
Remuneration Committee

Julie has more than 30 years distinguished public service with the police. She retired as Chief Constable of Cambridgeshire in late 2010. Appointed as Trust Chair of the Trust in 2014, she is experienced operating with high levels of public scrutiny and accountability. Julie chaired the Police Mutual Assurance Society during 2018-19 and is a Trustee of Ormiston Families. She has lectured on leadership and organisational management at the University of Cambridge and Anglia Ruskin University.

Julian Baust
Deputy Trust Chair and Non-Executive Director

Julian has more than 30 years' commercial experience including organisational transformation, redesign and performance management gained within product and service industries. Prior to taking early retirement, he was Chairman and Managing Director of Kodak (UK) Ltd. In addition to his role within the Trust, Julian serves as Vice-Chairman of Diabetes UK and as a Non-Executive Director at Settle Group (formerly North Hertfordshire Homes).

Jo Lucas
Senior Independent Director and Non-Executive Director

Chair of:
Charitable Funds Management Committee (CFMC)

Jo has more than 40 years' experience working in mental health services in the UK and internationally. She served as a Board member for a number of organisations that included Chair for a special needs housing association. Currently a psychotherapist in private practice in Cambridge, Jo is the Non-Executive lead for recovery. Jo was appointed as the Trust's Senior Independent Director in October 2016.

Karen Daber
Non-Executive Director

Karen was born in Cambridge and has spent the majority of her life in the county. With a highly successful career in the Cambridgeshire Police Force spanning 30 years, which included a period of secondment to the College of Policing retiring with a rank of Assistant Chief Constable, Karen was appointed as a NED in 2020 and has a particular interest in ethics, diversity and inclusion. Karen is a member of the Cambridgeshire and Essex Magistrates Advisory Committee and a member of the South-East Region Magistrates Conduct Advisory Committee. Karen is a consultant involved in coaching, mentoring and leadership development.

Mike Hindmarch
Non-Executive Director

Chair of:
Audit and Assurance Committee (AAC)

Mike is a chartered accountant with extensive experience at Board level in the private, public and third sectors. Following a successful career with multi-national companies, he most recently worked for Sense, a large UK charity supporting people with multi-sensory impairment. He previously served as a Non-Executive Director and Audit Chair at Cambridgeshire Community Services NHS Trust, and having reached his maximum tenure, recently served as Vice-Chair of the 'Joint Audit Committee for the Police and Crime Commissioner and Chief Constable' for Cambridgeshire and Peterborough.

Professor Peter B Jones
Half Time Advisory
Non-Executive Director

Peter has been Professor of Psychiatry in Cambridge since 2000, and Deputy Head of the Clinical School since 2014. Peter's research interests are in the epidemiology of mental illness, particularly in causes active in early life, and the mental health of young people. He was a founder of the award-winning Cameo Early Intervention service, and in 2008 took on the Directorship of the National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care East of England hosted by the Trust – this is a partnership between researchers and health services to accelerate the research evidence on policy and practice. Having helped form Cambridgeshire's specialist Mental Health Trust in 2002, Peter served as a Non-Executive Director until 2005 and re-joined the Trust as an advisory Non-Executive Director in 2017. He is a Trustee for MQ, the Mental Health Research Charity.

Brian Benneyworth
Non-Executive Director

Chair of:

People, Safety and Quality Committee (PSQC)

Brian is an experienced Non-Executive Director and is Managing Director of his own Consultancy Company. He is a Fellow of the Chartered Institute of Personnel and Development (CIPD). He works closely in the Trust regarding Equality and Diversity and Freedom to Speak Up. Brian has previously held Executive Director positions in both private and not-for-profit companies and has had extensive experience in housing, care and support sectors.

Geoff Turral
Non-Executive Director

Chair of:

Business and Performance Committee (B&PC)

Geoff currently works in the technology ventures sector, specialising in developing digital platforms to improve communication between organisations and their customers. Prior to this, he worked in the car industry, most recently as Managing Director of Porsche Cars GB Ltd.

Executive Directors 2020-21

Tracy Dowling
Chief Executive

Date in post: Aug 2017 - Present

Areas of special interest and / or responsibility:

Responsible for meeting all of the statutory and regulatory requirements of the Trust, in addition to being the Trust's Accounting Officer to Parliament. Special interests include developing a quality improvement culture and ensuring that meeting the needs of services users, families and carers are core to developing and delivering Trust services.

Tracy has more than 30 years' experience in the NHS, and more than 10 years' experience at Board level. She joined the NHS in a clinical capacity as a diagnostic radiographer before deciding to undertake a Masters degree in Business Administration and then to pursue a career in NHS management and leadership. She has experience in the acute sector, in commissioning, and in a regulatory role.

Tracy has done much to commission, increase and improve services for both community and mental health services in Cambridgeshire and Peterborough and is thrilled to be leading the Trust in the development and delivery of these vital services which support some of the most vulnerable service users, of all ages, in our community.

Kit Connick
Director of Corporate Affairs

Date in post: Oct 2018 – Mar 2021

Areas of special interest and / or responsibility:

Corporate projects, Trust secretariat, governance, communications and engagement, charitable funds, health and safety, equality, diversity and inclusion, risk management, emergency planning, medical devices, Recovery College East, partnership engagement and chaplaincy services.

Kit has worked in a number of NHS corporate leadership roles in Cambridgeshire for 17 years, prior to which she worked in the private sector. Kit has a particular interest in organisational and personal development and is an executive coach and mentor, as well as a healthcare leadership feedback facilitator and Belbin accreditor.

Rachel Gomm
Executive Director of Nursing, Allied Health Professionals & Quality

Date in post: March 2020 - Present

Areas of special interest and / or responsibility:

Rachel is responsible for a diverse range of areas in CPFT including patient experience, clinical effectiveness and compliance, patient safety, infection control and safeguarding. Rachel is Board level executive lead for nursing and Allied Health Professionals.

Rachel has more than 30 years' experience working in the NHS. A learning disability nurse by background, Rachel has held a range of clinical, service development and leadership positions in community and mental health settings for children and adults.

Dr Chess Denman
Executive Medical Director

Date in post: Jan 2012 – Present

Areas of special interest and / or responsibility:

Responsible officer for medical revalidation, consultant appraisal, clinical research development and governance, clinical effectiveness and medicines management, Caldicott Guardian.

Chess has more than 20 years' experience working in the NHS. She trained in medicine at Trinity College, Cambridge, and London University before studying psychiatry at London's Guys and St Thomas' and Cassel Hospitals. A consultant psychiatrist in psychotherapy at Addenbrooke's Hospital before joining the Trust in 2003, Chess is committed to improving services for mental health patients. She founded the Trust's Complex Cases Service for the treatment of personality disorders which won innovation site status and funding from the Department of Health.

Scott Haldane
Executive Director of Finance

Date in post: Jan 2015 - Present

Areas of special interest and / or responsibility:

Finance (including financial reporting, financial control, payroll, audit, capital planning, financial performance and management), procurement, business information and technology, information governance, security, and estates management.

Scott has more than 30 years' experience in senior management roles and more than 25 years as a Director of Finance. He graduated from the University of Stirling with a BA in Accountancy and Business Law in 1981 and qualified as a Chartered Accountant in 1984. His immediate past roles include Director of Finance at Cambridgeshire Community Services NHS Trust and NHS National Services Scotland respectively, in addition to four years as Strategy and Business Development Director (Scotland) for Atos IT Services (UK) Ltd. Scott previously served as President of the Healthcare Financial Management Association and was recognised as 'Public Sector Finance Director of the Year' in 2006. He is currently a lay member of the Court at the University of Stirling, a Non-Executive Director of Edinburgh Leisure Ltd. (an arms-length Charitable body of City of Edinburgh Council), and a Trustee of Ambient LTD (formally known as Heritage Care), a national Charity providing community-based care and support for people with learning disabilities, mental health support needs and older people.

Stephen Legood
Executive Director of People and Business Development

Date in post: Sept 2015 - Present

Areas of special interest and / or responsibility:

Strategy development, business planning and development, commissioning, client management and service transformation, human resources, learning and development, leadership and management development; workforce productivity and all personnel matters.

Stephen has more than 20 years' experience working in the NHS, which has taken him from ward to Board. Prior to his current role, Stephen served as interim Chief Operating Officer having previously served in several Associate Directors roles at the Trust, leading on commissioning, contracting, system redesign and development of large-scale services. He is a Governor of Cambridge University Hospitals NHS Foundation Trust.

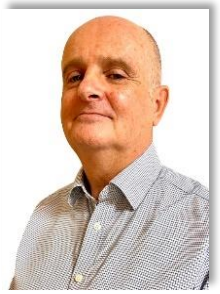
Debbie Smith
Executive Director of Operations and Systems Partnerships

Date in post: March 2020 - Present

Areas of special interest and / or responsibility:

Operational delivery of our clinical services and the development of our systems partnerships.

Debbie started in the NHS in 1987 in Derbyshire where she trained as a mental health nurse before moving to Staffordshire working in a number of clinical roles in both adult and older people's services. After returning to Derbyshire as a service manager in 2001, she then joined Rotherham, Doncaster and South Humber NHS Foundation Trust in 2005 as an Assistant Director for Older People's Mental Health Services and then as Deputy Director of Operations. In 2013, she was appointed Mental Health Service Director and completed an MBA with the Open University. In 2016 Debbie became Chief Operating Officer before joining CPFT in March 2020 as the Director of Operations and System Partnerships.



Gerard Newnham
Director of Transformation and Partnerships

Date in post: Dec 2019 – Mar 2021

Areas of special interest and / or responsibility:

Service Transformation, Quality Improvement and System Partnerships.

Gerard previously worked for the Ministry of Justice, Legal Services Commission and Cambridgeshire County Council. In 2009 he joined the Granta Medical practice, Sawston, Cambridgeshire and successfully merged four medical practices. This created a delivery model which was nationally recognised as being at the forefront of new models of care. He joined the Trust in November 2019.

Attendance at Board of Directors Meetings

Name	Title	2020/21 Period Served	Board Meeting Attended – 2020/21							Date Appointed	End of Term in Office or Leaving Date
			2020					2021			
			01/04	21/05	22/07	23/09	25/11	27/01	24/03		
Julie Spence, OBE *V	Trust Chair	Full Year	✓	✓	✓	✓	✓	✓	X	Jun-14	Jun-22 *(8/9 yrs in post)*
Julian Baust *V	Deputy Chair/Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	✓	Apr-13	Apr-22 *(9/9 yrs in post)*
Jo Lucas *V	SID/Non-Executive Director	Full Year	✓	✓	✓	X	✓	✓	✓	Oct-14	Oct-22 *(8/9 yrs in post)*
Mike Hindmarch *V	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	✓	May-15	May-22 *(7/9 in post)*
Prof. Peter Jones *NV	Advisory Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	✓	Mar-17	Mar-22 *(Advisory NED)*
Brian Benneyworth *V	Non-Executive Director	Full Year	✓	✓	✓	✓	X	✓	✓	Jan-18	Jan-24 *(4/9 yrs in post)*
Geoff Turral *V	Non-Executive Director	Full Year	✓	✓	X	✓	✓	✓	✓	Jan-18	Jan-24 *(4/9 yrs in post)*
Karen Daber *V	Non-Executive Director	10 months	N/A	N/A	✓	✓	✓	✓	✓	Jun-20	Jun-23 *(1/9 yrs in post)*
Tracy Dowling *V	Chief Executive Officer	Full Year	✓	✓	✓	✓	✓	✓	✓	Aug-17	Exec Director
Dr Chess Denman *V	Executive Medical Director	Full Year	✓	✓	✓	✓	✓	X	✓	Jan-12	Exec Director
Scott Haldane *V	Executive Director of Finance	Full Year	✓	✓	X	✓	✓	✓	✓	Jan-15	Exec Director
Stephen Legood *V	Executive Director of People and Business Development	Full Year	✓	✓	✓	✓	✓	✓	✓	Sep-15	Exec Director
Kit Connick *NV	Director of Corporate Affairs	Full Year	✓	✓	✓	✓	✓	✓	N/A	Oct-18	Left: March 2021
Rachel Gomm *V	Executive Director of Nursing and Quality	6 months	✓	✓	✓	X	✓	✓	✓	Mar-20	Exec Director
Debbie Smith *V	Director of Operations	1 month	✓	✓	✓	✓	✓	✓	✓	Mar-20	Exec Director
Gerard Newnham *NV	Director of Transformation and Partnerships	4 months	✓	✓	✓	✓	X	X	N/A	Dec-19	Left: March 2021

*V = Voting Board Member
*NV = Non-Voting Board Member

Board of Directors Sub-Committees

The work of the sub-committees and their Terms of Reference are reviewed annually to ensure they remain fit for purpose.

Audit and Assurance Committee (AAC)

This committee is responsible for ensuring an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The committee is tasked with reviewing all internal and external audit reports and accounts to ensure the Trust is compliant with all governance and audit standards.

Membership of the committee consists of three Non-Executive Directors, one of whom is appointed to the role of committee Chair. At least one member of the committee is required to have relevant and significant financial expertise. A nominated governor lead also attends.

Meeting held during 2020-2021 were:
- 15th April 2020
- 8th July 2020
- 14th October 2020
- 14th January 2021

Business and Performance Committee (B&P)

This committee is responsible for monitoring, reviewing and providing assurance to the Board on financial performance and service delivery against set targets and budget. The committee is tasked with providing assurance to the Board on delivery of the long-term business and financial strategy, and support to the service development strategy.

Membership of the committee consists of four Non-Executive Directors, one of whom is appointed to the role of committee Chair and three Executive Directors. A nominated governor lead also attends.

Meetings held during 2020-2021 were:
- 29th April 2020
- 24th June 2020
- 26th August 2020
- 28th October 2020
- 16th December 2020
- 24th February 2021

People, Safety and Quality Committee (PSQ)

This committee is responsible for monitoring the Trust's performance in developing and co-ordinating policy and practice of clinical governance and quality (including patient experience, patient safety and clinical effectiveness). The committee is tasked with providing assurance to the Board that high standards of care, appropriate governance structures, and efficient processes and controls are in place across the Trust. The committee also provides assurance to the Board in relation to workforce matters.

Membership of the committee consists of four Non-Executive Directors, one of whom is appointed to the role of committee Chair, and three Executive Directors. A nominated governor lead also attends.

Meetings held during 2020-2021 were:
- 29th April 2020
- 24th June 2020
- 26th August 2020
- 28th October 2020
- 16th December 2020
- 24th February 2021

Charitable Funds Management Committee (CFMC)

This committee is responsible for considering the general running and use of the charitable funds and makes recommendations to the Board, as Trustee. The committee also reviews operational activity/plans of the charity. The committee is tasked with considering any changes in investment policy, reviewing performance of current investments, receiving reports on the investment and charitable fund, and monitoring and reviewing the implementation of any recommendations. The committee regularly reviews spending compliance against the Reserves Policy.

Membership of the committee consists of three Non-Executive Directors, one of whom is appointed to the role of committee Chair, and two Executive Directors. The Director of Finance of the Trust is a voting member of the committee. There is also a nominated

governor lead who attends.

Meetings held during 2020-2021 were:
- 24th June 2020
- 30th September 2020
- 7th December 2020
- 11th March 2021

Sub-Committee Membership and Attendance

Name	Committee Member				AAC				B&P						PSQ						CFM				Voting Rights
	AAC	B&P	PSQ	CFM	15-Apr-20	08-Jul-20	14-Oct-20	14-Jan-21	29-Apr-20	24-Jun-20	26-Aug-20	28-Oct-20	16-Dec-20	24-Feb-21	29-Apr-20	24-Jun-20	26-Aug-20	28-Oct-20	16-Dec-20	24-Feb-21	24-Jun-20	30-Sep-20	07-Dec-20	11-Mar-21	
Julian Baust	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓					✓	✓	✓	✓	Voting
Jo Lucas			✓	Chair					✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Voting
Karen Daber			✓	✓			✓					✓	✓						✓	✓	✓		✓	✓	Voting
Mike Hindmarch	Chair	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓	✓	Voting
Brian Benneyworth		✓	Chair						✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓					Voting
Geoff Turral	✓	Chair	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					Voting
Scott Haldane	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓	✓	Voting
Dr Chess Denman			✓						✓	✓	✓				✓	✓	✓		✓	✓					Voting
Stephen Legood		✓	✓	✓			✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓				✓	Voting
Debbie Smith		✓	✓						✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓					Voting
Kit Connick	✓			✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓					✓	✓	✓	NIP	Non-Voting
Rachel Gomm			✓						✓	✓	✓				✓	✓	✓	✓	✓	✓					Voting
Gerard Newnham		✓							✓	✓					✓	✓								NIP	Non-Voting

OF NOTE: The Director of People and Business Development replaced the Director of Corporate Affairs at the CFM Committee from March 2021.
NIP = Not in post

Board and Sub-Committee Effectiveness

The Trust Scheme of Delegation outlines the level of decision making that can be delegated and those responsibilities reserved for the Board of Directors. The Board and sub-committee cycle of business and Terms of Reference are reviewed annually to ensure they remain up to date, effective and fit for purpose.

In line with NHSE/I guidelines, the Board and Committees completed annual reviews of their effectiveness. Results are collated and considered to form the basis for continuous improvement.

During 2020-21, the Trust has continued to develop governance systems and processes in line with the 2019-20 Well Led review supported by Grant Thornton, and the 2020-21 Risk Assurance Review supported by the Good Governance Institute.

Better Payment Practice Code

Public Sector Payment Policy - Unless other terms are agreed, we are required to pay our creditors within 30 days of the receipt of goods or a valid invoice, whichever is the later. This is to ensure that we comply with the Better Payment Practice Code. The Trust's performance against this metric is shown in the table below:

Better Practice Payment Code Summary 2020/21	Number of invoices	Value (£000)
NHS payables		
Total NHS trade invoices paid in the year	1,224	15,908,152
Total NHS trade invoices paid within target	330	2,905,047
Percentage of NHS trade invoices paid within target	27.0%	18.3%
Non-NHS payables		
Total non-NHS trade invoices paid in the year	38,583	61,541,638
Total non-NHS trade invoices paid within target	25,356	45,819,078
Percentage of non-NHS trade invoices paid within target	65.7%	74.5%

The performance against NHS payables has declined since 2019-20, however, this is largely a result of changes to invoicing arrangements with other providers as a result of Covid-19. This meant there was a delay in approving invoices relating to Provider-to-Provider agreements.

The Trust paid £nil (2019-20 £nil) interest under the Late Payment of Commercial Debts (Interest) Act 1998. Section 113(7) of the Public Contract Regulations 2015 requires the Trust to disclose the amount of interest that the Trust may be liable to pay in respect of late payment. The total potential liability to pay interest on invoices paid after their due date during 2020/21 would be £0.155m (2019-20 £0.327m). There have been no claims under this legislation and liability is only included within the accounts when a claim is received. This legislation does not apply to inter NHS invoices.

Enhanced Quality Governance Reporting

Quality governance reporting is detailed in the Annual Governance Statement.

Cost Statement

The Trust has complied with the cost allocation and charging requirements set out in the *HM Treasury and Office of Public Sector Information Guidance.*

Income Disclosures

NHSI, in exercise of the powers conferred on Monitor by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, directs that the keeping of accounts and the annual report of each NHS Foundation Trust shall be in the form as laid down in NHSI's NHS Foundation Trust Annual Reporting Manual, that is in force for the financial year.

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

As an organisation we are required by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to state whether our income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purpose. We can confirm that this was the case, as evidenced by our accounts.

We are also required by the same Act to provide information on the impact that other

income has had on our provision of healthcare. We can confirm that our other operating income has had no adverse impact on our provision of goods and services for the purposes of the health service in England.

NHS Improvement's Well-Led Framework

Information and disclosures relating to NHS Improvement's Well-Led Framework have been included within the Annual Governance Statement.

Patient Care

Due to our size, level of autonomy and strong working relationships in the wider Health and Social Care System, we can enter into partnerships and collaborations with other organisations and secure funding to develop new and innovative ways to deliver services.

We are a major contributor in the wider health and social care economy, and we use that influence to drive change and improvements which has been particularly evident during the pandemic, such as:

- The Discharge to Assess service
- Flexibility adapting Rehab beds to support Covid positive patients and supporting the surge during wave 2 of the pandemic.
- Various services and resources through the Exemplar Project in Peterborough, including the Dual Diagnosis and Outreach Team.
- The new Children's Hospital in Cambridge.
- Developing a new approach to Emergency Mental Health away from A&E including practitioners based with ambulance cars.
- Managing more risk within a community setting to avoid hospital admissions during the peak of the first and second waves of the pandemic.

We have plans for further developments in the coming year and look forward to working with our partner organisations within the Integrated Care System.

Performance against key healthcare targets is reported as part of our Mental Health Services Data Set (MHSDS) submissions, as well as within the Quality Report. Quality indicators reported in the Quality report includes:

- Various core performance indicators required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended), such as the Care Programme Approach (CPA) 7-day follow up, Crisis Resolution Treatment Team gate keeping, Patient Experience of Community Mental Health Services, and Patient Safety Incident rates.

Additional indicators mandated by NHS England and NHS Improvement (working together as a single organisation from 1st April 2019), include:

- Cardio metabolic assessments.
- Early intervention to psychosis.
- Improving access to psychological therapies.
- CPA 12-month review.
- Under 16 admissions to adult facilities, and
- Inappropriate out of area placements for adult mental health.

Freedom to Speak Up (FtSU) arrangements and rota gaps for doctors and improvement plans were added in 2018-19 and have been carried forward in subsequent years. In 2019-20, a new indicator was added requiring providers of mental health organisations to provide a statement on progress in bolstering staffing in adult and older adult community mental health services, following additional investment from local CCGs' baseline funding.

Improvements to Carer Information

The Carer's Handbook was first published in 2017. It was developed collaboratively with carer organisations through our Carer Programme Board and as part of our commitment to the Triangle of Care. The aim is to provide a practical guide for families and friends. It covers a range of topics including information about getting support, legislation, benefits and respite, understanding diagnosis, suicide prevention and maintaining wellbeing. A second edition is currently in progress and will be published in 2021.

Complaints Handling

Oversight and assurance for the complaints process is provided through the quality and safety governance structure, up to Board. All complaints are reviewed by the Complaints Clinical Review Panel, which includes the Complaints Officer, Patient Safety Manager, Nurse Specialist in Mortality and Head of Patient Safety and Complaints. The role of the panel is to agree the risk grading of the complaint, determine the level of investigation required, whether there are safeguarding issues or whether the concerns meet the criteria for further clinical investigation or escalation as a serious incident in line with the Trust's policy.

The People, Safety and Quality Committee receives a thematic review on complaints which provides information about complaints management, learning and themes. The Complaints Team provides monthly data on complaints to the Directorates, and at a Trust level within the Trust Quality and Safety Report, which is discussed at the People, Safety and Quality Committee and Trust Board.

The Complaints Team deal with formal and potential complaints, signposts service users/complainants to the Patient Advice and Liaison Service (PALS) and other NHS/Social Care organisations, and registers and responds to all health professional feedback.

The Complaints Team offers support to patients, service users, families and carers on the complaints process and it offers guidance and support to staff who undertake complaints investigations or who manage complaints.

The Trust received 118 formal complaints between 1st April 2020 and 31st March 2021. This is a 31% decrease from the number of complaints received in 2019-20 (n=170), and a 43% decrease when compared to 2018-19 (n=207). There has been an increased effort, where appropriate, to resolve complaints at an earlier stage, and this can be attributed to the reduction in formal complaints.

The average response rate target across the Trust for 2020-21 is 54 working days, however, there were periods of time where the response time increased to 75 working days (April to June 2020, and from January 2021) due to the Covid-19 response. The response rate demonstrates a slight increase when compared to 2019-20 (51 working days based on 200 responses) and 2018-19 (51 working days based on 227 responses). The 2020-21 response rate is based on 132 formal and reopened responses being sent between 1st April 2020 and 31st March 2021. The Trust's average response time has remained static but the number of responses being sent has seen a decrease of 34%.

The Complaints Team commenced a quality improvement project to review the complaints pathway and processes in 2019-20. A trial commenced within the Older People's and Adult Community Directorate between 1st November 2019 and 31st March 2020. The process changed so that formal complaints are investigated under two levels: 1) local investigation and 2) independent investigation. A reduced complaints system was implemented from April 2020 until 1st July 2020 due to the emergency response to Covid-19.

From 1st July 2020, the trial undertaken in Older Peoples and Adult Community Directorate was expanded across the other two clinical directorates, Adult and

Specialist Mental Health Directorate, and Children's, Young People and Families Directorate. This concluded on 31st March 2021. The quantitative and qualitative data gleaned from the trial is being analysed, and a proposal on the way forward will be presented to the Trust Board.

Stakeholder Relations

The Trust recognizes the importance of partnership working and collaboration to facilitate the delivery of improved healthcare and invests a significant amount of time, energy and resources in fostering good relationships with key stakeholders, partner organisations and the community.

The Associate Director of Involvement and Partnerships is responsible for proactively advancing involvement with people who use our services, their families and carers.

Participation and Partnership Forum

The Participation and Partnership Forum (PPF) is CPFT's main service user forum. This consists of fifteen adults who have used CPFT services. Each person has a contract of involvement for two years and additional people are recruited each year. The key aims of the PPF are to:

- Support CPFT to develop involvement within its core clinical services.
- Work with CPFT on projects which require a board service user / patient perspective.
- Create and support collaborations between CPFT and our wider community.

Recent and on-going examples of the work completed by the PPF are the co-creation of an app for people with emotional unstable personality disorder in conjunction with the company TTP and the co-production of the Think Family Policy. In addition, members of the PPF are an integral part to the Trust's Zero Suicide Alliance Steering group and the Carers Programme Board.

Co-production Collaborative for all Age Mental Health and for Children, Young People and Families was developed to ensure that there was a clear link between the clinical commissioning group and our wider community. It is attended by a range of non-statutory organisations, people who have used services and statutory organisations. The aims of the collaboration are to:

- ensure that services across the Mental Health System are always co-produced with service users / patients and their families so that their quality continuously improves.
- create a conduit for the views of service users / patients, their families, and carers to be heard throughout the System.
- ensure that co-production includes a clear feedback loop and that organisational responses are provided in a timely way.
- create a process in which the System can ask questions and receive feedback from a variety of different sources.
- promote individual co-production opportunities through our partners.
- act as a resource for co-production across the System.

Carers' Programme Board

Our established Carers Programme Board focuses on ensuring that carers are identified within CPFT and their needs acknowledged and addressed. Key members of the board are a number of carer organisations including Rethink Mental Illness, Caring Together, Making Space, Family voice, Pinpoint, Centre 33 and Cambridgeshire and Peterborough county councils. The Board is chaired by our Lead governor and both carers and service users are integral to the membership of the Board.

Zero Suicide Alliance Steering Group

The Zero Suicide Alliance Steering Group is chaired by CPFT's CEO. It's aims are on reducing the number of patients who complete on suicide who are known to the Trust, on reducing factors which may contribute to the likelihood of a person

completing on suicide and ensuring that the support available for people affected by suicide is robust and accessible for all. It is attended by service users from the PPF and people who have been affected by suicide including carers. Key members of the group also include CPSL Mind, one of the founding members of the Zero Suicide Alliance and Cambridgeshire and Peterborough Public Health. Further links to the Police and other non-statutory organisations established through robust links with the county wide zero suicide group.

Living Well, Living With

Living Well, Living With Meetings take place every two months and are attended by a range of individuals within the Trust.

Cambridge Children's Hospital

Cambridgeshire and Peterborough Foundation Trust continues to work collaboratively with Cambridgeshire Children's Services, Cambridge University Hospital Trust's and our wider community focusing on creating a world first hospital that cares for children's physical and mental health together, in a way no-one ever has before.

Remodelling of Children, Young People and Families Services

Stakeholder engagement formed a significant part of a number of events to review the current System approach to the provision of Children, Young People and Families Mental health services. This included feedback through a children and families questionnaire and engagement events inclusive of both statutory and non-statutory organisations. The final Partnership model included Cambridgeshire and Peterborough Foundation Trust, Cambridgeshire Community Services, Centre 33 and Ormiston Families.

Statement as to Disclosure to Auditors (S148)

To the best of their knowledge, the Board of Directors are not aware of any relevant audit information of which the auditors are unaware.

Each member of the Trust's Board of Directors is considered to have taken relevant steps to satisfy themselves that the auditors are fully aware of any relevant audit information.

Annual Statement on Remuneration

The Remuneration Committee is responsible for all contractual arrangements covering the Trust's Chief Executive, Executive Directors and any other staff groups not subject to national terms and conditions of service. Contractual arrangements include:

- All aspects of salary (including any cost-of-living increases).
- Provision of other benefits including pensions and cars.
- Any arrangement of termination of employment and other contractual terms.

The Committee is further responsible for identifying and appointing candidates to all Executive Director positions on the Board and overseeing their performance through an annual objective setting and review process.

Committee membership is outlined below:

- Julie Spence, Trust Chair
- Julian Baust, Non-Executive Director and Deputy Chair
- Jo Lucas, Non-Executive Director and Senior Independent Director
- Karen Daber, Non-Executive Director

There were two Remuneration Committee meetings during 2020–21, and attendance was as follows:

- 22nd June 2020
- 3rd December 2020

Other attendees may be co-opted from time-to-time in accordance with agenda items. During the course of 2020-21 the Committee was supported in its work by Tracy Dowling, Chief Executive and Stephen Legood, Executive Director of People and Business Development.

Meeting Attendance during 2020-21 is recorded as follows:

Name	22/06/20	03/12/20
Julie Spence	Y	Y
Julian Baust	Y	Y
Jo Lucas	N	Y
Karen Daber	Y	Y

Senior Managers' Remuneration Policy

The Trust's Remuneration Committee is responsible for determining Senior Managers' remuneration or any other staff not subject to Agenda for Change terms and conditions or Medical and Dental terms and conditions.

It is the policy of the Trust to pay salaries that are appropriate to recruit senior managers with the necessary skills, capability and experience to effectively run the Trust, whilst also having due regard to the importance of demonstrating pay restraint at a time of considerable pressure on NHS finances.

There were no substantial changes to remuneration made during the year or the process in place for review.

The Remuneration Committee follows CPFT's policy and objectives on diversity and inclusion, as outlined in the ED&I section on page 76.

Remuneration and performance conditions

The Remuneration Committee may use one or more of the following in determining appropriate role remuneration:

- Benchmarking data provided by NHS Providers surveyed among the Trust's peer group.
- National and regional analysis of NHS Chief Executives and Executive Directors remuneration.
- Reviews of advertised Executive Director roles across the NHS.

Amendments to annual salary are decided by the Remuneration Committee on the basis of the size and complexity of job portfolio.

Executive Director annual salaries are inclusive. Other payments such as overtime, long hours, on-call and stand by do not feature in Executive Directors' remuneration. The Executive Medical Director's salary is in accordance with national terms and conditions of the Service Consultant Contract 2003.

Cost-of-living increases or notice periods/loss of office for Executive Directors are linked to the Agenda for Change terms and conditions of employment, which apply to all staff.

For Very Senior Manager (VSM) positions, the Trust does not currently implement a performance-related pay policy.

The Trust uses detailed national data to benchmark the levels of remuneration for the Executive Directors.

Service Contracts

Executive Directors appointed to permanent contracts, are subject to six months' notice of termination by either party. Date of contract, the unexpired term and details of notice period are as follows:

Tracy Dowling, Chief Executive.
Date in post: Aug 2017. Unexpired term: permanent. Notice period: 6 months.

Kit Connick, Director Corporate Affairs.
Date in post: Oct 2018. Unexpired term: permanent. Left post: 26th March 2021.

Dr Chess Denman, Medical Director. Date in post: Jan 2012. Unexpired term: permanent. Notice period: 6 months. Was in post at 31st March 2021, however has since left the Trust.

Scott Haldane, Director of Finance. Date in post: Jan 2015. Unexpired term: permanent. Notice period: 6 months.

Stephen Legood, Director of People and Business Development. Date in post Sept 2015. Unexpired term: permanent. Notice period: 6 months.

Rachel Gomm, Director of Nursing and Quality. Interim: 30 Sept 2019. Substantive: 5 March 2020. Unexpired term: permanent. Notice period: 6 months.

Gerard Newnham, Director of Service Transformation. Date in post: 9 Dec 2019. Unexpired term: permanent. Left Post: 5th March 2021

Debbie Smith, Director of Operations and System Partnerships. Date in post: 2 March 2020. Unexpired term: permanent. Notice period: 6 months.

There are no special contractual compensation provisions for early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to either:

- The provisions of the Agenda for Change: NHS Terms and Conditions of Service Handbook (Section 16)
- Or for those above minimum retirement age, the provisions of 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

Remuneration of Senior Managers - Subject to Audit

Name and Title	Year ending 31 March 2021				Year ending 31 March 2020			
	Salary and Fees (bands of £5000) £000	Taxable Benefits (total to the nearest £100) £000	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5000) £000	Salary and Fees (bands of £5000) £000	Taxable Benefits (total to the nearest £100) £000	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5000) £000
Non-Executive Directors								
Julie Spence OBE - (Non - Executive Chairman)	50 - 55	0	0	50 - 55	50 - 55	0	0	50 - 55
Jo Lucas - (Non - Executive Director)	15 - 20	0	0	15 - 20	10 - 15	0	0	10 - 15
Sarah Hamilton (Non - Executive Director) - See Note 1	0	0	0	0	10 - 15	0	0	10 - 15
Mike Hindmarch (Non - Executive Director)	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
Julian Baust (Non - Executive Director)	15 - 20	0	0	15 - 20	15 - 20	0	0	15 - 20
Brian Benneyworth (Non - Executive Director)	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
Geoff Turral (Non - Executive Director)	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
Professor Peter Jones (Non - Executive Director) - See Note 12	0	0	0	0	0	0	0	0
Angela Single (Non-Executive Director) - See Note 2	0	0	0	0	5 - 10	0	0	5 - 10
Karen Daber (Non-Executive Director) - See Note 10	5 - 10	0	0	5 - 10	0	0	0	0
Executive Directors								
Tracy Dowling (Chief Executive)	175 - 180	0	Not available	175 - 180	160 - 165	0	Not available	160 - 165
Dr Francesca Denman (Medical Director)	155 - 160	0	Not available	155 - 160	135 - 140	0	Not available	135 - 140
Melanie Coombes (Director of Nursing and Quality) - See Note 3	0	0	0	0	65 - 70	0	22.5 - 25.0	90 - 95
Sarah Warner (Director of Service Transformation) - See Note 4	0	0	0	0	60 - 65	0	0	60 - 65
Stephen Legood (Director of People and Business Development)	120 - 125	0	32.5 - 35.0	155 - 160	120 - 125	0	20.0 - 22.5	140 - 145
Scott Haldane (Director of Finance)	155 - 160	0	37.5 - 40.0	195 - 200	150 - 155	0	32.5 - 35.0	185 - 190
Julie Frake-Harris (Director of Operations) - See Note 5	0	0	0	0	60 - 65	0	105.0 - 107.5	165 - 170
John Martin (Interim Director of Operations) - See Note 6	0	0	0	0	50 - 55	0	35.0 - 37.5	90 - 95
Gerard Newnham (Director of Service Transformation) - See Note 7	80 - 85	0	57.5 - 60.0	140 - 145	25 - 30	0	40.0 - 42.5	65 - 70
Debbie Smith (Director of Operations and System Partnerships) - See Note 8	125 - 130	0	0	125 - 130	5 - 10	0	0	5 - 10
Rachel Gomm (Director of Nursing, Allied Health Professionals and Quality) - See Note 9	105 - 110	4.2	125.0 - 127.5	235 - 240	50 - 55	3	155.0 - 157.5	205 - 210
Kit Connick (Director of Corporate Affairs) - See Note 11	110 - 115	0	35.0 - 37.5	150 - 155	90 - 95	0	22.5 - 25.0	115 - 120

Note 1 - Left 29th February 2020
Note 2 - Left 29th February 2020
Note 3 - Left 29th September 2019
Note 4 - Left 29th November 2019

Note 5 - Left 29th September 2019
Note 6 - Took up Interim position on 30th September 2019 and stepped down on 30th March 2020
Note 7 - Joined 9th December 2019 and left 5th March 2021
Note 8 - Joined 2nd March 2020
Note 9 - Took up Interim position on 30th September 2019 and then made substantive on 5th March 2020
Note 10 - Joined 1st June 2020
Note 11 - Left 26th March 2021
Note 12 - Performs an advisory role for which there is no recompense paid.

Disclosures required by the Health and Social Care Act 2012:

During the year the Trust reimbursed £3,651 in expenses to Directors (2019/20 £25,250) and £80 to Governors (2019/20 £1,440). 6 of the 16 Directors posts made claims for expenses and 1 of 20 Governors claimed expenses.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Fair pay multiples - Subject to Audit:

The Trust is 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 director in CPFT in the financial year 2020/21 was £175,000 - £180,000 (2019/20 £160,000 - £165,000). This was 5.7 times (2019/20 5.2 times) the median remuneration of the workforce, which was £31,365 (2019/20, £31,365).

In 2020/21, no employees (2019/20, also nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £1,691 to £175,381 (2019/20 £2,835 to £164,911).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. There were no payments made in either the current year or prior year in respect of performance related bonuses or long-term performance related bonuses, therefore those columns have not been reported.

There has been a restatement of 2019/20 taxable benefits relating to Rachel Gomm, which were omitted in error from last year's report. Having restated the prior period for this, the total for the year did not change. There has also been a restatement of 2019/20 salary and fees relating to John Martin, as the banding was incorrect in last year's report.

All Executive Directors receive remuneration based on a defined remuneration salary scale. Any movement on the scale is referred to the Trust's Remuneration Committee for approval before it is actioned, and is also benchmarked against similar organisations in order to satisfy the Committee that the remuneration is reasonable.

Pension Benefits 2020/21 - Subject to Audit

Name and Title	Real increase in pension at pension age (bands of £2500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age as 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 in CETV £000	Cash Equivalent Transfer Value at 31 March 2021 £000	Employer's Contribution to Stakeholder Pension £000
Tracy Dowling (Chief Executive)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	0
Dr Francesca Denman (Medical Director)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	0
Melanie Coombes (Director of Nursing and Quality)	0	0	0	0	0	0	0	0
Sarah Warner (Chief Operating Officer)	0	0	0	0	0	0	0	0
Steven Legood (Director of People and Business Development)	2.5 - 5.0	0.0 - 2.5	25 - 30	40 - 45	419	25	468	18
Scott Haldane (Director of Finance)	2.5 - 5.0	0	20 - 25	0	318	37	383	22
Julie Frake-Harris (Director of Operations)	0	0	0	0	0	0	0	0
Gerard Newnham (Director of Service Transformation)	2.5 - 5.0	0	15 - 20	0	210	45	275	11
Debbie Smith (Director of Operations and System Partnerships)	0	0	0	0	0	0	0	0
Rachel Gomm (Director of Nursing, Allied Health Professionals and Quality)	5.0 - 7.5	17.5 - 20.0	45 - 50	135 - 140	846	142	1,016	14
Kit Connick (Director of Corporate Affairs)	2.5 - 5.0	0.0 - 2.5	25 - 30	45 - 50	361	23	407	17

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Pension (GMP) on 8th August 2019. If any individuals were entitled to a GMP, this will have affected the calculation of the real increase in CETV. This is more likely to affect the 1995 section and 2008 section.

Please note, the Executives listed below reflect a nil return for the following reasons:

- Tracy Dowling - opted out of the NHS pension and NHS Pensions are unable to provide a current cash equivalent transfer value for the fund amassed up to the date of opt out.
- Dr Francesca Denman - opted out of the NHS pension and NHS Pensions are unable to provide a current cash equivalent transfer value for the fund amassed up to the date of opt out.
- Melanie Coombes - left the Trust on 29th September 2019 so not applicable for 2020/21, but has been included for comparison purposes.
- Sarah Warner - left the Trust on 29th November 2019 so not applicable for 2020/21, but has been included for comparison purposes.
- Julie Frake-Harris - left the Trust on 29th September 2019 so not applicable for 2020/21, but has been included for comparison purposes.
- Debbie Smith - opted out of the NHS pension prior to joining the Trust.

Pension Benefits 2019/20 - Subject to Audit

Name and Title	Real increase in pension at pension age (bands of £2500) £000	Real increase in lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age as at 31 March 2020 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Real increase in CETV £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Employer's Contribution to Stakeholder Pension £000
Tracy Dowling (Chief Executive)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	0
Dr Francesca Denman (Medical Director)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	0
Melanie Coombes (Director of Nursing and Quality)	0.0 - 2.5	(2.5) - 0.0	50 - 55	115 - 120	928	10	990	10
Sarah Warner (Chief Operating Officer)	0.0 - 2.5	(2.5) - 0.0	40 - 45	90 - 95	699	2	733	9
Steven Legood (Director of People and Business Development)	0.0 - 2.5	(2.5) - 0.0	20 - 25	40 - 45	378	14	419	17
Scott Haldane (Director of Finance)	2.5 - 5.0	0	15 - 20	0	261	30	318	21
Julie Frake-Harris (Director of Operations)	2.5 - 5.0	2.5 - 5.0	40 - 45	80 - 85	541	34	641	9
Gerard Newnham (Director of Service Transformation)	0.0 - 2.5	0	10 - 15	0	167	8	210	4
Debbie Smith (Director of Operations and System Partnerships)	0	0	0	0	0	0	0	0
Rachel Gomm (Director of Nursing, Allied Health Professionals and Quality)	2.5 - 5.0	10.0 - 12.5	35 - 40	115 - 120	656	76	846	12
Kit Connick (Director of Corporate Affairs)	0.0 - 2.5	(2.5) - 0.0	20 - 25	45 - 50	329	14	361	0

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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- Dr Francesca Denman - opted out of the NHS pension and NHS Pensions are unable to provide a current cash equivalent transfer value for the fund amassed up to the date of opt out.
- Debbie Smith - opted out of the NHS pension prior to joining the Trust.

The Remuneration Report has been signed by the Chief Executive:

Tracy Dowling
Chief Executive

25th June 2021

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Staff Report

This breakdown excludes social work staff on Local Authority contracts of employment who are seconded into the Trust under Section 75 Agreements.

Analysis of Average Staff Numbers:

Department / Role	No. of Staff by Contract Type		Average Staff	Average Staff
	Fixed-Term Temp	Permanent	2020-21	2019-2020
Medical and Dental	65.42	108.58	174	168
Ambulance Staff	0.08	10.83	10.92	12
Administrative and Estates	50.08	872.25	922.33	914
Healthcare Assistants and other support staff	181.67	938.75	1120.42	998
Nursing, Midwifery and Health Visiting Staff	11.75	1148	1159.75	1,205
Nursing, Midwifery and Health Visiting Learners	3.25	0	3.25	5
Scientific, Therapeutic and Technical Staff	19.17	792.08	811.25	783
Social Care Staff	1	59.83	60.83	0
Overall Average	**337.58**	**3897.58**	**4235.17**	**4,085**

Workforce Gender Breakdown by headcount

Role Category	Female	Male	Total
Board of Directors	7	7	14
Other Employees	3585	760	4345
Total Employees	3592	767	4359

Board of Directors

Name	Gender	Role
Julie Spence	Female	Chair
Tracy Dowling	Female	Chief Executive
Scott Haldane	Male	Director of Finance
Chess Denman	Female	Medical Director
Rachel Gomm	Female	Director of Nursing
Debbie Smith	Female	Director of Operations and System Partnerships
Stephen Legood	Male	Director of People and Business Development
Kit Connick	Female	Director of Corporate Affairs (left 26th March 2021)
Julian Baust	Male	Non-Executive Director
Peter Jones	Male	Non-Executive Director
Mike Hindmarch	Male	Non-Executive Director
Joanna Lucas	Female	Non-Executive Director
Karen Daber	Female	Non-Executive Director
Brian Benneyworth	Male	Non-Executive Director
Geoffrey Turral	Male	Non-Executive Director
Gerard Newnham	Male	Director of Partnerships and Transformation (left 5th March 2021)

Staff Costs - Subject to Audit			2020 - 21	2019 - 20
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	138,509	10,123	148,632	136,974
Social security costs	12,738	784	13,522	12,029
Apprenticeship levy	692	-	692	639
Employer's contributions to NHS pensions	17,582	-	17,582	16,362
Pension cost - other	113	-	113	-
Termination benefits	22	-	22	132
Temporary staff	-	7,012	7,012	6,832
Total gross staff costs	169,656	17,919	187,575	172,968
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	169,656	17,919	187,575	172,968
Of which				
Costs capitalised as part of assets	-	397	397	884

2020/21 Staff Costs figure excludes the additional 6.3% NHS pension contributions paid centrally by NHS England, totaling £7.655m in 20/21.

Average Number of Employees (WTE basis) – Subject to Audit

			2020-21	2019 - 2020
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	154	19	173	169
Ambulance staff	10	0	10	11
Administration and estates	835	11	846	781
Healthcare assistants and other support staff	1,012	153	1,165	1,069
Nursing, midwifery and health visiting staff	1,028	124	1,152	1,162
Nursing, midwifery and health visiting learners	0	0	-	-
Scientific, therapeutic and technical staff	685	12	697	690
Other	0	0	-	3
Total average numbers (WTE)	3,724	319	**4,043**	**3,885**
Of which:				
Bank staff		233	233	192
Agency and Contract staff		86	86	89
Number of employees (WTE) engaged on capital projects	5	2	7	27

Workforce Strategy

The current Workforce Strategy is from 2019 to 2022 and details the workforce plans over this period.

There are four core strategic goals of this strategy:

- **Sustainable Workforce for the Future:** Ensure we have the workforce for the future, with the right numbers, professions and skills to deliver the care our patients need informed by robust data. Support future talent with careers and opportunities to grow, develop and reach their own personal goals along with developing and nurturing quality leaders within the Trust.
- **Healthy Working Environment:** Create a supportive, safe and healthy working environment for all our staff to be able to recruit and retain talent and to be in the top 25% of Trust's that staff would recommend as a good place to work.
- **Improved Staff Engagement:** Promote a culture where staff feel engaged, empowered and valued, which is inclusive and culturally diverse recognising everyone's contributions.
- **System Partnership:** Work with our System partners to create a flexible, skilled and adaptable workforce for the System, which can support the demand for our services, enabling productive and effective working utilising and enhancing technology

At CPFT, action from the Interim People Plan, published in June 2019 was already being taken to increase the support and recognition for our people. However, at the onset of the pandemic in March 2020, services were stood down and work to progress key people outcomes became focused on supporting our services and our workforce in the most challenging of times. Our experience at CPFT mirrored the wider local and national picture.

The Trust's workforce strategy will be reviewed during FY2021-22. Before Covid-19 there were national, regional and local level workforce challenges. To address these challenges now, and for the future, we are creating one, fully aligned People Strategy, inclusive of all aspects of workforce, that supports the key aims of the People Plan; supporting change and growth, supporting and enabling people to work differently, in a compassionate and inclusive culture which includes a positive just learning culture and a culture of civility and respect. The strategy will set out our vision, ambitions and plans for the development of our organisation, its talent and leadership to ensure we respond to and take forwards the key aims of We Are the NHS: People Plan for 2020/21 Actions for Us All, embedded in our own strategic direction. Taking a planned and systematic approach to enabling sustained organisational performance through the involvement of its people and under the umbrella of the NHS People Promise.

Workforce Initiatives

The main challenges during 2020/21 have been responding appropriately to the Covid-19 pandemic. During the pandemic our workforce rose to the many challenges it faced and true innovation emerged. Some examples of innovation include;

A shared purpose and permission to act: During this time we sought to reduce bureaucracy, standing down elements of our work to enable focus on Covid efforts. This included leadership development, learning and development, appraisals etc., and a similar picture emerged across our System, however we prioritised supervision and staff support. We fast tracked our recruitment processes to onboard staff more swiftly, across the Trust we reviewed all project work to ensure we placed priority where needed. We implemented a co-ordinated command and control structure to support a whole organisation response to Covid.

Highlighting existing and deep-rooted inequalities: CPFT too has witnessed the disproportionate impact of Covid-19 on BAME communities and colleagues. Our leaders have stepped up and role modelled compassionate, inclusive leadership through open and honest conversations with teams, strengthening inclusion and the role of BAME staff networks in decision-making. Our Equality, Diversity and Inclusion (ED&I) Leads continued throughout to progress actions highlighted in our Workforce Race Equality Standards (WRES), and Workforce Disability Equality Standards (WDES) action plans and annual plan. Our staff networks were active, and measures put in place to support colleagues through these challenging times. All staff had an individual risk assessment to support them in their roles.

Flexible and remote working and digital transformation: Remote working increased significantly. Our teams have embraced this technology to hold virtual student placements, provide preceptorship remotely, to hold multi-disciplinary team meetings, board meetings and consultations remotely. This has enabled staff across our range of services in primary, secondary and community care to work differently, with some able to do part of their work from home. CPFT can be proud of its use of technology, building on work already in place, to enable a smooth transition to a more digital workplace.

The changes to how we work will be continuing in the short term which will also inform how we work in the future. The Trust is taking steps to ensure an appropriate balance can be provided between delivering an effective service and supporting the needs and wellbeing of our staff. A working group has been established to define what our future ways of working looks like and how we can ensure measures, processes and practices are established to support our services and workforce. Feedback from staff has been sought to understand their experiences along with an overarching learning the lessons, which will inform the way forward.

Returning and new staff: Our staff numbers have been bolstered by clinicians returning from academia, retirement, and other industries. Students have stepped out of training to increase their direct support to patient care. Staff have been redeployed to areas experiencing pressure utilising clinical, operational, and administrative skills.

During this time, we changed our recruitment, induction and training processes which enabled us to increase our temporary workforce in a short space of time. We were able to recruit additional nurses, therapy and admin staff along with a new larger pool of healthcare support workers to be able to work in our inpatient and community services across the Trust. A focused recruitment campaign has also seen us expanding our integrated care workers roles to support an enhanced Discharge to Assess service.

Innovative roles and support for our community: Our existing staff have taken on new roles. We provided additional input into care homes to support their growing need and worked closely with the CCG to establish how best to support community roles. With our System partners we have provided system wide mental health support, to address the needs of our wider community. We recognise that our ability to innovate and shape services at the point of need is critical to ensuring the best outcomes for patients and to ensuring our workforce has the development and skills required to deliver.

Research: Our research team have both led and contributed to key Covid-19 research linked to vaccine development and studies into the effects of Covid on mental health. Staff at CPFT have supported national and international research projects whilst maintaining their existing research portfolio. CPFT is one of the UK's top performing research active NHS Trust's and the only integrated physical, mental health and social care Trust in the NHS to join a vaccine trial. During the first wave, 303 volunteers stepped up to test one of the world's most promising vaccines. 1249 staff contributed to a global survey investigating the psychological impacts of Covid-19 and 647 staff responded to the specific NHS Check survey, to understand the impacts on our workforce.

Other initiatives:
During the year there have been a number of other initiatives that include:

- A new Early Resolution Grievance and Dignity at work policy and process which moves towards an approach to resolve issues raised by staff at the earliest opportunity.
- Relaunch of the Trust's mediation service with a new cohort of staff from across the Trust trained and accredited as mediators.
- The development of a Trust charter underpinning the Trust's values co-produced with staff to identify the behaviours that are expected from all who work within the organisation.

Developing a Skilled and Engaged Workforce and Education and Training Activities

Throughout the continuous challenge of Covid-19 CPFT has seen great examples of our people, rising to challenges, innovating, problem solving, working more flexibly and adaptably than ever before. Many staff have been working outside their normal scope of practice, many staff have been working across boundaries and outside of their traditional roles, for example through the implementation of virtual consultations.

Our technology enhanced learning team have risen to the challenge of shifting a huge amount of learning online, developing and deploying new Covid-specific learning through our e-Academy, upskilling on demand in both clinical and non-clinical areas to support staff and patients. This responsive approach enabled many staff who were redeployed to access the skills required to support their transition safely. Our IT teams have adapted and kept pace with the demand to support staff as they moved to greater levels of online and remote working than ever before. Indeed, CPFT has been seen as a leader in the System in the technology to enhance both the staff and patient experience, through effective deployment of Office 365.

Our success in these areas has been made possible by good communication, distributed leadership, strong multi-professional and cross system partnerships and team working. Many people have embraced developing new capabilities and new ways of working and we are keen to build on this momentum as an organisation and System, to transform the way we work together and how the best care is delivered to patients.

Like so many of our peers, during our response to Covid-19, we had to put many formal training pathways and placement on hold, not only to focus on the immediate priorities of supporting patients, but indeed of keeping both our patients and our workforce safe. Focus is now on developing new and innovative placement opportunities, working with our HEI's to establish safe and engaging placements. This included streamlining the core mandatory training requirements.

The Trust continues to be committed to providing learning and development opportunities to support staff in further developing and in turn improving patient experience and care. We have enhanced the digital learning programme to support creative and innovative ways of developing our diverse workforce, with enhanced blended learning. More CPD opportunities are now available on our online learning portal and CPFT Academy. The Trust also continues to support apprenticeships across the organisation.

The Trust has participated in an International Recruitment Programme and 22 nurses have been recruited in the first round of appointments. There are 18 of our current Health Care Assistants who the Trust is supporting to be able to practice as nurses within the UK and to support a conversion course for their professional qualification they undertook in their home country. The Trust is also part of a Health Care Support Worker programme working with Health Education England to reduce the number of vacancies.

Equality, Diversity and Inclusion

CPFT is committed to:

- Developing policies, processes, procedures, practices and behaviours that challenge all forms of discrimination and promotes equality of opportunity at all levels.
- Creating an organisation that harnesses the different perspectives and skills of all staff and provides a working environment free from discrimination, harassment or victimisation.

The Trust has in place an Equality, Diversity and Human Rights Policy.

To support our long-term ambitions, the Trust has an Equality Diversity and Inclusion (EDI) Year One Operating Plan 2020-2021 (updated August 2020) in place along with supporting plans for Workforce Race and Disability Standards**.**

At CPFT we have started to expand BAME representation at senior levels, including on our Trust Board, and will be taking this further as part of our wider planned actions in relation to the Model Employer goals spanning all protected characteristics. At CPFT we are committed to encouraging and celebrating diversity in all its forms. We have a range of active staff networks and encourage staff to get involved in these networks to help challenge difference and share learning and best practice, driving improvements for all.

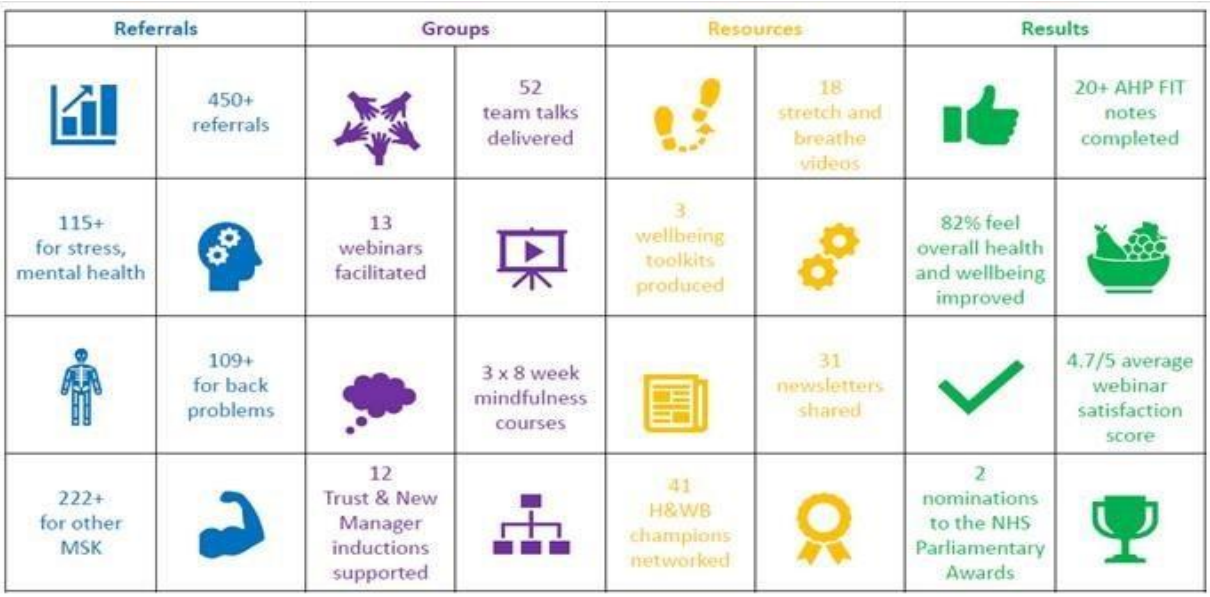
Within the Trust, colleagues from across HR, Learning & Development, Freedom to Speak Up, Equality, Diversity & inclusion, Staff Side and Health and Wellbeing work collaboratively together on a range of issues and plans to ensure that data is reviewed and a whole working perspective informs future actions. During 2020/21 a joint conference was delivered specifically focusing on discrimination in the workplace.

Health, Safety and Occupational Health

During the pandemic over the last year, there has been a greater focus on the health and wellbeing of our colleagues, with support offered in teams and organisations. This Trust has been at the forefront of the offer across our System setting up a Staff Mental Health Service to be accessed by all our provider partners. The service works alongside existing services to provide confidential, specialist mental health care rapidly for NHS staff dealing with increased pressure and challenges during the coronavirus pandemic. This new service is designed to support people who require specialist care for moderate mental health needs.

Many of our staff are also carers or were shielding through the Pandemic and there has been greater recognition and support given to flexibility for staff to support them through this challenging time.

In CPFT, the Staff Wellbeing Service is now fully established following a successful pilot in 2019. The service has been supporting our whole workforce throughout the pandemic. This has involved establishing toolkits for staff working at home and within the workplace, a range of information provided on SharePoint for all to access, Wellbeing webinars and mindful exercise sessions, establishing a call back service working with our internal psychologists, spaces for staff to destress and our normal referral access to the service. The service was nominated for a National Parliamentary award. The activity of the service is shown in the chart below.



The Trust's Sickness Absence and Wellbeing Policy details support available to staff in relation to their health and working environment. A health and wellbeing strategy is in place and continues to focus on:

- Leadership and management
- Data and communication
- Healthy working environments
- Mental health
- Musculoskeletal support
- Healthy lifestyles- which is being developed to support our staff activities

A number of other support channels include:

- Occupational health service provided by Optima
- Counselling services provided by Optima
- Relevant Health Promotion information is regularly updated on the Staff Wellbeing Service intranet page
- Health promotion and activity weeks continued throughout 2021, although were modified due to the Covid-19 response.

Consultation with and Involvement of Employees

Many service changes were put on hold whilst dealing with the response to the Covid-19 pandemic, however, any service changes within the year were carried out in consultation with staff involved.

The Trust's Joint Consultative and Negotiating Partnership Forum has met regularly throughout the past year to discuss and support employment related issues in connection with Covid-19 and has increased the meetings to monthly. These meetings engage and consult with Trade Union colleagues on any employment-related or organisational changes. They also meet to review and develop employment policies.

During the Covid-19 incident a Command-and-Control structure was established. Our trade union colleagues have been part of that structure and regularly attended the meetings.

Our Trade Union colleagues are now part of the Trust's People Board which reports into the

People, Safety & Quality Sub Committee of the Trust Board.

Direct communication with staff at all levels is supported by regular communications via Staff Bulletins, a weekly Talk to Tracy session where topics are discussed and staff can put direct questions to the Trust Chief Executive. Whilst the previous back-to-the-floor sessions have not happened in person, all members of the Trust Board had carried out virtual team visits across all areas of the Trust.

Union Facility Time

Facility time is paid time off for union representatives to carry out Trade Union activities. The information below relates to Trade Union facility time within NHS England.

The Trust works in partnership with recognised Trade Unions to ensure that a full disclosure, stating information relating to the percentage of time spent on facility time and percentage of pay bill spent on facility time and paid trade union activities in line with the Trade Union Regulations 2017 (Facility Time Publication Requirements) is published on its website and uploaded onto the Government website.

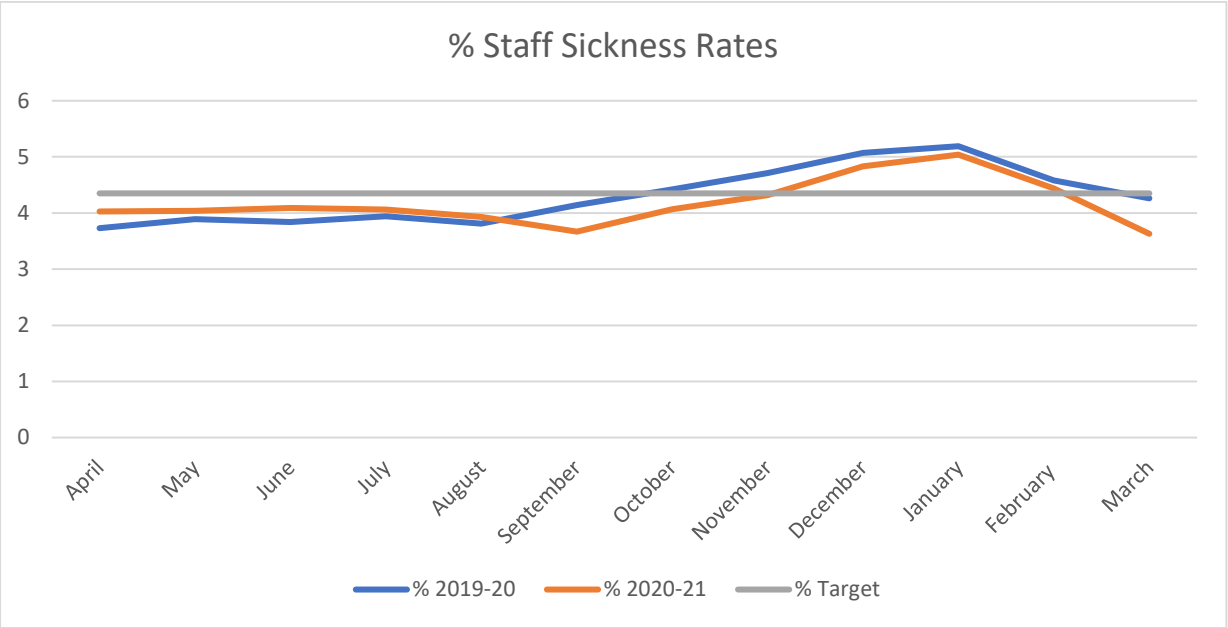
Information on NHS Sickness Data

The average percentage sickness rate for the Trust was 4.17% across 2020-21 which was below our set target of 4.35%.

Sickness Analysis (2020 - 2021)				
Average FTE	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE Days Available	FTE Days Lost to Sickness Absence
3,742	-	1.27	1,363,520	56,991

The sickness analysis figures shown above are for the 2020/2021 financial year.

The below table shows the sickness trend which follows seasonal peaks.



Information on NHS Turnover

Within CPFT our turnover is monitored monthly and reported via the Trust's workforce scorecard. The 12 month average turnover for 2020-2021 is 10.43% which is in line with the Trust target of 10.50%. The chart below shows the full year's monthly turnover.

2020/21 Trust Turnover	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	12 Month Average
Turnover Rolling	12.21%	11.87%	11.58%	11.02%	10.42%	9.96%	10.22%	9.50%	9.75%	9.65%	9.56%	9.43%	10.43%
Turnover Monthly	0.76%	0.45%	0.62%	0.81%	0.41%	0.80%	0.95%	0.66%	0.89%	0.96%	0.60%	0.80%	0.73%
Number of Leavers	32	19	26	34	17	34	40	28	38	41	26	35	30.83

Staff Survey

The National Staff Survey was completed by 48% of Trust staff, which equates to 1954 individuals, a decrease in the % of respondents from 51% from the previous year. Overall, the Trust is comparable to similar mental health, learning disability and community organisations. For 2020, results are organised into ten themes.

National Staff Survey Results - Trust Scorecard - 2019 - 2020 Comparison					
Theme	**2019 Score**	**2019 Respondents**	**2020 Score**	**2020 Respondents**	**Change 2019/2020**
Equality, Diversity & Inclusion	9.2	1975	9.1	1900	↓
Health & Wellbeing	6.1	1985	6.2	1907	↑
Immediate Managers	7.2	1987	7.2	1906	↑
Morale	6.2	1951	6.3	1888	↑
Quality of Care	7.4	1768	7.3	1668	↓
Safe Environment - Bullying and Harassment	8.2	1970	8.4	1835	↑
Safe Environment - Violence	9.6	1970	9.6	1901	↔
Safety Culture	6.9	1966	6.9	1898	↔
Staff Enagagement	7	2009	7	1929	↔
Team Working	6.8	1982	6.9	1907	↑

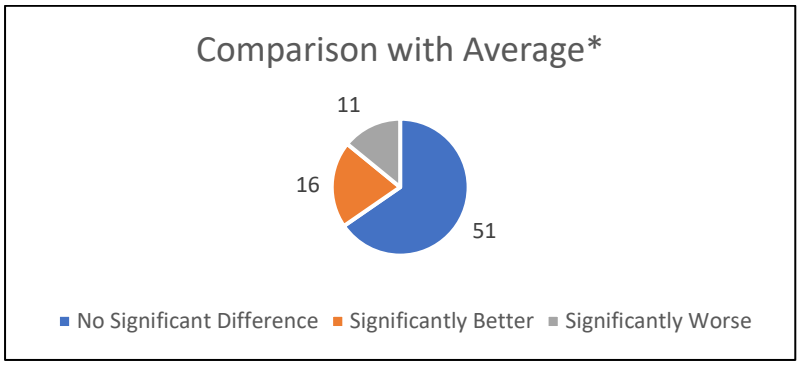
Key questions from the family and friends test are highlighted below which shows an increase in all areas:

	Q18c. Would recommend organisation as place to work	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation	Q18a. Care of patients/service users is organisation's top priority
2019	**59%**	**69.6%**	**77.1%**
2020	**62%**	**72.8%**	**80.6%**

However, it should be noted that from the most recent pulse survey in March 2021, the following were the results which shows a continued improvement and above the Trust's target.

% Likely to recommend CPFT to friends & family if they needed care or treatment?	79.76%
% Likely to recommend CPFT to friends & family as a place to work?	70.00%

In comparison with the average scores out of 78 questions, 51 of these showed no significant difference, 16 showed a significant improvement whilst 11 showed a decrease.



The below table highlights the Trust's top five and bottom five scores:

Top 5 scores (compared to average)	
78 %	Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
73 %	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
89 %	Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public
80 %	Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours
85 %	Q26b. Disability: organisation made adequate adjustment(s) to enable me to carry out work

Bottom 5 scores (compared to average)	
67%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
62%	Q18c. Would recommend organisation as place to work
72%	Q4a. Opportunities to show initiative frequently in my role
46%	Q19a. I don't often think about leaving this organisation
66%	Q8c. Immediate manager gives clear feedback on my work

The following tables show the most improved and least improved areas from the previous year.

Most improved from last survey	
40 %	Q11a. Organisation definitely takes positive action on health and well-being
53 %	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
46 %	Q9b. Communication between senior management and staff is effective
38 %	Q4g. Enough staff at organisation to do my job properly
63 %	Q5h. Satisfied with opportunities for flexible working patterns

Least improved from last survey	
67%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
53%	Q11c. In last 12 months, have not felt unwell due to work related stress
71%	Q2b. Often/always enthusiastic about my job
80%	Q11e. Not felt pressure from manager to come to work when not feeling well enough
59%	Q2a. Often/always look forward to going to work

The results continue to be analysed and the People Board will oversee the progress in responding to the survey. An overarching workforce plan in response to the People Plan and Staff survey results has been developed.

Staff Policies

Staff policies and procedures reviewed and/or developed for 2020/2021 are:

- Early Resolution Grievance & Dignity at Work
- HR Guidance – Major & Critical Incidents
- Annual Leave Policy
- Special Leave Policy
- Pay Progression Policy

The Trust constantly reviews policies as a result of changes in the law or changes within Trust processes. However, due to the pandemic it was agreed that policies would receive an automatic 6-month extension. All policies are reviewed and agreed in partnership with the Joint Consultation and Negotiating Partnership (JCNP). The JCNP works collaboratively with the Trust's Management Team, human resources team and staff to support a number of different areas, which include:

- Receiving and analysing workforce information
- Negotiating with the organisation on issues affecting terms and conditions of employment
- Other workforce related matters.

Policies related to Medical & Dental Staff are discussed and agreed with the Medical Negotiating Group.
All policies are assessed in accordance with the Equality Act 2010 for compliance requirements relating to any staff connected to any of the nine protected characteristics.

Our *Wearing 2 Hats* group continues to support the development of policies, particularly those

which affect individuals with long term conditions.

Modern Slavery Act

CPFT continues to take a number of steps to ensure slavery and human trafficking is not taking place in any of its supply chains or in any part of its own operations. We do this by:

- working towards full compliance with the relevant legislation and regulatory requirements;
- working to promote the requirements of the legislation, making our approach known to our suppliers and service providers;
- building on our existing workforce awareness of human trafficking and modern slavery, through our safeguarding policies/ protocols and commercial learning; and
- considering human trafficking and modern slavery issues when making procurement decisions.

In line with the Modern Slavery Act 2015, the Trust publishes a Slavery and Human Trafficking Statement on its public website. This is approved by the Board of Directors on an annual basis.

Expenditure on Consultancy

During the year CPFT spent £0.392m on consultancy. This included £0.073m on consultancy support through the System Development Unit, hosted by the Trust on behalf of the local System Transformation Partnership, including strategic reviews of the Health System financial plans. The Trust specific spend includes support for the implementation of Clinical Systems, and to support the roll out of remote digital working across the Trust.

Reporting High Paid Off-Payroll Arrangements

Table 1:

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

Number of existing engagements as of 31 March 2021	18
Of which…	
No. that have existed for less than one year at time of reporting	4
No. that have existed for between one and two years at time of reporting	9
No. that have existed for between two and three years at time of reporting	1
No. that have existed for between three and four years at time of reporting	3
No. that have existed for four or more years at time of reporting	1

Table 2:

For all off-payroll engagements, between 1 April 2020 and 31 March 2021, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	59
Of which…	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	59
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3:

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.	16

Exit Packages - Subject to Audit

There was one exit package agreed in 2020/21 totaling £0.022m (4 in 2019/20 totaling £0.132m).

Reporting of Compensation Schemes: Exit Packages 2020-2021			
	Number of compulsory redundancies	**Number of other departures agreed**	**Total number of exit packages**
	Number	**Number**	**Number**
Exit package cost band (incl. any special payment element)			
£10,001 - £25,000	1	-	1
Total Number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£22,000	-	£22,000

Reporting of compensation schemes: exit packages 2019 - 2020			
	Number of compulsory redundancies	**Number of other departures agreed**	**Total number of exit packages**
	Number	**Number**	**Number**
Exit package cost band (incl. any special payment element)			
<£10,000	-	1	1
£10,001 - £25,000	-	1	1
£25,001 - 50,000	-	1	1
£50,001 - £100,000	1	-	1
Total Number of Exit Packages by Type	**1**	**3**	**4**
Total resource cost (£)	£75,000	£57,000	£132,000

Gender Pay Gap

Reporting gender pay gap figures was not formally required due to Covid-19. The reporting schedule has changed and updated reports will be published in October 2021. The latest figures published in 2019 are below:

Figure 3 Gender Pay Gap		
	Mean	Median Hourly Rate
Pay Gap% as at 31st March 2019	18.07	12.18
Pay Gap% as at 31st March 2018	16.78	7.2

Council of Governors (CoG)

Established in 2008, the CoG's primary role is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of Trust members and the wider public.

The CoG's wider statutory duties and how they were actioned during 2020-21, are outlined below:

COG RESPONSIBILITY	ACTIONS IN FY 2021
Approving appointment and, if appropriate, removal of the Trust Chair.	No required actions in year.
Approving appointment and, if appropriate, removal of other Non-Executive Directors.	Approved the appointment of Karen Daber as Non-Executive Director for one three-year term.
Approving changes to remuneration and allowances for the Trust Chair and Non-Executive Directors.	This is discussed as a regular item on the Cycle of Business for the Nominations Committee.
Approving appointment, reappointment, or removal of the Trust's External Auditors.	Electronically approved the appointment of BDO as External Auditors in July 2020.
Approving amendments to the Constitution.	The Constitution is under review.
Approving significant transactions.	No required actions in year.
Receiving the Annual Report and Accounts.	Received at the Annual Members Meeting on 9th September 2020.

CoG Meetings, Governor and Board Involvement

The CoG met in full four times during 2020-21. The Trust Board of Directors is required to attend each CoG meeting and provide commentary on relevant areas of clinical, operational and financial performance.

Governors, members and the wider public attending CoG meetings are given the opportunity to ask questions of any Director on any relevant matter.

The views of Governors, members and the wider public are heard and considered by the Board of Directors through various means, including, but not limited to:

- Attendance at public CoG meetings.
- Attendance at public Board of Directors meetings.
- Governor observers at Board Sub-Committee meetings.
- Governor development sessions.
- Specific Governor Lead roles.
- Governor observers on Non-Executive Director service visits.
- Governor involvement in task and finish groups.
- Governor involvement in stakeholder and interview panels.
- Membership events.
- Attendance at the Annual Members' Meeting.

Development of Strategy and Forward Planning

Routine reports, updates and progress against the Trust's Strategic Plan are received by Governors at CoG meetings, Board of Directors meetings, Governor development sessions and Governor Induction.

Representing the Interests of Trust Members and Wider Public

The CoG established a Sub-Group, the Membership Working Group, to carry out specific duties on its behalf, primarily developing the Trust's Membership Strategy and communications with members and amongst Governors. The Group has a core membership comprising of four Governors, but its meetings are open to all interested Governors. An update from the Group should be provided to the CoG every six months to ensure that the CoG and Board of Directors are sighted on representation of and engagement with Trust members. The Group was stood down during 2020-21 due to the Covid-19 pandemic but will be re-started early in 2021-22.

Composition of the Council of Governors and Meeting Attendance

The CoG is composed of 25 Elected Governors (15 Public, 6 Patient and 4 Staff) and 9 Appointed Governors (5 Stakeholder and 4 Partner). As at 31st March 2021, the CoG had one vacancy in the Patient (Service User, Rest of England) constituency, two Stakeholder vacancies and three Partner vacancies. The CoG is chaired by the Trust Chair and Keith Grimwade is the Lead Governor.

The CoG holds four formal public meetings annually. In 2020-2021, these were held on: 23rd April 2020, 2nd July 2020, 9th September 2020 and 3rd December 2020. Due to the Covid-19 pandemic, all four meetings were held virtually.

Elected Governors:

NAME	CONSTITUENCY OF GOVERNOR	DATE ELECTED	DATE(S) OF RE-ELECTION	CURRENT TERM ENDS	MEETINGS ATTENDED OF 4
Kripa Dwarakanath	Public (Cambridgeshire)	December 2020		December 2023	**1 out of 1**
Andrea Hill	Public (Cambridgeshire)	December 2020		December 2023	**1 out of 1**
Adrian Howson	Public (Cambridgeshire)	June 2018		June 2021	**3 out of 4**
Jeremy Johnson	Public (Cambridgeshire)	December 2020		December 2023	**1 out of 1**
Margaret Johnson *(Note 1)*	Public (Cambridgeshire)	July 2011	May 2014, May 2017	Retired in December 2020	**2 out of 3**
Sarah Jordan	Public (Cambridgeshire)	December 2020		December 2023	**1 out of 1**
Fiona Kerr	Public (Cambridgeshire)	June 2018		June 2021	**0 out of 4**
Stephen Mallen	Public (Cambridgeshire)	June 2018		June 2021	**2 out of 4**
Margaret Peers	Public (Cambridgeshire)	June 2019		Stood down in September 2020	**0 out of 2**
Richard Shorrocks	Public (Cambridgeshire)	December 2020		December 2023	**1 out of 1**
Clare Tevlin	Public (Cambridgeshire)	June 2019		June 2022	**4 out of 4**
Chris Thornhill *(Note 2)*	Public (Cambridgeshire) *(Interim)*	December 2020		June 2021	**1 out of 1**
Maggie Barker	Public (Peterborough)	June 2018		Stood down in April 2020	**0 out of 4**
Pamela Blades	Public (Peterborough)	December 2020		December 2023	**1 out of 1**
Rick Harris	Public (Peterborough)	June 2018		June 2021	**4 out of 4**
John Parkes	Public (Peterborough)	June 2019		June 2022	**1 out of 4**
Maureen Stygall	Public (Peterborough)	December 2020		December 2023	**0 out of 1**
David Westbrook	Public (Peterborough)	June 2019		June 2022	**0 out of 4**

NAME	CONSTITUENCY OF GOVERNOR	DATE ELECTED	DATE(S) OF RE-ELECTION	CURRENT TERM ENDS	MEETINGS ATTENDED OF 4
Helen Brown	Public (Rest of England)	June 2018		June 2021	**4 out of 4**
Jo Griffin *(Notes 1 and 3)*	Patient (Carer, Cambridgeshire)	June 2017	December 2020	December 2023	**2 out of 4**
Keith Grimwade *(Note 1)*	Patient (Carer, Cambridgeshire)	May 2014	May 2017, December 2020	December 2023	**4 out of 4**
Anthony Mitchell *(Note 4)*	Patient (Service User, Cambridgeshire) *(Interim)*	December 2020		June 2021	**0 out of 0**
Hannah Touhey	Patient (Service User, Cambridgeshire)	June 2019		June 2022	**3 out of 4**
Mark Prince	Patient (Service User, Peterborough)	June 2018		June 2021	**2 out of 4**
Ollie Ayres	Staff	June 2019		June 2022	**3 out of 4**
Matthew Barker	Staff	June 2018		June 2021	**3 out of 4**
Norest Mararike	Staff	June 2019		June 2022	**4 out of 4**
Nora O'Shea *(Note 1)*	Staff	June 2017	December 2020	December 2023	**4 out of 4**

Note 1 – Due to the Covid-19 pandemic, the Governor Elections scheduled for June 2020 were postponed to the Autumn and the Governors whose terms were due to expire were asked to continue on an advisory basis. This affected the terms of Margaret Johnson, Jo Griffin, Keith Grimwade and Nora O'Shea.

Note 2 – Chris Thornhill was initially elected as a Governor in the Patient (Service User, Cambridgeshire) constituency, but subsequently moved to the Public (Cambridgeshire) constituency, relinquishing the elected status and becoming an Interim Governor.

Note 3 – Jo Griffin was initially elected as a Governor in the Public (Cambridgeshire) constituency, but was subsequently re-elected to the Patient (Carer, Cambridgeshire) constituency.

Note 4 – Anthony Mitchell was appointed as an Interim Governor in December 2020 on a temporary basis as a vacancy arose due to an Elected Governor moving constituency before the expiry of their term.

Appointed Governors:

NAME	ORGANISATION REPRESENTED	ORGANISATION TYPE	DATE OF APPOINTMENT	MEETINGS ATTENDED OF 4
Graham Wilson	Cambridgeshire County Council	Stakeholder	July 2016	**3 out of 4**
Kathy Hartley	Peterborough City Council	Stakeholder	March 2020	**3 out of 4**
Diana Wood	University of Cambridge	Stakeholder	June 2008	**3 out of 4**
Susie Willis	Care Network Cambridgeshire	Partner	March 2019	**2 out of 4**

Board of Directors Council of Governor Meeting Attendance:

NAME	EXECUTIVE POSITION	MEETINGS ATTENDED OF 4
Julie Spence (OBE)	Trust Chair	4 out of 4
Julian Baust	Deputy Chair / Non-Executive Director	4 out of 4
Jo Lucas	Non-Executive Director / Senior Independent Director	3 out of 4
Brian Benneyworth	Non-Executive Director	4 out of 4
Karen Daber	Non-Executive Director	3 out of 3
Mike Hindmarch	Non-Executive Director	4 out of 4
Prof Peter Jones	Non-Executive Director	3 out of 4
Geoff Turral	Non-Executive Director	4 out of 4
Tracy Dowling	Chief Executive	4 out of 4
Scott Haldane	Director of Finance	4 out of 4
Debbie Smith	Director of Operations and System Partnerships	3 out of 4
Dr Chess Denman	Medical Director	1 out of 4
Rachel Gomm	Director of Nursing, AHPs and Quality	4 out of 4
Stephen Legood	Director of People and Business Development	4 out of 4
Kit Connick	Director of Corporate Affairs	4 out of 4
Gerard Newnham	Director of Transformation	3 out of 4

Governor Elections 2020

Due to the Covid-19 pandemic and with approval from the Board of Directors and ratification by the CoG, the Governor Elections scheduled for June 2020 were postponed to the Autumn and the Governors whose terms were due to expire were asked to continue on an advisory basis for a further six months.

The Elections commenced in September 2020 with Civica Election Services acting as Independent Returning Officer. At the time of election, a total of 12 Elected Governor vacancies existed. The following results of the Elections were published in November 2020 and subsequently ratified by the CoG on 3rd December 2020:

NAME	CONSTITUENCY OF GOVERNOR	TERM OF OFFICE
Kripa Dwarakanath	Public (Cambridgeshire)	First three-year term
Andrea Hill	Public (Cambridgeshire)	First three-year term
Jeremy Johnson	Public (Cambridgeshire)	First three-year term
Sarah Jordan	Public (Cambridgeshire)	First three-year term
Richard Shorrocks	Public (Cambridgeshire)	First three-year term
Pamela Blades	Public (Peterborough)	First three-year term
Maureen Stygall	Public (Peterborough)	First three-year term
Jo Griffin	Patient (Carer, Cambridgeshire)	Second three-year term
Keith Grimwade	Patient (Carer, Cambridgeshire)	Third three-year term
Chris Thornhill	Patient (Service User, Cambridgeshire)	First three-year term
Nora O'Shea	Staff	Second three-year term

Nominations Committee

The Nominations Committee, a standing committee of the CoG, held two meetings during 2020-2021, on:
- 9th April 2020; and
- 3rd December 2020.

Membership of the Committee comprises:

- The Trust Chair or Deputy Chair (unless standing for appointment).
- x3 Elected Governors (one of these to be the Lead Governor by virtue of office).
- x1 Appointed Governor.

The CoG has appointed Jo Lucas as Senior Independent Director. Working with the Lead Governor, the Senior Independent Director appraised the Trust Chair's performance and reported to the April 2020 CoG meeting.

The CoG approved the appointment of Karen Daber as Non-Executive Director for one three-year term at its July 2020 meeting. The CoG also electronically ratified extensions of the terms for the Trust Chair, Julian Baust, Prof Peter Jones and Jo Lucas in April 2020 and Brian Benneyworth and Geoff Turral at its December 2020 meeting.

Register of Interests

All Governors are required to declare any (potential) conflicts of interest at the time of their election and annually thereafter. Governors are also given the opportunity to declare any new interests at the beginning of every CoG meeting.

The CoG Register of Interests is maintained by the Trust Secretary. It is available for public inspection via the website and also upon written request to the following address:

Trust Secretary
Cambridgeshire and Peterborough NHS Foundation Trust
Elizabeth House, Fulbourn Hospital
Fulbourn, Cambridge CB21 5EF

The Trust's website provides further details about the CoG, who the current Governors are and how to contact them, upcoming CoG meetings, and information on becoming a Governor:
https://www.cpft.nhs.uk/council-of-governors

Trust Membership

The Trust's membership is divided into three constituencies:

- Public
- Patient
- Staff

Public Membership

Any individual aged 14 years or over can be a member of the Public constituency, assuming:

- They live within the electoral areas of Cambridgeshire County Council.
- They live within the electoral areas of Peterborough City Council.
- They live in the rest of England.

This is subject to the exclusions for membership set out in the Trust Constitution.

Patient Membership

Any individual aged 14 years or over can be a member of the Patient constituency, assuming:

- They are or have been a user of any of the Trust's services.
- They are or have been a Carer of a patient that has used the Trust's services.
- They live within the electoral areas of Cambridgeshire County Council, Peterborough City Council and the rest of England.

This is subject to the exclusions for membership set out in the Trust Constitution.

Staff Membership

All staff who have a contract of employment with the Trust are automatically members unless they choose to opt out.

Membership Numbers

As at 31st March 2021, the membership numbers reported as follows:

- Public – **1,129** *(2020 – 1,130)*
- Patient – **274** *(2020 – 277)*
- Staff – **4,251** *(2020 – 5,237).*

Membership Benefits

By becoming a member of the Trust, individuals are eligible to receive the following benefits:

1. An opportunity to help **influence** the future of your local health services
2. Receive **news and updates** through our website and newsletter
3. Be invited to attend member **events/training** and learn about mental health, physical health and general wellbeing
4. Take part in surveys **and consultations** on our services
5. Support our campaigns to promote good health and **fight mental health stigma**
6. Vote for or put yourself forward as **a Governor** of the Trust
7. Register to receive **NHS discounts**

NHS Foundation Trust Code of Governance

The Code of Governance is best practice guidance and is designed to assist NHS Foundation Trust Board of Directors in improving their governance practices. The code sets out a common overarching framework for the corporate governance of NHS Foundation Trust's and complements their statutory and regulatory obligations.

Cambridgeshire and Peterborough NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foundation Trust Code of Governance is based upon principles of the UK Corporate Governance Code issued in 2012.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation that justifies departure from the Code. The Board of Directors considers that, overall, it complies with the main and supporting principles outlined within the Code of Governance. The main exceptions being:

B.1.2 The Trust Board of Directors currently consists of seven Non-Executive Directors (including the Trust Chair) and one advisory NED, and eight Executive Directors. Non-Executive Directors are considered by the Board to be independent.

B.1.3 The Trust's Director of People and Business Development, Stephen Legood, is an appointed Partnership Governor for Cambridge University Hospitals NHS Foundation Trust.

B.3.3 Scott Haldane, Director of Finance, is a Chair and Board Member of Edinburgh Leisure; a Lay Member of Court, Chair of the Finance and Audit Committee and Chair of the Joint Policy Planning and Resourcing Committee for the University of Stirling; and a Trustee, Non-Executive Director and Chair of the Business, Information, Finance and Performance Committee for Ambient Support.

Reference	Summary
A.1.1	The Council of Governors appointed a Senior Independent Director. In certain circumstances, the Senior Independent Director will work with the Trust Chair and other Directors and Governors (as necessary) to resolve any significant issues. The Trust has in place a Scheme of Delegation which outlines the types of decisions to be taken by the Board of Directors, Executive Management and Council of Governors.
A.1.2	Contained within the Directors' Report.
A.5.3	Contained within the Directors' Report.
B.1.1	Contained within the Directors' Report.
B.1.4	Contained within the Directors' Report.
B.2.10	Contained within the Directors' Report.
B.3.1	Contained within the Directors' Report. These commitments are also captured within the Directors' Register of Interest, and upon appointment to the Trust.
B.5.6	Contained within the Directors' Report.
B.6.1	Contained within the Directors' Report.

B.6.2	There was no external evaluation of the Board of Directors during 2020-21.
C.1.1	Contained within About This Report, External Auditor's Report and the Annual Governance Statement.
C.2.1	Contained within the Annual Governance Statement.
C.2.2	Contained within the Annual Governance Statement.
C.3.5	Not applicable.
C.3.9	Contained within the Directors' Report.
D.1.3	Not applicable.
E.1.4	Contained within the Directors' Report.
E.1.5	Contained within the Directors' Report.
E.1.6	Contained within the Directors' Report.

NHS England/Improvement's Single Oversight Framework

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

Segmentation

The Trust has been segmented as a '2' in NHS Improvement's assessment process. This segmentation information is the Trust's position as at 31 March 2021. Current segmentation information for NHS Trust's and Foundation Trust's is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources rating is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 scores				2018/19 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	**Capital service capacity**	**1**	**3**	**3**	**3**	**1**	**3**	**2**	**2**
	Liquidity	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
Financial efficiency	**I&E margin**	**1**	**2**	**2**	**2**	**1**	**3**	**2**	**2**
Financial controls	**Distance from financial plan**	**1**	**1**	**1**	**1**	**1**	**3**	**1**	**1**
	Agency spend	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
Overall scoring		**1**	**2**	**2**	**2**	**1**	**2**	**1**	**1**

Serious Incidents (SI) involving data loss or confidentiality breaches

SI LEVEL	FY2020-21	FY2019-20	FY 2018–19	FY 2017-18
Level one	0	4	9	26
Level two	2	5	3	5

Two incidents graded as *Level Two* SIs were reported to the Information Commissioners Office (ICO), there were no incidents graded as *Level One* SIs followed the Clinical Review process.

As a result of the Trust investigations into the incidents and mitigations put into place confirmation was received from the ICO that no action would be taken in relation the reported incidents.

All Information Governance incidents are reported using the internal incident reporting system. The Information Governance team reviews each incident against the *NHS Digital Guide for the Notification of Data Security and Protection Incidents.*

Incidents that reach the threshold for reporting are entered onto the *Data Security and Protection Toolkit* reporting tool.

All incidents were thoroughly investigated, and measures were put in place to learn and share, to prevent and minimise recurrence.

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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 Cambridgeshire and Peterborough 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 Cambridgeshire and Peterborough NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The Purpose of the System of Internal Control

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

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

Capacity to Handle Risk

The leadership structure within each of the Directorates (including Corporate services) has been designed to support comprehensive management of the Directorate risks including those risks that impact on key overarching and strategic risks for the Trust. All Directorates (and individual teams within each Directorate) are expected to identify, understand and mitigate local risks, ensuring that these are reviewed and managed at various levels within the organisation, depending on the mitigated risk score.

The Trust produces a corporate risk profile, which is logged on an electronic system (Datix) and mapped to each Directorate. Each Directorate risk register is reviewed and updated monthly by the respective Associate Directors of Operations and Clinical Directors. This is then reviewed at the main performance management forum for Directorates; the monthly Performance and Risk Executive (PRE) meetings where key risk issues are discussed.

The Executive Directors hold each Directorate Leadership Team to account for their management and mitigation of these risks and to understand the collective risk on the organisation. This forum is also an opportunity for key directorate-level issues that may pose a risk to the achievement of the Trust's strategic objectives to be added to the Operational Risk Register and, where appropriate, the Board Assurance Framework (BAF).

Another key governance forum where information is shared between Directorates and the Executive Directors is the monthly Trust Leadership Team (TLT). This meeting is attended by Clinical Directors, Associate Directors of Operations, Directorate Nurse Leads, Associate Directors of Corporate Functions and Executive Directors. It is used as an information sharing and problem-solving forum, where good practice relating to management and
mitigation of risks is shared and cross-Directorate learning can take place. The Trust Leadership Team reports to the Board through the Chief Executive's report.

The Trust's Operational Risk Register and Board Assurance Framework includes clinical and non-clinical risks. Together,

these registers reflect the current risks facing the organisation, which are assessed and mitigated based on the Board of Directors' collectively agreed 'risk appetite' and in accordance with the Trust's Risk Management Framework. Risk is also regularly reviewed in the following formally constituted subcommittees of the Trust Board:

- Business and commercial risks are reviewed by the **Business and Performance Committee.**
- Clinical risks affecting quality and safety are reviewed at the **People, Safety and Quality Committee.**
- The **Audit and Assurance Committee** reviews the Trust-wide Board Assurance Framework and Risk Register at each of its meetings and has oversight of the risk discussions that have taken place at the above two Committees.

The Chairs of each of these Committees provide an update and overview to the Trust Board, in line with the agreed cycle of business.

All staff within the Trust receive risk management training at Trust induction, and there is a 'Working Safely' module within the Mandatory Training programme, in addition to Risk Assessor Training that is available to all staff. Further bespoke training is available for teams on request. This rigorous approach highlights the Trust's commitment to delivery of an effective risk recognition, management, mitigation and reporting system at both operational and strategic level.

The Risk and Control Framework

The Trust's Risk Management Strategy describes the organisation's values and strategic priorities against which key risks are identified and monitored. Key priorities for the management of those risks are clearly defined, alongside performance measures against which the Trust will measure its success in the management and mitigation of risk.

The Trust's strategic aims define the Board of Directors' vision of how the organisation's services should be delivered; they are the measure by which risk is assessed. These aims reflect the commitment made by the Trust to enhance stakeholder confidence in quality, safety and governance.

To enable the Trust to measure how successfully it is managing risk, a number of risk indicators are used. The Board Assurance Framework ("BAF") and Operational Risk Register ("ORR") are updated monthly as 'live' documents to ensure they reflect up to date risks and mitigations. Operational risks are escalated monthly through Directorate Performance Risk Executive (PRE) meetings as described above, with appropriate actions discussed and agreed to reduce or manage operational risks.

Together the ORR and BAF set out the key risks to the achievement of the Trust's strategic objectives and the mitigations against each risk. These documents provide a simple, comprehensive, but constantly evolving document to inform discussions regarding the management of strategic risks that could affect the delivery of strategic aims. At the end of each Trust Corporate Meeting the final agenda item is to consider whether any issues discussed at the meeting need to be included in the BAF or ORR, which has proved to be an effective way to ensure that the strategic and operational discussions happening at these meetings are reflected in the BAF/ORR.

The relevant sections of the BAF/ORR are regularly reviewed by Board sub-committees to seek assurance on the effectiveness of controls in place to manage the strategic risks via the relevant Executive risk owner. In addition, annual internal audits are used to evaluate the successful day-to-day management of risk by the Trust and there is a detailed annual review by the Trust Leadership Team and the Board of all the risks on the Board Assurance Framework to ensure that these appropriately reflect the current risk status and that the BAF/ORR is a 'live' document.

In response to the Covid-19 pandemic, the Trust implemented its command-and-control framework and in turn established an incident specific risk register. Risks have been regularly overseen by the Gold command tier throughout the pandemic, and reported subsequently to the Board of Directors in addition to the Board Assurance Framework.

Together, the Business and Performance Committee and the People, Safety and Quality Committee hold the Trust to account for performance against quality and governance targets. Feedback from the Performance and Risk Executive meetings is shared with both committees. The Finance Report is considered by the Business and Performance Committee before being presented to the Board, together with the Integrated Performance Report, which incorporates clinical and other performance targets.

Business and Performance Committee:

1. Considers and comments upon revisions to the Trust's Risk Management Strategy and supporting policies and procedures.
2. Receives the Risk Register in order to consider and provide views regarding financial and business risks prior to reporting to Trust Board.
3. Considers and highlights to the Trust Board, any areas of business, performance or financial risk that may escalate and impact upon delivery of the annual plan and Trust objectives.
4. Receives and reviews Commissioning, Business Development and Capital spend plans and reports.

People, Safety and Quality Committee:

1. Ensures the Trust Board is sighted on areas of good practice and emerging risks in relation to clinical governance and ratifies the policy assurance process.
2. Leads on compliance with the CQC fundamental standards for quality and safety and including preparation for any CQC assessments and actions to be taken following the inspection.
3. Leads on the implementation of the Trust's Quality Strategy and ensures issues that impact on the quality of our services are dealt with as they emerge.

This approach ensures the Board develops a better understanding of governance issues, which may not necessarily be reflected in performance targets.

Audit and Assurance Committee:

1. Has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives.
2. Is comprised of three Non-Executive Directors, including a Chairperson, who is required to have significant recent financial experience.

Quality and Compliance Executive:

The Quality and Compliance Executive (QCE) is responsible for considering operational responses to Serious Incident reviews, Infection Control and Safeguarding, as well as 'Freedom to Speak-Up' (whistleblowing) and a 'Stop the Line' initiative (see below). Risk and safety priorities for the year were to continue to strengthen and improve processes, systems and practices and to better support staff to identify and effectively manage risk. The objective being to focus on continued improvements in the quality and safety of Trust services.

The Quality and Compliance Executive has over-arching responsibility for monitoring quality and compliance matters in the Trust, particularly in relation to patient safety, clinical effectiveness, patient experience and risk management. It also has delegated responsibility over ensuring Trust compliance with the CQC standards, as well as identifying and acting on cross-cutting themes across the three clinical directorates.
In addition to the output from the PRE-meetings, the Executive Directors are held

to account by the Non-Executive Directors as described above, through the People, Safety and Quality Committee and Business and Performance Committee. The Non-Executive Directors are held to account for their role in scrutinising performance by the Council of Governors, both informally on an on-going basis, and formally at the quarterly Council meetings. Control measures are also in place to ensure that the organisation's obligations under Equality, Diversity and Human Rights legislation are complied with.

We have a range of mechanisms to provide the Trust Board with assurance in respect of compliance with the CQC registration requirements. This includes certain metrics within the Integrated Performance Report (IPR) and the more detailed Quality and Safety Report; both produced on a monthly basis. Other sources of assurance include internal patient, carer and staff surveys, as well as bespoke assessments tools such as our Quality Improvement and Evaluation Tool (QuIET) which monitors practice around care planning standards. We also use intelligence from safeguarding and Serous Incident (SI) investigations, complaints, compliments, and concerns raised from the Freedom to Speak Up Guardian process; as well as through clinical audit and service reviews, NICE scoping and gap analysis, accreditations, and other benchmarking information.

Within the Clinical Directorates, there is a programme of regular Quality Assurance and Engagement Visits (QAEV) that have been designed around the CQC Key Lines of Enquiry (KLoE). Emerging themes are triangulated against known data and other information to support the development of improvement actions.

Periodic internal reviews of services are conducted, having been commissioned by the Board, as well as a planned series of Executive and Non-Executive Director visits to facilities as part of ensuring the quality of services is maintained.

Specifically, risks to data security are managed via the normal governance structure and reporting process. The Information Governance Steering Group is responsible for overseeing Information Governance within the organisation and is chaired by the Director of Finance in his capacity as Senior Information Risk Officer (SIRO). During the year information governance has also been reviewed as part of the process of preparation for the Data Security and Protection Toolkit (formerly known as the Information Governance Toolkit) submission. The Trust successfully recorded compliance with the NHS Digital Information Governance requirements.

The Trust is a committed partner in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP). As a result, the Trust is actively involved in the System-wide governance arrangements that support the Integrated Care System. The STP progress and initiatives are managed through Board Sub-Committee structures. The Chief Executive updates the Board in her report. Any risks associated with delivery against STP projects are captured within the Board Assurance Framework, with the risk being recognised as the impact on the Trust's own ability to achieve its statutory duties. Whilst all attempts are made to balance organisational risks against any risks pertaining to the wider System, ultimately the Chief Executive is accountable for discharging the Trust's own responsibilities as defined in statute.

Description of Risk Mitigation

The organisation's major risks, as identified within the Board Assurance Framework and Operational Risk Register are reported to the Board of Directors at each meeting. Details of our risks on the BAF and ORR are detailed in pages 17 and 18 of this report.

Equality Impact Assessments (EIA)

An Equality Impact Assessment (EIA) is a tool aimed at improving the quality of local health services by ensuring that individuals and teams think carefully about the likely impact and consequences of their work on

different communities or groups when redesigning services and reviewing strategies and policies.

To facilitate the integration of EIAs into core Trust business, a policy for the production and management of Policies and Procedural documents is in place. This specifically requires those developing policies to have regard to the impact of their policy – and therefore the operation of the organisation – on equality. This takes the form of a statement within each policy relating to whether or not an equality assessment has taken place and, if it has been judged that one is not necessary, the reasoning for this. This cascades through the development and revision of all policies, underlining the Trust's commitment to equality.

Between 1st April 2020 and 31st March 2021, the Trust has trained 12 new Diversity Champions to help support the Equality Diversity and Inclusion (ED&I) Team. Capacity constraints, as a result of the pandemic, has resulted in reduced training, with each new recruit receiving ED&I overview training as part of their introductory meeting, and five receiving detailed ED&I training.

Incident Reporting

Incident reporting is openly encouraged throughout the Trust. A Serious Incident (SI) Group is in place, chaired by the Director of Nursing, AHPs and Quality, to review all incidents and to ensure learning is shared throughout the organisation. This information is triangulated with complaints and other patient experience information at a specific Triangulation Meeting and at the People, Safety and Quality Committee, to ensure that themes can be identified across the Trust. The Board receives regular reports throughout the year on Serious Incidents.

Stop the Line

The Trust has in place an innovative patient safety initiative called 'Stop the Line'. The initiative is driven by proactive Executive-led communication and encourages staff at all levels to 'call a halt' to any proceeding that gives them cause for concern, from a safety or quality perspective. From the most junior to the most senior members of staff 'stopping the line' is widely recognised throughout the Trust as a legitimate, non-confrontational way to pause proceedings and re-evaluate the situation. A structured process is in place, with rapid escalation of issues to divisional leadership and the Executive Directors, with an Executive response provided within 24 hours. The 'Stop the Line' process was paused during the Covid pandemic.

Freedom to Speak Up

The Freedom to Speak Up process has continued throughout the pandemic. The Director of Nursing, AHP and Quality is the Executive Lead for Freedom to Speak Up, there is also a designated Non-Executive Lead. There is an established governance process in place in the Trust for escalating concerns to senior leaders and for reporting to the Trust Sub-Board and Board of Directors. The Freedom to Speak Up Guardian has regular meetings with the Trust Chief Executive Officer, Executive Lead for Speaking Up and the Director of People and Business Development to discuss emerging themes from Speaking Up and Trust-wide developments.

Bi-monthly meetings are held with colleagues from HR, Equality and Diversity, Staffside and Staff Well-Being teams to triangulate common themes and collaborate on improvement actions. Additionally, a local Freedom to Speak Up Guardians network has been established to offer peer support and to share learning.

Freedom to Speak Up is a standing item on the Trust Leadership Team agenda. In addition, the Public Board receive a regular Safer Staffing report for all bed-based services, highlighting exceptions and possible impact on patient care. This provides figures and analysis of the RNs and HCAs monthly average fill rates for day and night shifts, where the figures fall below or above threshold (i.e. below 80%

and above 120%). Data is derived from the Trust's live on-line safer staffing reporting system, entered at ward level and collated centrally. This system was originally based on the Hurst Multiplier Tool. Information is triangulated with other data including: Datix reports/complaints regarding inpatient staffing; deep dives; Stop the lines; noting changes e.g. bed reconfigurations, skill mix; recruitment. The monthly Safer Staffing Report also includes a narrative regarding any staffing hotspots and Directorate plans to mitigate the risks.

The Trust has committed to implementing the SafeCare module on Healthroster to manage and report demand versus acuity for inpatient areas. This shows live data based on actual patient acuity per shift, clear visibility across the organisation of real-time staffing levels, identifying hot spots and potential risk, thereby enabling informed decision making.

Care Hours Per Patient Day - MHOST

The Trust's Performance Team continues to submit Care Hours per Patient Day (CHPPD) data to NHSI every month. The CHPPD data is designed to allow for a national picture of how nursing staff are deployed on inpatient units and for Trust's to be able to compare their staff deployment with similar Trust's. CHPPD also includes AHP staff, with the data for this aspect of the return currently being drawn from the 'Staff in Post' list.

The Trust has its own licences for the Mental Health Wards and Physical Health Wards. This process of calculating the CHPPD sits within the SafeCare module of the Health Roster system – Allocate.

MHOST covers all mental health wards (including Tier 4, Older People, Eating Disorders and forensic). The acuity tool for LD is currently in development by Imperial Innovations and as at 20/05/2021 is still not available to procure. The OPAC Physical Health wards will be utilising the Shelford Nursing tool.

The Children's Directorate (Tier 4 wards) are now live on SafeCare and have been inputting data and utilising the system since March 2021.

OPAC Physical Health wards will be the next patient group scoped for rollout, which is planned for June 2021.

A project group overseeing these developments is being led by the Associate Director People and Business Development and the Director of Nursing and Quality. Updates on the project are being reported to the Transformation Board and People Board.

Safer Staffing

On a monthly basis the Trust reviews vacancies. Any areas that cause concern are analysed in detail to identify and develop specific plans to recruit or cover vacancies. The Trust's temporary staffing service will also support covering gaps via the bank and, if required, agency to ensure there are enough staffing numbers in place.

In relation to developing workforce safeguards, the process in place for safer staffing is in line with the principles stated and this will be improved with the implementation of Safecare within the rostering system. The Trust continues to develop the use of rostering to incorporate job planning for staff. This has already commenced with medical staff and the plan is to progress to other staff groups. The Trust has submitted an operational plan to NHSI which contains 12-month workforce planning figures. Further work is starting to develop a Trust and system-wide longer-term workforce plan.

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

As an employer with staff entitled to membership of the NHS Pension Scheme,

control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

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

Review of economy, efficiency, and effectiveness of the use of resources

The key processes that have been applied to ensure that resources are used economically, efficiently and effectively across the Trust involve a hierarchy of scrutiny of the use of resources throughout the Trust. The Audit and Assurance Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The Committee receives and considers reports from both Internal and External Auditors and approves the Annual Report and Accounts for submission to the Board of Directors. The Committee exercises Non-Executive scrutiny over the Executive Directors for the efficient use of public funds.

The Audit and Assurance Committee carries out an annual self-assessment of its performance and reports this formally to the Trust Board. Any changes that may be deemed necessary to its terms of reference are also made to reflect best practice.

Internal Audit presents a proposed schedule of audits to the Committee, which is then agreed, executed and reported upon. Via the Committee, the Executive Directors are held to account for any actions arising because of audit findings through challenge at the Committee. In addition, each executive attends the meeting by invitation, to update on issues within their area.

The Audit and Assurance Committee reports to the Board of Directors and the Board seeks assurance from the Committee that it is satisfied that the Trust is using resources in an efficient and effective manner.

Data Quality and Governance

Cambridgeshire and Peterborough NHS Foundation Trust has an Information Governance Strategy in place which identifies how the Trust ensures information is appropriately and effectively managed, properly controlled, is accessible and available for use. The Trust has an Information Governance Steering Group which reports into the Business and Performance Committee.

A risk-assessment process is embedded to ensure that the severity of any information governance incident is assessed consistently, with appropriate and timely action taken to address any associated risks. Any incidents relating to actual or potential breaches in confidentiality involving personal identifiable information, including data loss, are reported appropriately through the information governance assurance framework. Two data-related incidents were reported externally to the Information Commissioner's Office (ICO) for 2020-2021. The ICO closed the two incidents stating no further action was required due to the remedial and proactive measures put in place by the Trust.

In respect of other non-reportable personal data-related incidents experienced during

the year, we have carried out investigations to ensure that the root causes are properly understood and addressed. In addition, where necessary, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions we have taken to prevent recurrence.

Information governance risks are managed as part of the integrated Risk Management Strategy and assessed using the Data Security and Protection Toolkit. The Trust has a Senior Information Risk Owner (SIRO) (Executive Director of Finance), who reviews all confidentiality and data protection issues with the Information Governance Manager and Caldicott Guardian (Executive Medical Director).

The deadline for submission of organisations self-assessment of the Data Security and Protection Toolkit has been extended until 30th June 2021 compliance with National Data Opt out has been extended to 30th September 2021. The Trusts self-assessment will be published as standards met. The Trust published a baseline self-assessment on 26th February 2021.

The Trust's Internal Auditors conducted an audit of the Trust's Data Security and Protection Toolkit self-assessment 16 Data Security Standards were selected for sample testing The Trust is awaiting the final report from the auditors, based on our response to the draft audit, assurance rating has not yet been given.

Improvement Board

The Trust remains committed to a strategic and values-led approach to improvement ensuring that this is sustainable and utilises the skills and contribution of all staff, to deliver excellence in every aspect of our service delivery.

At the beginning of the year, the Trust reviewed its approach to quality improvement and rebranded this as 'Improvement Board'. This reinforces the message that our pursuit for quality is a continual cycle of improvement.

Our established Improvement Board will act as a collaborative steering group with the responsibility for developing and embedding a culture of continuous service improvement and benefits realisation within the Trust.

Staff empowerment and co-production are key to our approach and underpin our programme of improvement, building on our strong track record on research, clinical audit, service improvement and transformation and working in close partnership with our patients, their families and carers and our staff.

We continue to deliver the Quality, Service Improvement and Redesign (QSIR) programme developed by NHS Improvement (NHSI) and delivered through the ACT Academy, to develop quality and efficiency capability across the Trust.

Since 2019-20 when the programme began the Trust has supported 26 staff members to complete the national QSIR course and six have successfully completed the QSIR College exams to become QSIR associates. This has enabled the Trust to establish a QSIR Faculty to deliver the training in-house.

As of March 2020, 25 staff have completed the first in-house training cohort bringing the total QSIR practitioners in CPFT to 51. Over the past year QSIR delivery has been paused due to restrictions on face-to-face assessments and we are currently developing plans with System partners to re-start delivery of our QSIR training for future cohorts. In the meantime, we have continued to promote our two-hour introduction session in QI to patients and carers.

The Trust's Quality Improvement Support Team has been in post since August 2019. In addition to running the QSIR Faculty, the team also provides support to staff from across the Trust's clinical and non-clinical services with their QI projects.

The continuous service improvement work is aligned to both internal improvement objectives linked to the over-arching quality strategy, as well as, beyond the Trust's organisational boundaries to encompass System wide improvement objectives.

Moreover, the Trust continues to establish links with other organisations undertaking continuous service improvement and are part of the network of Trust's who have adopted QSIR methodology.

Annual Quality Report

Changes to the Quality Report introduced in 2020 in response to the Covid-19 pandemic remains in place. Whilst the deadline of 30th June for Quality Accounts is specified in Regulation, the Department of Health and Social Care is reviewing whether the deadline should be changed for 2020-21 (to be amended when updated guidance is published).

There is no requirement for NHS Foundation Trust's to include the quality report in the annual report, however they are encouraged to include the additional quality report content in their Quality Accounts. In addition, there is no formal requirement for NHS Foundation Trust's to commission external assurance on its quality report for 2020-21. As in the previous year, the Trust will take a light touch approach to the preparation of the report where necessary, to take account of the ever-changing priorities of clinical services and the Trust as a whole in response to Covid-19.

It is important to note that the priorities of the services throughout this period have been focused on the management of the impact of Covid-19 and continuing efforts to provide high quality care to the people who use our services and the wider population in our health economy, in collaboration with our partners and stakeholders. Needless to say, the over-arching quality objectives set out in the Trust's Quality Strategy is still around *improving health outcomes, reducing levels of harm, improving experience of care and developing and supporting our staff*.

The Trust has maintained robust, albeit scaled down, governance processes in line with government guidelines throughout the year to ensure data and its associated information relating to the Trust's activities and performance continue to be documented, scrutinised and reported upon accurately and in a timely manner through the Trust's reporting structures.

The People, Safety and Quality Committee (formerly Quality, Safety and Governance Committee) has Board-delegated responsibility for receiving and scrutinising data and information, as well as providing guidance and direction relating to clinical quality and safety and making recommendations to the Trust Board on actions required to improve our services. At directorate level, data is reported and discussed at the Quality & Safety (QS) meetings and Directorate Management Team (DMT) meetings, temporarily paused during Phase 1 of the pandemic and reinstated later in the year. Clinical services continue to be held to account through the monthly Performance & Risk Executive (PRE) meetings.

In response to Covid-19 and in line with national guidance, the Trust entered into full Incident Command and Control (ICC) status throughout the whole organisation at the start of the pandemic. This consisted of the Incident Control Centre (ICC) supported by Bronze, Silver and Gold command structures. The Director of Operations and System Partnerships was identified as the Covid Director, with other members of the Trust's leadership team allocated specific roles within this structure. These arrangements were integrated with System wide working across the STP as the parallel tracks of Covid response and routine service delivery were expected to run alongside for the remainder of this financial year.

Board members were kept informed of progress and issues via the Staff News, through virtual weekly meetings of Non-Executive Directors with the Chief Executive and accompanied by the Lead Governor, and at Committee and Board meetings which were streamlined to focus on highlights and exceptions ensuring that focus is maintained on key areas that require oversight and decision-making. In addition, Non-Executive Directors had direct oversight of Gold command meetings and continued to undertake virtual service visits with executive colleagues.

Considerable work undertaken in the previous year on the Trust Integrated Performance Report (IPR) and Quality & Safety Report (QSR) to map the quality and performance indicators against the CQC Key Lines of Inquiry (KLoEs) and the quality priorities of the Trust were maintained, maximising use of statistical process control charts (SPC) ensuring quality of reporting and allowing us to focus our attention and resources on areas that matter.

Directorate dashboards are in place to ensure each clinical team has its own set of quality measures and performance indicators that inform decision making and service developments. Quality, safety and clinical governance data is collected, triangulated and reported monthly in line with the Trust's governance framework.

We provide our staff with training, development and support to enable them to effectively discharge their duties and responsibilities, and the Trust has policies and procedures that provide staff with guidance for the delivery of care in line with national guidance and evidence of best practice. In order to prioritise the delivery of front-line services during the first wave of Covid-19, active mandatory training compliance monitoring and automated staff training reminders were paused from March to August 2020 in line with national guidance.

In August 2020, Trust induction was moved online and essential face to face training was recommenced, such as the Medical Emergency Response Course (MERC)/Basic Life Support, Moving and Handling and Prevention and Management of Violence and Aggression. Active training compliance monitoring and staff training reminders were restarted at this point. The Learning & Organisational Development team increased the availability of the Microsoft Office 'Teams' based training to cover key areas, including use of the Mental Health Act, Mental Capacity Act and Suicide Mitigation. The team has also focused on ensuring that staff subject to Covid redeployment and new starters had priority access to face-to-face mandatory training required for role in strict accordance with IPAC guidance including limited capacity.

We have a range of processes in place to monitor compliance with evidence-based quality standards and the Trust's policies and procedures, as well as our progress in meeting our targets and objectives. These include patient, carer and staff surveys and feedback, incidents and complaints, as well as regular service reviews, among others. It is, however, worth noting that some of these were either paused or maintained at a reduced level during Phase 1 in line with national guidance.

Whilst initially paused during Phase 1, the Trust maintained its programme of national, local and service level clinical and non-clinical audit (both internal and external) to examine our compliance with standards of practice and service delivery and identify areas for improvement, particularly in relation to new ways of working introduced in response to Covid-19.

A number of our services are accredited under the Quality Improvement Network and other accreditation bodies, and we have continued to take part in national benchmarking activities throughout the pandemic. These provide us with a view of our performance and level of compliance with the CQC regulation requirements.

The Trust is fully compliant with the requirements of the Care Quality Commission (CQC) and retained its rating of 'Good' from the inspection carried out in May-June 2019. In July 2019, the Trust received a Section 29A Warning Notice in relation to the seclusion environment and paperwork, and fire safety issues. We developed and implemented improvement actions to address the concerns. On 6 April 2020, the CQC formally confirmed that the Trust had demonstrated sufficient progress for them to consider that the requirements of the warning notice had been met.

During 2020-21, the Care Quality Commission (CQC) carried out three focused reviews of the following areas during the year:

- Infection Prevention and Control (IPC), including its compliance with the Public Health England IPC Board Assurance Framework on 29 July 2020.
- Medicines Management arrangements on 1st September 2020.
- Blanket Do not Attempt Cardiopulmonary Resuscitation (DNACPR) on 25th November 2020.

In addition, the CQC also carried out a Trust level review under the new Transitional Monitoring Approach (TMA) on 8th March 2021.

The reviews resulted in very positive outcomes and identified numerous areas of good practice.

We employ a range of measures to ensure open and effective communication with our staff and promote engagement and ownership of matters that are important to the Trust, which have been increased and strengthened during the pandemic.

The processes and measures described above provide the Board with assurance that appropriate governance processes have remained in place throughout the pandemic and that the Trust continues to provide safe, high quality care to the people who use our services.

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 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 result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, the Business and Performance Committee and the Quality, Safety and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent, effective controls which enables risk to be assessed and managed.

The Directorate management teams have processes in place to ensure that whilst risks can be escalated to the Board through the Directorate, services are supported to manage their own risks where appropriate.

The Trust has a comprehensive Programme of clinical audit, service evaluation / development and other projects using quality improvement methodologies. The list of projects includes national mandatory and CQUIN audits, Trust and service-specific priorities, as well as those requested by clinicians; and are based on evidence-based standards. The programme is developed in collaboration with the clinical Directorates to ensure it meets the requirements of the Trust and objectives of the services. The outcome of the audit projects and actions agreed are reported to the Directorates through the Directorate Management Team (DMT) meetings, and to the Quality, Safety and Governance Committee through quarterly reporting. Risks of possible non-compliance with quality standards and regulations are highlighted, as required. Completion of actions is monitored through the same process.

Internal Audit

Internal Audit has reviewed and reported on systems of internal control, governance and risk management processes based on an internal audit plan approved by the Audit Committee. Internal Audit's work included identifying and evaluating controls and testing their effectiveness, in accordance with Public Sector Internal Audit Standards. Where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management. Internal Audit reports to the Audit Committee on management's progress in implementing agreed recommendations. The Trust receives Internal Audit Services from RSM Risk Assurance Services

The Head of Internal Audit Opinion (HoIAO) is set out below:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

The Head of Internal Audit considered a range of factors and findings in coming to an overall opinion, having issued seven final assurance opinions and one final advisory review for the year. Of these, there were two substantial assurance, four reasonable assurances and one partial assurance report across the areas of internal audit work undertaken.

Conclusion

As Accounting Officer and based on the review process outlined above, I conclude that the Trust has identified and has taken the necessary action on the control issues during the year which have been identified in detail in the body of the Annual Governance Statement above.

This Annual Governance Statement is signed by the Chief Executive as Accounting Officer.

Tracy Dowling
Chief Executive

25th June 2021

END OF SECTION 2: Accountability Report

The Trust's Auditors have reviewed the Accountability Report for consistency with the Financial Statements.

Tracy Dowling
Chief Executive

25th June 2021

Voluntary Disclosures

Freedom to Speak Up

In response to the Freedom to Speak Up Review by Sir Robert Francis in 2015; all NHS Trust's in England are required to have a Freedom to Speak Up Guardian. This key role contributes to the development of an open organisational culture by:

- Protecting patient safety and quality of care.
- Improving the experience of everyone who works in health and care; and
- Promoting learning and improvement.

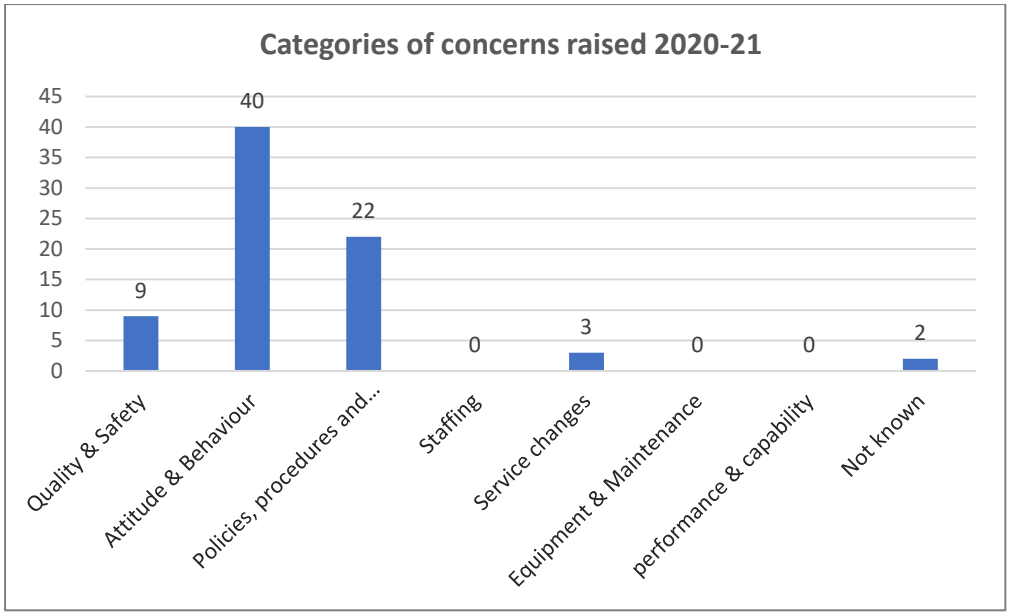
By ensuring that:

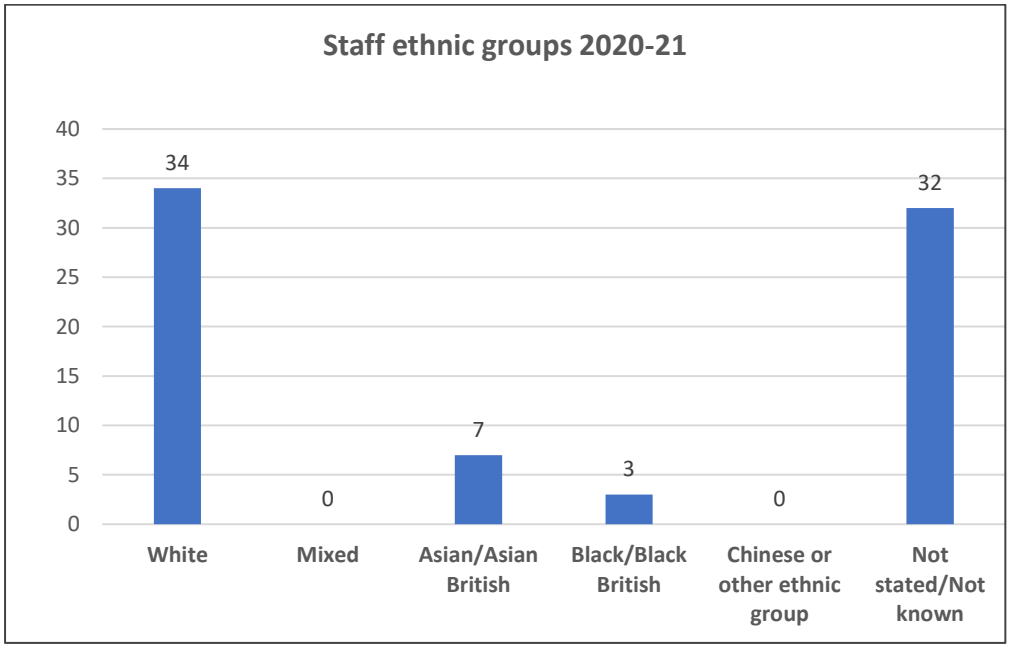
- Workers are supported in Speaking Up.
- Barriers to Speak Up are addressed.
- A positive culture of Speaking Up is fostered.

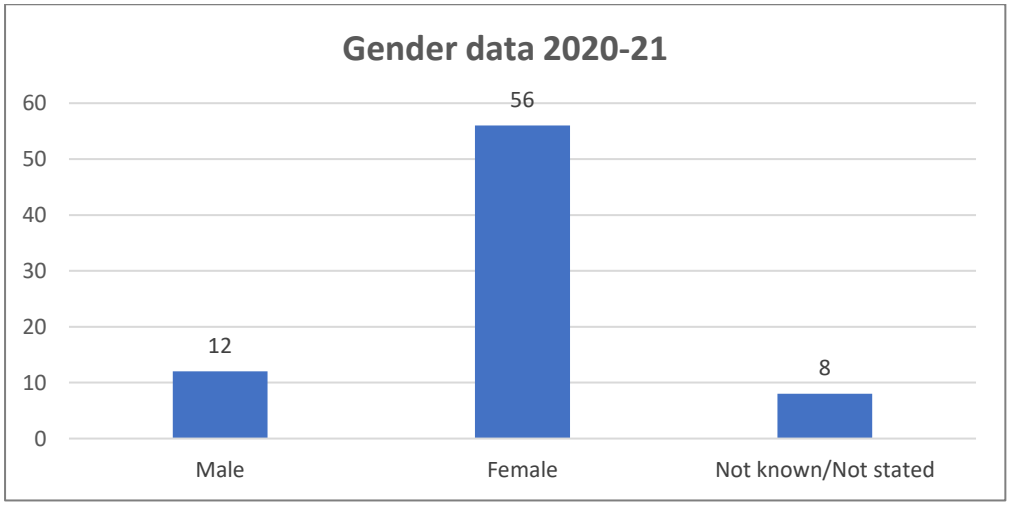
The Freedom to Speak Up Guardians works alongside the Trust Leadership Team to support the organisation in becoming a more open and transparent place to work and where 'Speaking Up' becomes business as usual.

76 concerns were raised with the Freedom to Speak Up Guardians in 2020-21. The primary categories of the concerns raised the staff group and ethnicity and gender data of the individuals who raised concerns are shown in the three graphs below. The percentage of colleagues from the ethnic minorities who contacted the Freedom to Speak Up Guardians in 2020-21 was 13% compared with 15% in 2019-20.

The Trust's quarterly staff barometer surveys consistently indicate a vast majority of Trust staff know how to raise concerns and would raise concerns. On average, in 2020-21 98% indicated they know how to raise concerns and 92% said they would raise concerns if they needed to. These figures are broadly the same as the previous years' data.


Categories of concerns raised 2020-21
45
40
35
30
25
20
15
10
5
0
9
40
22
0
3
0
0
2
Quality & Safety
Attitude & Behaviour
Policies, procedures and...
Staffing
Service changes
Equipment & Maintenance
performance & capability
Not known


Staff ethnic groups 2020-21
40
35
30
25
20
15
10
5
0
34
0
7
3
0
32
White
Mixed
Asian/Asian British
Black/Black British
Chinese or other ethnic group
Not stated/Not known


Gender data 2020-21
60
50
40
30
20
10
0
12
56
8
Male
Female
Not known/Not stated

Examples of improvements and achievements made include:

- Finalist in Health Service Journal award 2020 for Freedom to Speak Up Organisation of the Year.
- Learning from Freedom to Speak Up during the Covid pandemic have been embedded into the overall Trust learning, improvements and actions.
- Successful recruitment and training of Freedom to Speak Up Ambassadors.
- Jointly designed and delivered Trust conference 'Tackling Racism: Learning and improving through collaboration'.
- The continued development on building a culture of civility and respect that has culminated in a number of key Trust developments which include:
  - Jointly reviewed and launched an expanded Trust mediation service.
  - Contributed to the review and relaunch of Trust's Early Resolution, Dignity at Work and Grievance Policy.
  - Development of Trust Charter.
  - Contributions to the development of Trust's mandatory training module on Respect.
- Represented Freedom to Speak Up and Trust at both local, regional and national levels.
- Publication of a number of high-profile articles and promotional films that were distributed nationally showcasing the Trust's Freedom to Speak Up work.
- Continued development to embed a restorative just culture approach in the Trust.
- Strengthening the triangulation of different sources of data and intelligence to inform areas of improvements in the Trust.

Freedom of Information

The Trust operates an open and transparent system of access to information about its services, whilst recognising and adhering to the best practice on protecting the confidentiality of certain types of information.

The Covid-19 pandemic affected the FOI response times as the main focus of the Trust shifted to responding to the pandemic. As a result, it took longer to gather the information requested, leading to delayed response times. As things return to normal, it is expected that response times will improve significantly.

From 1st April 2020 to 31st March 2021 the Trust received 397 Freedom of Information requests, which is a decrease of 17.12% when compared to 2019-20. Most requests contain multiple questions that require input from across the Trust's Directorates. Compliance with the 20-day working response target was 55%, with 96 FOIs outstanding at time of writing.

Although requestors are not obliged to disclose the capacity in which they are submitting their request, it is estimated that the majority of requests came were from individuals (52.1%), although this may conceal other categories as requesters from commercial and media organisations do not always identify themselves. Private Companies (22.2%) and Media (11.8%) requests follow. The topics most frequently asked about were Patient Statistics (13.6%), Budget/Expenditure/Finance (11.3%), Covid-19 (10.8%), Clinical Services (10.3%) and Contracts (9.3%).


4

Section 3: Annual Accounts

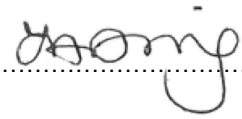
Cambridgeshire and Peterborough NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Cambridgeshire and Peterborough NHS Foundation Trust

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

Signed 

Name **Tracy Dowling**
Job title **Chief Executive**
Date **25 June 2021**

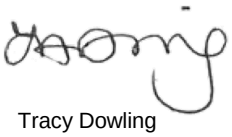
Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	225,743	213,024
Other operating income	4	28,988	23,155
Operating expenses	6	(252,395)	(231,559)
Operating surplus from continuing operations		**2,336**	**4,620**
Finance income	11	1,082	1,422
Finance expenses	12	(1,818)	(1,930)
PDC dividends payable		(1,441)	(2,108)
Net finance costs		**(2,177)**	**(2,616)**
Other gains	13	0	874
Surplus for the year		**159**	**2,878**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(682)	(229)
Revaluations	16	0	800
Remeasurements of the net defined benefit pension scheme liability / asset	30	326	102
Total comprehensive income / (expense) for the period		**(197)**	**3,551**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 Restated £000
Non-current assets			
Property, plant and equipment	15	88,009	85,978
Other assets	21	160	0
Total non-current assets		**88,169**	**85,978**
Current assets			
Inventories	19	96	124
Receivables	20	17,329	22,846
Other investments / financial assets	18	20,220	20,220
Assets held for sale	22	227	227
Cash and cash equivalents	23	59,055	40,646
Total current assets		**96,927**	**84,063**
Current liabilities			
Trade and other payables	24	(38,173)	(33,147)
Borrowings	26	(794)	(816)
Provisions	28	(222)	(229)
Other liabilities	25	(15,677)	(10,198)
Total current liabilities		**(54,866)**	**(44,390)**
Total assets less current liabilities		**130,230**	**125,651**
Non-current liabilities			
Borrowings	26	(22,478)	(23,274)
Provisions	28	(1,638)	(1,470)
Other liabilities	25	(2,466)	(2,278)
Total non-current liabilities		**(26,582)**	**(27,022)**
Total assets employed		**103,648**	**98,629**
Financed by			
Public dividend capital		14,968	9,752
Revaluation reserve		23,272	23,954
Other reserves		33,733	33,733
Income and expenditure reserve		31,675	31,190
Total taxpayers' equity		**103,648**	**98,629**

The notes on pages 7 to 49 form part of these accounts.



Name Tracy Dowling
Position Chief Executive
Date 25 June 2021

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**9,752**	**23,954**	**33,733**	**31,190**	**98,629**
Surplus for the year	0	0	0	159	**159**
Impairments	0	(682)	0	0	**(682)**
Remeasurements of the defined net benefit pension scheme asset	0	0	0	326	**326**
Public dividend capital received	5,216	0	0	0	**5,216**
Taxpayers' and others' equity at 31 March 2021	**14,968**	**23,272**	**33,733**	**31,675**	**103,648**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**8,380**	**23,519**	**33,733**	**28,074**	**93,706**
Surplus for the year	0	0	0	2,878	**2,878**
Impairments	0	(229)	0	0	**(229)**
Revaluations	0	800	0	0	**800**
Transfer to retained earnings on disposal of assets	0	(136)	0	136	**0**
Remeasurements of the defined net benefit pension scheme liability	0	0	0	102	**102**
Public dividend capital received	1,372	0	0	0	**1,372**
Taxpayers' and others' equity at 31 March 2020	**9,752**	**23,954**	**33,733**	**31,190**	**98,629**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Other reserves

Other reserves within the Statement of Financial Position relate to the difference between the value of fixed assets taken over by the Cambridge and Peterborough Mental Health Partnership NHS Trust at inception on 1 April 2002 and the corresponding value of the Opening Capital Debt. The balance of Other Reserves will remain fixed for the foreseeable future.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		2,336	4,620
Non-cash income and expense:			
Depreciation	6	4,473	4,198
Net impairments	7	486	281
Non-cash movements in on-SoFP pension asset/liability		25	51
Decrease in receivables and other assets		6,023	433
(Increase) / decrease in inventories		28	(42)
Increase in payables and other liabilities		11,629	8,493
Increase in provisions		161	54
Net cash flows from operating activities		**25,161**	**18,088**
Cash flows from investing activities			
Interest received		576	1,422
Purchase of Property, Plant and Equipment		(8,469)	(6,169)
Sales of Property, Plant and Equipment		0	1,655
Net cash flows used in investing activities		**(7,893)**	**(3,092)**
Cash flows from financing activities			
Public dividend capital received		5,216	1,372
Capital element of finance lease rental payments		(25)	(20)
Capital element of PFI		(793)	(788)
Interest paid on finance lease liabilities		(44)	(47)
Interest paid on PFI		(1,707)	(1,684)
PDC dividend paid		(1,439)	(1,870)
Cash flows used in other financing activities		(67)	(199)
Net cash flows from / (used in) financing activities		**1,141**	**(3,236)**
Increase in cash and cash equivalents		**18,409**	**11,760**
Cash and cash equivalents at 1 April - brought forward		**40,646**	**28,886**
Cash and cash equivalents at 31 March	23	**59,055**	**40,646**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going Concern

International Accounting Standards (IAS1) require the directors to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern (i.e. that it will continue in the business of healthcare provision for the foreseeable future). The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Trust's cashflow projections for the next 12 months indicates cash levels will be retained at a balance which is more than sufficient to cover our obligations. There is no identified requirement for borrowing or other financial support. The Directors have a reasonable expectation that this will continue to be the case,

Note 1.2 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods. The following judgement, apart from those involving estimations (see Note 1.2.1), that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charitable Funds

From 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns was removed. Under the provisions of IFRS 10 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns.

IAS 1, Presentation of annual report and accounts, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. In addition accounting policies need not be developed or applied if the impact of applying them would be immaterial. The Trust has concluded that in the current financial year the accounts of the Charitable Fund are not material and have not therefore consolidated them in these accounts.

Note 1.2.1 Key Sources of estimation uncertainty

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

Property Valuations

Valuation assumptions for Property, Plant and Equipment with a net book value of £72.3m as at 31 March 2021, are in line with note 15.

The Trust has applied an indexation figure of -1% based on the Royal Institution of Chartered Surveyors (RICS) reports and are reflected in these financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation.

A 1% decrease in the index used has had £0.682m impact on the statement of financial position with a £0.010m impact on the PDC Dividend due to be paid next year and accrued in these financial statements.

Of the £72.3m net book value of land and buildings subject to valuation, £61.7m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost of replacing the service potential, rather than the extent of the service.

Note 1.3 Interest in other entities

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed. This income was received in advance with no income due in March 2021 from commissioners.

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. During 2020/21 there was no Commissioning for Quality and Innovation (CQUIN) income.

Comparative period (2019/20)

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

The majority of the Trust's healthcare contracts are on a block basis, where it is deemed that performance obligations are met on an equal monthly basis. To this end, commissioners pay the annual contract value in 12 equal instalments during the year. Each instalment is paid during the month to which it relates. Where a contract is on a cost and volume basis, invoices are raised as the performance obligation is discharged in line with the timeline mandated within the NHS Standard Contract.

The Trust receives income from commissioners under CQUIN schemes. The Trust agrees schemes with its commissioner against which performance obligations and payments are agreed on a quarterly basis.

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

Revenue from research contracts

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

Note 1.4.1 Revenue grants and other contributions to expenditure

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.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other Income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The quinquennial valuation of land and buildings was undertaken as at 31st March 2019. Current values in existing use are determined as follows:

Land and non-specialised buildings – market value for existing use.

Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

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 carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

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

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

Revaluation gains 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.

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of
(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.
An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 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 IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate. The Trust has also elected under IAS 23 to captalise any borrowing costs associated with the PFI as these are considered to be the borrowing costs of the operator.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.6 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 are shown in the table below:

	Min life	**Max life**
	Years	**Years**
Buildings, excluding dwellings	5	56
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	5	10

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

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

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

Note 1.9 Cash and cash equivalents

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

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

Note 1.10 Financial assets and liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.10.2 Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

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

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

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

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

Note 1.10.3 Derecognition

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

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

Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

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

Operating leases

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

Leases of land and buildings

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

Note 1.11.2 The Trust as lessor

Operating leases

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

Note 1.12 Provisions

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.13 Contingencies

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

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

Contingent liabilities are defined as:

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

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the 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.

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

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,

(iii) any PDC dividend balance receivable or payable, and

(iv) any Capital expenditure associated with COVID-19.

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

Note 1.15 Value added tax

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

Note 1.16 Corporation tax

The Cambridgeshire and Peterborough NHS Foundation Trust is a Health Service body within the meaning of s 519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly the NHS Foundation Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000pa. There is no tax liability arising in respect of the current or previous financial year.

Note 1.17 Foreign exchange

The functional and presentational currency of the Trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19 Gifts

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

Note 1.20 Early adoption of standards, amendments and interpretations

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

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

IFRS16 Leases

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

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

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term. The judgement of the lease term will be assessed on a number of factors such as ability of the lessor to re-lease the property, any break penalties and the life of any capital works carried out by the Trust.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected lease activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

IFRS 17 - Insurance Contracts. This applies for accounting periods beginning on or after 1st January 2023, this is not yet adopted by the FReM. Therefore early adoption is not permitted.

Note 2 Operating Segments

Segment information is presented on the same basis as that used for internal reporting purposes by the "Chief Operating Decision Maker". The operating segments to be disclosed in these accounts are therefore identified on the basis of internal reports regularly reviewed by the Board of Directors, the Board of Directors being considered to be the chief operating decision-maker for the Trust, in order to allocate resources to the segments and to assess their respective performance.

The Board considers the Trust from a service perspective, organised into one business segment, Healthcare.

The internal directorates of the healthcare reportable segment (Adult and Specialist Mental Health, Children, Young People and Families, Older People's and Adult Community and Corporate Services), do not qualify as reportable segments as decisions about the allocation of resources and the assessment of performance are not made at this level by the Board.

The Board assesses the performance of the operating segments based on gross expenditure and income where the service contract is discrete to that service. The Board do not receive a breakdown by segment for the Trust's performance in terms of interest receivable or payable, depreciation or amortisation and any other material non-cash items.

Other information provided to the Board is measured in a manner consistent with that in the accounts.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2020/21 £000	2019/20 £000
Acute services		
Other NHS clinical income	1,624	1,480
Mental health services		
Block contract / system envelope income*	123,132	115,065
Clinical partnerships providing mandatory services (including S75 agreements)	9,723	12,419
Community services		
Block contract / system envelope income*	73,764	71,185
Income from other sources (e.g. local authorities)	6,723	5,212
All services		
Private patient income	93	168
Additional pension contribution central funding**	7,655	7,195
Other clinical income	3,029	300
Total income from activities	**225,743**	**213,024**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. For 2020/21 this equates to £7.655m (2019/20 £7.195m).

Note 3.2 Income from patient care activities (by source)	2020/21 £000	2019/20 £000
Income from patient care activities received from:		
NHS England*	21,583	21,556
Clinical commissioning groups	175,661	162,248
Other NHS providers	8,950	8,189
Local authorities	15,735	16,897
Non-NHS: private patients	93	168
Injury cost recovery scheme	0	25
Non NHS: other	3,721	3,941
Total income from activities	**225,743**	**213,024**
Of which:		
Related to continuing operations	225,743	213,024

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. For 2020/21 this equates to £7.655m (2019/20 £7.195m).

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	4,118	0	**4,118**	4,699	0	**4,699**
Education and training	10,367	335	**10,702**	9,542	349	**9,891**
Non-patient care services to other bodies***	3,359	0	**3,359**	96	0	**96**
Provider sustainability fund (2019/20 only)	0	0	**0**	1,745	0	**1,745**
Reimbursement and top up funding **	6,476	0	**6,476**	0	0	**0**
Charitable and other contributions to expenditure*	0	1,801	**1,801**	0	0	**0**
Other income***	2,532	0	**2,532**	6,724	0	**6,724**
Total other operating income	**26,852**	**2,136**	**28,988**	**22,806**	**349**	**23,155**
Of which:						
Related to continuing operations			28,988			23,155

* In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £1.801m of items purchased by DHSC

** 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. During 2020/21 the Trust received £6.396m.

*** The Trust has undertaken a review of it's income and has reclassifield items previously recorded under Other income to Non-Patient care services to other bodies in year.

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

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	5,110	3,888
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	290	258

Note 5.1 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	15,677	10,198
after one year, not later than five years	2,466	2,137
Total revenue allocated to remaining performance obligations	**18,143**	**12,335**

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

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

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	185,480	178,331
Income from services not designated as commissioner requested services	40,263	34,693
Total	**225,743**	**213,024**

Note 6 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,264	791
Purchase of healthcare from non-NHS and non-DHSC bodies	2,311	1,587
Staff and executive directors costs*	187,169	170,577
Remuneration of non-executive directors	141	160
Supplies and services - clinical (excluding drugs costs)	5,259	3,501
Supplies and services - general	9,712	9,619
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,377	1,264
Consultancy costs	392	811
Establishment	2,766	2,417
Premises	11,644	10,026
Transport (including patient travel)	2,064	3,370
Depreciation on property, plant and equipment	4,473	4,198
Net impairments	486	281
Movement in credit loss allowance: contract receivables / contract assets	(67)	441
Movement in credit loss allowance: all other receivables and investments	(193)	0
Change in provisions discount rate(s)	59	105
Audit fees payable to the external auditor		
audit services- statutory audit**	76	72
Internal audit costs	107	78
Clinical negligence	1,369	1,018
Legal fees	828	485
Insurance	41	47
Research and development*	4,938	4,885
Education and training*	5,000	5,727
Rentals under operating leases	6,219	6,367
Redundancy	22	132
Charges to operating expenditure for on-SoFP PFI schemes	2,273	2,226
Car parking & security	603	128
Hospitality	6	44
Losses, ex gratia & special payments	51	38
Other	2,005	1,164
Total	**252,395**	**231,559**
Of which:		
Related to continuing operations	252,395	231,559

*Staff numbers and executive directors costs exclude £3.696m for Research and Development staff (2019/20 £4.153m) and £3.946m for Education and Training staff (2019/20 £4.417m)

** The audit services - statutory audit expenditure is inclusive of VAT and there are no non audit services provided

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £2 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus resulting from:		
Abandonment of assets in course of construction	486	66
Changes in market price	0	215
Total net impairments charged to operating surplus	**486**	**281**
Impairments charged to the revaluation reserve	682	229
Total net impairments	**1,168**	**510**

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	148,632	136,974
Social security costs	13,522	12,029
Apprenticeship levy	692	639
Employer's contributions to NHS pensions*	25,237	23,557
Pension cost - other	113	0
Termination benefits	22	132
Temporary staff (including agency)	7,012	6,832
Total staff costs	**195,230**	**180,163**
Of which		
Costs capitalised as part of assets	397	884

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts. For 2020/21 this equates to £7.655m (2019/20 £7.195m).

Note 8.1 Retirements due to ill-health

During 2020/21 there was 1 early retirement from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is below £1k (£15k in 2019/20). These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

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

a) Accounting valuation

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

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

b) Full actuarial (funding) valuation

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

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

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

Note 10 Operating leases

Note 10.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Cambridgeshire and Peterborough NHS Foundation Trust is the lessee.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	6,219	6,367
Total	**6,219**	**6,367**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,980	5,968
- later than one year and not later than five years;	20,482	20,371
- later than five years.	1,731	594
Total	**28,193**	**26,933**

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	8	223
Other finance income	1,074	1,199
Total finance income	**1,082**	**1,422**

Note 12 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Finance leases	44	48
Main finance costs on PFI scheme obligations	1,043	1,081
Contingent finance costs on PFI scheme obligations	664	603
Total interest expense	**1,751**	**1,732**
Other finance costs	67	198
Total finance costs	**1,818**	**1,930**

Note 13 Other gains

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	0	874
Total other gains	**0**	**874**

Note 14 Adjusted Financial Performance (control total basis)

	2020/21	2019/20
	£000	£000
Adjusted financial performance (control total basis):		
Surplus for the period	159	2,878
Remove net impairments not scoring to the Departmental expenditure limit	0	215
Remove I&E impact of capital grants and donations	2	2
Remove non-cash element of on-SoFP pension costs	25	51
Adjusted financial performance surplus	**186**	**3,146**

Note 15 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**9,665**	**72,514**	**5,967**	**2,616**	**15,800**	**1,389**	**107,951**
Additions	0	40	7,424	181	24	3	**7,672**
Impairments	(97)	(615)	(486)	0	0	0	**(1,198)**
Reclassifications	0	1,063	(2,831)	36	1,717	15	**0**
Valuation/gross cost at 31 March 2021	**9,568**	**73,002**	**10,074**	**2,833**	**17,541**	**1,407**	**114,425**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**7,407**	**0**	**1,316**	**12,046**	**1,204**	**21,973**
Provided during the year	0	2,816	0	252	1,355	50	**4,473**
Impairments	0	(30)	0	0	0	0	**(30)**
Accumulated depreciation at 31 March 2021	**0**	**10,193**	**0**	**1,568**	**13,401**	**1,254**	**26,416**
Net book value at 31 March 2021	**9,568**	**62,809**	**10,074**	**1,265**	**4,140**	**153**	**88,009**
Net book value at 1 April 2020	**9,665**	**65,107**	**5,967**	**1,300**	**3,754**	**185**	**85,978**

Note 15.1 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**9,550**	**70,694**	**1,314**	**2,025**	**14,412**	**1,389**	**99,384**
Additions	0	681	5,396	589	1,226	0	**7,892**
Impairments	0	(229)	(66)	0	0	0	**(295)**
Revaluations	115	702	0	0	0	0	**817**
Reclassifications	0	437	(601)	2	162	0	**0**
Transfers to / from assets held for sale	0	229	0	0	0	0	**229**
Disposals / derecognition	0	0	(76)	0	0	0	**(76)**
Valuation/gross cost at 31 March 2020	**9,665**	**72,514**	**5,967**	**2,616**	**15,800**	**1,389**	**107,951**
Accumulated depreciation at 1 April 2019 - as previously stated	**0**	**4,833**	**0**	**1,144**	**10,645**	**1,136**	**17,758**
Provided during the year	0	2,557	0	172	1,401	68	**4,198**
Revaluations	0	17	0	0	0	0	**17**
Accumulated depreciation at 31 March 2020	**0**	**7,407**	**0**	**1,316**	**12,046**	**1,204**	**21,973**
Net book value at 31 March 2020	**9,665**	**65,107**	**5,967**	**1,300**	**3,754**	**185**	**85,978**
Net book value at 1 April 2019	**9,550**	**65,861**	**1,314**	**881**	**3,767**	**253**	**81,626**

Note 15.2 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	9,568	29,151	10,074	1,265	4,140	153	**54,351**
Finance leased	0	3,588	0	0	0	0	**3,588**
On-SoFP PFI contract	0	30,043	0	0	0	0	**30,043**
Owned - donated/granted	0	27	0	0	0	0	**27**
NBV total at 31 March 2021	**9,568**	**62,809**	**10,074**	**1,265**	**4,140**	**153**	**88,009**

Note 15.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned - purchased	9,665	29,915	5,967	1,300	3,754	185	**50,786**
Finance leased	0	3,616	0	0	0	0	**3,616**
On-SoFP PFI contracts	0	31,547	0	0	0	0	**31,547**
Owned - donated/granted	0	29	0	0	0	0	**29**
NBV total at 31 March 2020	**9,665**	**65,107**	**5,967**	**1,300**	**3,754**	**185**	**85,978**

Note 16 Revaluations of property, plant and equipment

All the freehold properties owned by the Foundation Trust were valued by Boshier & Company Chartered Surveyors in the 2018/19 financial year. This valuation represents the Trust's Quinquennial valuation. The properties were valued as at 31st March 2019. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. In practice the Trust will ensure that there is a full quinquennial valuation and an interim valuation in the third year of each quinquennial cycle. In any intervening year the Trust will carry out a review of movements in appropriate land and building indices and where material fluctuations occur, will engage the services of a professional valuer to determine appropriate adjustments to the valuations of assets to ensure that book values reflect current values. For 2020/21, the Trust has engaged the services of the District Valuer and using the RICS indexation supplied, has applied a reduction of 1% based on the March 2021 BCIS forecast. The Trust has not undertaken an additional valuation. Current values are determined as follows:

- Land and non specialised buildings – market value for existing use/modern equivalent asset.
- Specialised building - Depreciated Replacement Cost.

The valuations were in accordance with the requirements of the RICS valuation standards sixth edition and the international valuation standards. The valuation of each property was on the basis of market value, subject to the following assumptions:-

i) For owner occupied property: that the property would be sold as part of the continuing enterprise in occupation;
ii) For surplus property and property held for development: that the property would be sold with vacant possession in its existing condition;

The Valuer's opinion of market value was primarily derived using:

i) Comparable recent market transactions on arm's length terms;
ii) The depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transactions of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

Plant and equipment that have not been revalued are shown at their depreciated value.

Note 17 Other investments / financial assets (current)

	31 March 2021 £000	31 March 2020 £000
Other current financial assets	20,220	20,220
Total current investments / financial assets	**20,220**	**20,220**

Other current financial assets relates to a cash loan provided to the Department of Health and Social Care. This loan was transacted on 1st June 2018 and will remain in place until the Trust notifies the Department of Health and Social Care of the intention to terminate the agreement.

The loan yields 5% interest per annum.

Note 18 Disclosure of interests in other entities

Cambridge University Health Partnership

Cambridge University Health Partners (CUHP) was designated an Academic Health Science Centre by the Department of Health and Social Care in March 2009. The entity became fully established as a company limited by guarantee on 11th September 2009, with CPFT (as one of the four partners) underwriting 25% of the guarantee costs. The objectives of CUHP are to drive forward the partnership between the National Health Service (NHS) and the University of Cambridge.

The Trust accepted as part of the members agreement a recurrent funding of £106,192 (2019/20 £103,300), however the agreement requires unanimous confirmation of partners for any additional funding.

In view of the arrangements set out in the members agreement with CUHP, the Trust considers CUHP to be an associate. However it has not been accounted for under the equity method as it is the Trust's view that the investment is not material.

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	62	94
Other	34	30
Total inventories	**96**	**124**

Inventories recognised in expenses for the year were £1,833k (2019/20: £0k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £1,801k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 20 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	13,678	20,986
Allowance for impaired contract receivables / assets	(638)	(705)
Allowance for other impaired receivables	(152)	(387)
Prepayments (non-PFI)	2,601	1,838
Interest receivable	843	337
VAT receivable	725	539
Other receivables	272	238
Total current receivables	**17,329**	**22,846**
Of which receivable from NHS and DHSC group bodies:		
Current	11,636	16,525

Note 20.1 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**705**	**387**	**264**	**409**
New allowances arising	0	0	441	0
Reversals of allowances	(67)	(193)	0	0
Utilisation of allowances (write offs)	0	(42)	0	(22)
Allowances as at 31 Mar 2021	**638**	**152**	**705**	**387**

Note 20.2 Exposure to credit risk

The main receivables of the Trust are accounts receivable and loans receivable related to the loan to the Department of Health and Social Care (DHSC). The former has a low degree of credit risk (risk concerning non-payment of an agreement by the counterparty). In accordance with good practice, the Trust strives to promptly identify and reduce concerns about collection by regularly monitoring the Trust's aged debt and providing an update to the Board and other Committees as to actions being taken to address outstanding payment. Collection risk is minimal as the majority of income sources are DHSC bodies. The Trust has no significant concentrations of credit risk with any counterparty.

Note 21 Other assets

	31 March 2021	31 March 2020
Non-current	**£000**	**£000**
Net defined benefit pension scheme asset	160	0
Total other non-current assets	**160**	**0**

Note 22 Assets held for sale

	2020/21	2019/20
	£000	**£000**
NBV of assets for sale at 1 April	**227**	**1,375**
Assets sold in year	0	(704)
Impairment of assets held for sale	0	(215)
Assets no longer classified as held for sale, for reasons other than sale	0	(229)
NBV of assets for sale at 31 March	**227**	**227**

During 2018/19, following Board approval, the Trust classified the following assets as held for sale:

- Drybread Road, Whittlesey - as at 31st March 2021, it is still available for sale.

Drybread Road carries a net book value as at 31st March 2021 of £95,000 relating to land and £132,000 buildings.

Note 23 Cash and cash equivalents movements

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

	2020/21	2019/20
	£000	£000
At 1 April	**40,646**	**28,886**
Net change in year	18,409	11,760
At 31 March	**59,055**	**40,646**
Broken down into:		
Cash at commercial banks and in hand	337	337
Cash with the Government Banking Service	58,718	40,309
Total cash and cash equivalents as in SoCF	**59,055**	**40,646**

Note 24 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	7,688	7,444
Capital payables	1,147	1,944
Accruals	20,771	15,545
Other taxes payable	3,725	3,313
PDC dividend payable	5	3
Other payables	4,837	4,898
Total current trade and other payables	**38,173**	**33,147**
Of which payables from NHS and DHSC group bodies:		
Current	2,182	3,627

Note 25 Other liabilities

	31 March 2021	31 March 2020 Restated
	£000	£000
Current		
Deferred income: contract liabilities*	15,677	10,198
Total other current liabilities	**15,677**	**10,198**
Non-current		
Deferred income: contract liabilities*	2,466	2,137
Net pension scheme liability	0	141
Total other non-current liabilities	**2,466**	**2,278**

***** The comparatives have been restated to reflect the long term nature of the Qatar Mental Healthcare Project, which was classified as a current liability in the prior year in error.

Note 26 Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Obligations under finance leases	19	24
Obligations under PFI contracts	775	792
Total current borrowings	**794**	**816**
Non-current		
Obligations under finance leases	135	155
Obligations under PFI contracts	22,343	23,119
Total non-current borrowings	**22,478**	**23,274**

Note 26.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Finance leases	PFI scheme	Total
	£000	£000	£000
Carrying value at 1 April 2020	**179**	**23,911**	**24,090**
Cash movements:			
Financing cash flows - payments and receipts of principal	(25)	(793)	**(818)**
Financing cash flows - payments of interest	(44)	(1,043)	**(1,087)**
Non-cash movements:			
Application of effective interest rate	44	1,043	**1,087**
Carrying value at 31 March 2021	**154**	**23,118**	**23,272**

Note 26.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Finance leases	PFI scheme	Total
	£000	£000	£000
Carrying value at 1 April 2019	**198**	**24,699**	**24,897**
Cash movements:			
Financing cash flows - payments and receipts of principal	(20)	(788)	**(808)**
Financing cash flows - payments of interest	(47)	(1,081)	**(1,128)**
Non-cash movements:			
Application of effective interest rate	48	1,081	**1,129**
Carrying value at 31 March 2020	**179**	**23,911**	**24,090**

Note 27 Finance leases

Note 27.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**347**	**416**
of which liabilities are due:		
- not later than one year;	59	67
- later than one year and not later than five years;	190	202
- later than five years.	98	147
Finance charges allocated to future periods	(193)	(237)
Net lease liabilities	**154**	**179**
of which payable:		
- not later than one year;	19	24
- later than one year and not later than five years;	68	64
- later than five years.	67	91

Note 28 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**230**	**1,237**	**102**	**130**	**1,699**
Change in the discount rate	0	59	0	0	**59**
Arising during the year	78	42	30	183	**333**
Utilised during the year	(72)	(68)	(38)	(53)	**(231)**
At 31 March 2021	**236**	**1,270**	**94**	**260**	**1,860**
Expected timing of cash flows:					
- not later than one year;	72	56	94	**0**	**222**
- later than one year and not later than five years;	164	229	0	**260**	**653**
- later than five years.	0	985	0	**0**	**985**
Total	**236**	**1,270**	**94**	**260**	**1,860**

Pension: Early Departure Costs - This reflects the liabilities arising from early retirements.

Pension: Injury Benefits - This reflects the liabilities arising from injury benefits.

Legal claims - This reflects potential claims against the NHSLA scheme and provision for employer tribunal costs.

Other - reflects provisions arising from dilapidations for Trust properties.

Note 28.1 Clinical negligence liabilities

At 31 March 2021, £14m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Cambridgeshire and Peterborough NHS Foundation Trust (31 March 2020: £15m).

Note 29 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	3,001	2,371
Total	**3,001**	**2,371**

The Capital commitment relates to the George Mackenzie House and Mulberry 2 Seclusion Room and is based on the future payments outlined in the contract less amounts paid to date.

Note 30 Defined benefit pension schemes

The Trust employs eight members of staff that transferred from Cambridgeshire Community Services NHS Trust on 1 April 2015 as members of the Local Government Pension Scheme (LGPS). These staff formerly worked for Cambridgeshire County Council but transferred into the NHS in April 2004 as part of the Cambridgeshire wide section 75 agreement for the provision of Health and Social Care for Older People. The LGPS is a defined benefit statutory scheme administered in accordance with the Local Government Pension Scheme Regulations. The Trust became an admitted body to the scheme effective on 1 April 2015.

Note 30.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2020/21	2019/20
	£000	£000
Present value of the defined benefit obligation at 1 April	**(2,731)**	**(2,055)**
Current service cost	(94)	(290)
Interest cost	(67)	(198)
Contribution by plan participants	(15)	(53)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	560	(224)
Benefits paid	33	89
Present value of the defined benefit obligation at 31 March	**(2,314)**	**(2,731)**
Plan assets at fair value at 1 April	**2,590**	**1,863**
Interest income	63	188
Remeasurement of the net defined benefit (liability) / asset:		
- Return on plan assets	0	326
- Actuarial losses	(234)	0
Contributions by the employer	73	249
Contributions by the plan participants	15	53
Benefits paid	(33)	(89)
Plan assets at fair value at 31 March	**2,474**	**2,590**
Plan surplus/(deficit) at 31 March	**160**	**(141)**

Note Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	2021	2020
	£000	£000
Present value of the defined benefit obligation	(2,314)	(2,731)
Plan assets at fair value	2,474	2,590
Net asset / (liability) after the impact of reimbursement rights	**160**	**(141)**

Note Amounts recognised in the SoCI

	2020/21	2019/20
	£000	£000
Current service cost	(94)	(290)
Interest expense / income	(4)	(10)
Total net charge recognised in SOCI	**(98)**	**(300)**

Note 31 On-SoFP PFI arrangements

Note 31.1 On-SoFP PFI arrangement obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI liabilities	**36,044**	**37,879**
Of which liabilities are due		
- not later than one year;	1,783	1,835
- later than one year and not later than five years;	7,234	7,207
- later than five years.	27,027	28,837
Finance charges allocated to future periods	(12,926)	(13,968)
Net PFI arrangement obligation	**23,118**	**23,911**
- not later than one year;	775	792
- later than one year and not later than five years;	3,568	3,390
- later than five years.	18,775	19,729

Note 31.2 Total on-SoFP PFI arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI arrangements	**133,009**	**137,617**
Of which payments are due:		
- not later than one year;	4,723	4,608
- later than one year and not later than five years;	20,102	19,612
- later than five years.	108,184	113,397

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**4,773**	**4,698**
Consisting of:		
- Interest charge	1,043	1,081
- Repayment of balance sheet obligation	793	788
- Service element and other charges to operating expenditure	2,273	2,226
- Contingent rent	664	603
Total amount paid to service concession operator	**4,773**	**4,698**

The Trust is committed to make payments in relation to service charges on its PFI scheme. The charges are subject to an index linked inflation adjustment each year.

On 19th June 2007 the Trust concluded contracts under the Private Finance Initiative (PFI) with Peterborough (Progress Health) PLC for the construction of a new 102 bed hospital and the provision of hospital related services.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, being acquired through a finance lease. The payments to Progress Health in respect of the facility (Cavell Centre) have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in the accounting policies note.

The service element of the contract was £2,273,000 (2019/20: £2,226,000). The Cavell Centre was handed over to the Trust in two phases in November 2008 and May 2009. Payments under the scheme commenced in November 2008. The agreement is due to end in November 2042.

The estimated value of the scheme at inception was £25,700,000.

Note 32 Financial instruments

Note 32.1 Financial risk management

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. 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.

Market Risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. A significant proportion of the Trust's transactions are undertaken in sterling and so its exposure to foreign exchange risk is minimal. It holds no significant investments other than short-term bank deposits. Other than cash balances, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cashflows are substantially independent of changes in market interest rates.

Interest Rate Risk

The Trust exposure to interest rate risk is primarily in relation to the PFI, details which are set out in Note 31.

Credit Risk

Because the majority of the Trust revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust operating costs are incurred under contracts with healthcare commissioners which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Note 32.2 Carrying values of financial assets

The book values (carrying values) below are a reasonable approximation of the fair value.

Carrying values of financial assets at 1st April	2020/21 Held at amortised cost	2019/20 Held at amortised cost
	£000	£000
Trade and other receivables excluding non financial assets	14,003	20,469
Other investments / financial assets	20,220	20,220
Cash and cash equivalents	59,055	40,646
Total at 31st March	**93,278**	**81,335**

Note 32.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 1st April	2020/21 Held at amortised cost	2019/20 Held at amortised cost Restated*
	£000	£000
Obligations under finance leases	154	179
Obligations under PFI, LIFT and other service concession contracts	23,118	23,911
Trade and other payables excluding non financial liabilities	34,443	29,831
Total at 31st March	**57,715**	**53,921**

***** The comparatives have been restated to exclude provisions, which are not financial instrustments, were included in error in prior years.

Note 32.4 Maturity of financial liabilities

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	36,285	31,733
In more than one year but not more than five years	7,424	7,409
In more than five years	27,125	28,984
Total	**70,834**	**68,126**

* This disclosure has previously been prepared using discounted cash flows, in error. The comparatives have therefore been restated on an undiscounted basis.

Note 33 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	0	0	0
Bad debts and claims abandoned*	97	42	31	14
Stores losses and damage to property	4	2	1	0
Total losses	**103**	**44**	**32**	**14**
Special payments				
Compensation under court order or legally binding arbitration award	1	6	0	0
Ex-gratia payments	7	1	9	24
Total special payments	**8**	**7**	**9**	**24**
Total losses and special payments	**111**	**51**	**41**	**38**

* Comparative numbers have been stated to include bad debts and claims abandoned that were omitted in the prior year in error.

Note 34 Related parties

All Bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS Foundation Trust including the Department of Health and Social Care as the Trust's parent organisation. The main entities within the public sector that the Trust has dealings with are:-

Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridgeshire County Council
Department of Health and Social Care
Essex Partnership University NHS Foundation Trust
Head to Toe Charity
Health Education England
Hertfordshire County Council
HM Revenue and Customs
HMP Whitemoor
NHS Cambridgeshire and Peterborough CCG
NHS England
NHS England - East of England Regional Office
NHS Lincolnshire CCG
NHS Norfolk & Waveney CCG
NHS Pension Agency
NHS Property Services
NHS Resolution
Norfolk and Norwich University Hospitals NHS Foundation Trust
North West Anglia NHS Foundation Trust
Northamptonshire County Council
Peterborough City Council
Supply Chain Co-ordination Ltd

Note 35 Events after the reporting date

As at 31st March 2021, the Trust is not aware of any material non-adjusting events that will effect these financial statements.

Independent auditor's report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust

Opinion on financial statements

We have audited the financial statements of Cambridgeshire and Peterborough 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 a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the 2020-21 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2020-21, and the NHS Foundation Trust Annual Reporting Manual 2020-21 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2020-21; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

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

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Accounting Officer is 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 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 have nothing to report in this regard.

Opinion on the Remuneration Report and Staff Report

Qualified opinion on the Remuneration Report and Staff Report

We have also audited the information in the Remuneration Report and Staff Report that is described in that report as having been audited.

Except for the matter referred to in the Basis for qualified opinion on information in the Remuneration Report paragraph of our report, in our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020-21.

Basis for qualified opinion on information in the Remuneration Report

The Remuneration Report does not include the required pension benefit disclosures for two senior managers who became deferred members of the NHS pension scheme prior to 2019/20 and for whom no contributions were made in 2020/21 or 2019/20. The Trust has been unable to obtain the required information in respect of these individuals from NHS Pensions, the administrator of the scheme, and is unable to obtain this information from other sources. This matter results in the information included in all the columns of the 'Pension Benefits' table for 2020/21 and the pension related benefits in the 2020/21 and 2019/20 'Remuneration of Senior Managers' tables being incomplete for the senior managers in question.

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 Accountable Officer

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

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

We are required under paragraph 1 of Schedule 10 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, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not misleading or inconsistent with other information that is forthcoming from the audit.

We also report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities the Accounting Officer

As explained more fully in the Statement of Chief Executive's responsibilities as the Accounting Officer of Cambridgeshire and Peterborough NHS Foundation Trust, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively.

Auditor's responsibilities for the audit of the financial statements

In respect of our 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.

Extent to which the audit was capable of detecting irregularities, including fraud

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. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- enquiring of management, Internal Audit, the Local Counter Fraud Specialist, and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and

    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations;
- discussing among the engagement team and involving relevant internal specialists, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, posting of unusual journals, cut off of expenditure around year end and property valuations;
- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. The key laws and regulations we considered in this context included the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. Other relevant laws and regulations identified include, VAT legislation, PAYE legislation, the NHS Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual.

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

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management and the Audit and Assurance Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business;
- Substantively testing an increased sample of expenditure around the year end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

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

Auditor's other responsibilities

As set out in the Other matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

Certificate - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the Cambridgeshire and Peterborough NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of

Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust those matters we are required to state to it 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 NHS Foundation Trust and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.

DocuSigned by:
Janine Combrinck
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Janine Combrinck, Director
For and on behalf of **BDO LLP**, Statutory Auditor
London, UK

30 June 2021

Audit Completion Certificate issued to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 30 June 2021 we explained that the audit could not be formally concluded until we had completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

This work has now been completed and we have reported the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report.

No matters have come to our attention since 30 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 Cambridgeshire and Peterborough NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 and Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

DocuSigned by:
Janine Combrinck
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Janine Combrinck, Director
For and on behalf of **BDO LLP**, Statutory Auditor
London, UK

1 September 2021