



Royal Papworth Hospital
NHS Foundation Trust

ROYAL PAPWORTH

Annual Report & Accounts
2018/19

**Royal Papworth Hospital
NHS Foundation Trust**

**Annual Report
and Accounts**

April 2018 to March 2019

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Quality Report

See separate contents page

Annual Accounts

This report is based on guidelines issued by NHS Improvement and was approved by the Board of Directors on the 23 May 2019.

Care

Innovation

Valued

Excellence

1. Performance Report

1.1 Overview of Performance

Statement from Chief Executive Officer

The last year 2018/19 has been an incredibly important one for Royal Papworth Hospital.

In the last year, our staff and partners have worked extremely hard to maintain our excellent quality standards whilst remaining on our Papworth Everard site for an extended period following the delay in the move to our new hospital. We had to carefully manage the consequences of the delay in our move whilst continuing to providing an excellent experience for our patients and supporting our staff who had been eager to move to their new site. Despite the huge amount of change we have experienced as an organisation, in the last 12 months we have seen 22,795 inpatients and day cases, and 93,852 outpatients, and we have maintained excellent clinical outcomes and very high scores in our NHS Friends and Family test, with 97% of our inpatients and 98% of our out patients saying they would recommend us as a place to receive treatment (February 2019). Our move is now complete and we treated our first patients at the new hospital on the Cambridge Biomedical Campus in May 2019.

We can also be proud of a number of significant achievements made in the last year. In June 2018 we moved over 200 staff to Royal Papworth House. In September we introduced a new pathway for patients suffering from high-risk NSTEMI; a type of heart attack caused by a severely narrowed artery. This new pathway means that patients identified as being high-risk are now transferred directly to Royal Papworth Hospital for treatment within 24 hours, rather than being admitted to an acute hospital first. This offers huge benefits to patients as high-risk patients achieve better outcomes if they receive treatment to unblock the heart's blood supply within 24 hours. In the six months since the new 'Rapid NSTEMI' pathway was launched in September, 134 patients have been accepted onto the pathway (over twice as many as predicted) with 87.3% patients receiving treatment within 24 hours of referral (and 91.8% receiving treatment within 24 hours of arrival at the Trust). As well as helping our patients receive quicker, safer treatment, the pathway has also led to a range of efficiencies in the wider healthcare system saving ambulance transfers; bed days spent in referring hospitals and reduced A&E attendances. The service is a key part of STP plans for pathway reforms and improving the quality of care for patients and has helping to ease pressures on NHS across the region.

2018 marked the centenary of the Trust and the 70th birthday of the NHS and we held a number of events that celebrated our centenary, the wider NHS and our relationship with the village of Papworth Everard since the foundation of the hospital.

Over the last 12 months we have improved digital maturity, becoming a Lorenzo Digital Exemplar site. We have introduced new functionality such as 'Lorenzo on the Wall' screens in clinical areas. We have achieved interoperability between our electronic patient record and the Epic system used at Cambridge University Hospitals through a two-way interface to record laboratory results

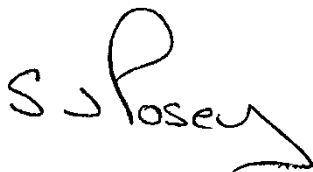
Of course, there have been many challenges too, as well as the delay in the move to our new hospital, like other hospital Trusts across England, we have faced many pressures due to staffing, finances and the increasing demand for our services. During the winter period in particular, we experienced a huge increase in demand for our for Extracorporeal Membrane

Oxygenation (ECMO) service, as well as high levels of transplant activity, which unfortunately led to cancellations for other patients and poor bed occupancy across the hospital.

However, while we have faced challenges with regards to staffing throughout the year, I must recognise the huge efforts of staff across the hospital to attract and retain high quality staff to support our patients before, during and after our move to the new hospital. A co-ordinated approach to recruitment campaign has seen for example our critical care nursing now having a waiting list of staff who want to work with our Trust.

The consolidated Trust financial position for the year is a reported a deficit of £11.45m (post impairment) and £9.89m (pre-impairment). This deficit is driven by the additional costs associated with the transition costs relating to the management of the move to the new Royal Papworth Hospital and the ongoing running costs of the site.

The year ahead will be another important one for the hospital as we move into our new, state-of-the-art hospital on the Cambridge Biomedical Campus. The challenge of moving a hospital safely cannot be underestimated, but I know we can count on the support of our staff, patients and partners to make it a success. I would like to take this opportunity to extend my sincere thanks to all of our stakeholders – from staff and patients to governors, Foundation Trust members and the wider NHS community – for your support of our hospital and our charity throughout the year.

A handwritten signature in black ink, appearing to read 'S. Posey', with a stylized flourish at the end.

Stephen Posey
Chief Executive
23 May 2019

Overview of Performance

The purpose of the Overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Hospital History and Statutory Background

Royal Papworth Hospital NHS Foundation Trust (“Royal Papworth Hospital” or “the Trust”) is the UK’s largest specialist cardiothoracic hospital and the country’s main heart and lung transplant centre. We have an extraordinary commitment to delivering the highest levels of clinical quality and outcomes and for providing the best possible standards of personalised care to our patients.

Royal Papworth Hospital was one of the first foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003 and came into existence in July 2004 as Papworth Hospital NHS Foundation Trust. Since then it has been licenced by the Regulator (previously named Monitor, now NHS Improvement). From 2018 we became Royal Papworth Hospital NHS Foundation Trust.

Royal Papworth Hospital has an associated charity – Royal Papworth Hospital NHS Foundation Trust Charity (Royal Papworth Hospital Charity) registered Charity number 1049224. From 2013/14, Royal Papworth Hospital has been required to produce group accounts which include the charity. Funds are still retained in the Charity which produces a separate annual report and accounts and continues to be regulated by the Charity Commission.

Royal Papworth Hospital is a founder member of Cambridge University Health Partners (CUHP), a partnership between one of the world’s leading Universities and three NHS foundation trusts. It is a strategic partnership aiming to improve patient care, patient outcomes and population health through innovation and the integration of service delivery, health research and clinical education across the Cambridgeshire region and beyond. CUHP is a not-for-profit Company Limited by Guarantee, the members of which are the University of Cambridge, Cambridge and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust and Royal Papworth Hospital NHS Foundation Trust.

Our Services

Whilst Royal Papworth Hospital is a regional centre for the diagnosis and treatment of cardiothoracic disease, it is also a national centre for a range of specialist services, including pulmonary endarterectomy (PEA) and Extra Corporeal Membrane Oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.

The Hospital treated 22,795 inpatient/day cases and 93,852 outpatient episodes in 2018/19 from across the UK. Royal Papworth Hospital’s services are internationally recognised and include cardiology, respiratory medicine, cardiothoracic surgery and transplantation.

New Royal Papworth Hospital

In May 2019, we will move into our brand new heart and lung hospital on the Cambridge Biomedical Campus.

The state-of-the-art new Royal Papworth Hospital offers cutting-edge facilities for patients requiring heart and lung treatment in a bespoke building. The facilities include:

- 310 beds, with virtually all being single rooms
- 46-bed Critical Care Area including Cardiac Recovery Unit and Cardiac High Dependency Unit

- 7 state-of-the-art theatres
- 5 Catheter Laboratories
- 6 inpatient wards and a 24-bed day ward
- A centrally-located outpatient unit
- State-of-the-art diagnostic and treatment facilities

Information about the new hospital can be found on the Trust's website:

<https://royalpapworth.nhs.uk/>

Heart and Lung Research Institute

In 2018/19 the Trust has continued to develop joint plans with the University of Cambridge to create a world-class Heart and Lung Research Institute (HLRI) alongside the new Royal Papworth Hospital. The HLRI will establish one of the largest concentrations of biomedical and scientific research into heart and lung disease in the UK leading to many future benefits to patients. The Institute will allow for significant expansion of basic and clinical research capacity in Cambridge and will also enable the co-location of research groups that are currently dispersed across Cambridgeshire.

Capital contributions totalling c.£12m have been committed by the UoC and the Trust, and the BHF have committed a £10m Strategic Initiative Award to the HLRI. The UoC has requested £30m from RPIF to bring the total available funds to c. £52m. If successful the remaining funds, c. £12.6m, are expected to be secured by the UoC from other philanthropic donations. The Trust and the UoC have agreed to work together in good faith and have formed a joint Project Board to oversee all aspects of the project including specification, construction, financial controls, equipment fit-out and building operational management arrangements.

Diseases of the heart and lung are some of the biggest killers worldwide. Despite a growing awareness of risk factors, such as smoking and poor diet, the prevalence of such diseases is increasing. The HLRI will provide a unique opportunity to establish a world-leading centre of excellence for heart and lung research and will be used by the Trust for research, clinical trials and education facilities.

Research and Development (R&D)

Recruitment and Research Activity

During 2018/19 we enrolled 3038 patients across a balanced portfolio of 63 studies that were open to recruitment with over 55% of these studies being interventional (testing of new therapies and treatments) (see the Quality Accounts for further information). In addition to this recruitment activity we managed the follow up visits for over 120 ongoing studies.

Royal Papworth Hospital ranked as the top recruiting site in the UK for over 20% and in the top 3 highest recruiters for over 50% of the multicentre NIHR portfolio studies we supported. The R&D department has worked hard to improve processes within the department and with the clinical teams. The department has restructured with the introduction of research teams with designated team leaders. This has resulted in an increase in studies recruiting to time and target.

R&D Highlights

- Mr Sam Nashef was awarded a £850K grant from the Moulton Trust to evaluate the impact of cardiac surgery on patient's quality of life. The study aims to recruit 8004 patients from all cardiac surgical centres in the UK over the next 2 years.
- Dr Robert Rintoul and Dr Nitzan Rosenfeld (Cancer Research UK (CRUK)) were awarded a £2.6M CRUK programme grant to study circulating tumour DNA (ctDNA) in early stage lung cancer. This will also include set up of an 850 patient cohort of patients who have

had curative treatment for lung cancer and monitor them for development of second primary lung cancer.

- In September 2018, Papworth Clinical Trials unit gained full accreditation status from the UKCRC.
- The Trust is a collaborator on a number of Innovate UK grants in conjunction with a range of SME companies around the UK. These include, a novel treatment for Bronchopleural fistula (Mr Aman Coonar), a diagnostic test for Mycobacterium (Prof A Floto), and a National Artificial Intelligence project (Dr N Screamton).

Research Impact and Publications

Over 290 papers with Royal Papworth Hospital authors were published during 2018 across a breadth of clinical disciplines and published in a range of journals. This is over 30% increase from 2017.

The Trust remains committed to improving patient outcomes by undertaking clinical research that will lead to better treatments in the NHS. We would like to say thank you to all those who participated in our research over the past year.

Royal Papworth Hospital Charity

The Foundation Trust also administers the Royal Papworth Hospital NHS Foundation Trust Charity (Royal Papworth Hospital Charity) registered Charity number 1049224. These funds have resulted from fundraising activities and donations received over many years. These funds are used for the benefit of both patients and staff in accordance with the purpose for which the funds were either raised or donated. Such uses include equipment for wards and funding for Research. The funds are administered by the Trust's Finance Department. The funds are overseen by the Charitable Funds Committee, which is chaired by a Non-Executive Director of the Trust, and includes representatives from the Board of Directors.

The Papworth Hospital Charity Office works hard to attract additional funding into the hospital, by supporting those who fundraise in the community and by organising various activities during the year. Among the popular annual events is the carol service at Ely Cathedral. The Charity receives wonderful support from members of the public, patients and their families and we are especially grateful to those who make the most personal of gifts by remembering the hospital in their will.

The Charity Annual Report and Accounts for the year ended 31 March is published separately and will be available on the Trust's website after it is submitted to the Charity Commission by the January 2020 deadline.

Further information on Papworth Hospital Charity is available at:
www.papworthhospitalcharity.org.uk.

Cambridge University Health Partners (CUHP)

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

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

Academic Health Science Centres (AHSC) have been created by the Department of Health as they looked to identify outstanding clinical partnerships in England. Six centres in total have been created and they were chosen due to their links with university research, clinicians and business as well as their capacity to further develop collaboration to improve healthcare

for patients. CUHP was set up as a Limited Company in 2009 and was reaccredited in 2014 by the National Institute for Health Research for three years.

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

The Chairman and the Chief Executive of Royal Papworth Hospital NHS Foundation Trust are ex officio Directors of CUHP, as are the Chair and Chief Executive of CUH and CPFT, the Vice-Chancellor of the University of Cambridge, the University Registrar and the Regius Professor of Physic. There are also three further Directors with both clinical and academic responsibilities, one linked with each of the NHS Trusts.

For more information on CUHP see <http://www.cuhp.org.uk/>

Highlights 2018/19

Rapid NSTEMI pathway

On Monday 10 September we launched a new pathway for patients with high-risk NSTEMI (a type of heart attack) in partnership with the East of England Ambulance Service, Cambridge University Hospitals and North West Anglia NHS Foundation Trusts. The Rapid NSTEMI pathway sees high-risk patients transferred immediately to Royal Papworth Hospital for coronary angiography and revascularisation, rather than being admitted to an acute trust first. In its first year, the new pathway has the potential to save the NHS 125 ambulance transfers, 604 occupied bed days and £238,000 while improving outcomes for patients.

Bidirectional interface with CUHFT

Blood test results from patients at Royal Papworth Hospital can now be sent electronically from the laboratory at CUH back to Royal Papworth, thanks to a new link between the different electronic patient record systems used at the two Trusts. The complex link between the two systems means that clinicians will receive results from blood tests – which are analysed at the CUH laboratory – much more quickly than if they had to wait for them to arrive by post. It is hoped that the electronic link will also lead to a reduction in transcribing errors, as clinicians will no longer have to enter test results manually into Lorenzo, the electronic patient record system used here at Royal Papworth. The interface, which went live on 16 October 2018, marks the first ever connection between Lorenzo and the Epic electronic patient record system used at CUH. Eventually it is hoped that further connections will be developed to allow other types of clinical information to be shared, benefitting the many patients who receive treatment at both hospitals.

Completion of new hospital construction

Construction work on our new hospital building on the Cambridge Biomedical Campus was completed in January 2019 and we received handover of the building from our construction partner, Skanska. Several teams – including the Project team, Digital and Medical Engineering teams – moved into the new building to carry out equipping and staff training in preparation for our move in May 2019.

Cardiovascular Outcomes – NICOR report 2014-2017

Royal Papworth Hospital is the best-performing NHS hospital in the country for cardiac surgery survival, according to a report published in January. Over a three-year period, the hospital had a risk adjusted survival rate of 98.81%. The national survival rate for this group of patients is 98.16%. During that time, Royal Papworth also performed the most procedures, recording 5,722 cases, making it both the biggest and best-performing cardiac surgery unit in the UK. The data comes from the National Institute for Cardiovascular Outcomes Research (NICOR) report, which looked at hospital performance between 2014 and 2017.

Annual Report on Cardiothoracic Transplantation

Royal Papworth Hospital had a number of the UK's best survival rates for heart and lung transplants, according to a report published by NHS Blood and Transplant (NHSBT) in September 2018.

The report identifies that the national 30 day rate of survival following adult heart transplantation was 90.8%, which ranged from 83.6% to 95.3% across centres (risk-adjusted), with some evidence of a significantly higher rate of survival at Papworth (95.3%). The national 1 year survival rate was 83.2%, ranging from 76.3% to 90.0% across centres (risk-adjusted), again with some evidence of a significantly higher rate at Papworth. The national 5 year survival rate was 69.2%, ranging from 48.5% to 76.8% across centres (risk-adjusted). There was also some evidence of higher survival at five and ten years at Papworth, compared with the national rates.

For lung transplant the 90-day post-transplant all centres were statistically consistent with the national rate of survival which was 89.4%. Papworth had a rate of 92.6% (92.9% risk adjusted).

According to NHSBT's Annual Report on Cardiothoracic Transplantation, Royal Papworth Hospital performed more adult heart transplants each year than any other hospital in the UK. It also had the lowest decline rate for donor organs, meaning it accepts more organs offered for donation than any other UK centre.

Celebrating our staff

On Thursday 14 March, we held our annual staff awards ceremony in our new hospital, just a few weeks before it opened to patients. We were able to put on a fantastic evening of celebration for around 160 staff members.

Strategy and operational plans

In 2019 the Royal Papworth Hospital NHSFT (RPH) is developing its strategy for 2019 – 2024. The current strategy will essentially be completed in 2019 with the move to the Cambridge Biomedical Campus. A new strategy is needed to set out a clear direction of travel for the future, guide decisions on priorities and investments, and steer the ongoing development of both services and partnerships. This is being developed at a time when the environment is characterised by unprecedented challenges, opportunities, and change. The strategy must respond appropriately and positively to these drivers; and so it is vital that these factors are clearly understood by all involved in the development of our strategy.

The new NHS Plan helpfully identifies both cardiovascular and respiratory disease as priority areas for attention and investment, as major contributors to death and disability. The emphasis throughout is firmly on prevention, early detection and treatment in primary care, and rehabilitation; with the aim being to avoid or reduce the need for care in an acute setting.

At Royal Papworth Hospital, our vision is to be the leading hospital in the UK providing excellence in specialist heart and lung patient care, based on research, education and innovation. Our focus is to keep pace with demand, and to deliver value and effectiveness, with a commitment to the highest levels of clinical quality and providing the best standards of personalised care possible to our patients.

The implementation of this strategy aims to ensure that Royal Papworth Hospital maintains its position as a cardiothoracic centre of international standing, and supports our new state of the art hospital and research centre on the Cambridge Biomedical Campus.

We have agreed Strategic Objectives for 2019/20 as set out in the table below together with the method of measurement:

Strategic Objectives

2019/20 Strategic Objectives	Measure:
1.1 Our Patients: We will implement our Quality Strategy (2019-2022) and further embed our Quality Improvement methodology to deliver continuous quality improvement, supporting excellent care and outcomes.	PIPR: Safe KPIs & Caring KPIs and Quality Account measures.
1.2 Our Patients: We will deliver our activity plan and meet our patient access targets.	PIPR: Responsive KPIs, Effective KPI's, Contract compliance and RTT recovery plan measures.
2.1 Our Staff: We will, during this period of change, invest in our leaders to enable them to be the best they can be to support our incredible staff to deliver excellent patient care.	PIPR: People, Management and Culture KPIs and Staff survey results.
2.2 Our Staff: We will continue to enhance our reputation as an employer and attract high quality staff to work with us in all roles and departments.	PIPR: People, Management and Culture KPIs and Staff survey results.
3.1 Our Resources: We will deliver a safe and effective move to our new Royal Papworth Hospital.	PIPR: Transformation KPIs and the MCP .
3.2 Our Resources: We will deliver our financial plan and recovery programme, supporting the Trust's return to financial sustainability.	PIPR: Responsive KPIs, Effective KPI's, Contract compliance and RTT recovery plan measures.
4.1 Our Partners: We will use the opportunity of our new hospital and location to innovate, develop partnerships with external organisations and further build upon our reputation as one of the world's leading heart and lung hospitals.	Develop 24/7 Cardiology services across the patch; developing & extending the N-STEMI pathway; STP, CTP, MCP plan delivery.
4.2 Our Partners: We will work closely with our Sustainability and Transformation Partnership (STP) partners to support delivery of our system plan and, through our leadership of cardiothoracic services, to refine patient pathways to improve outcomes and patient experience.	NHS Digital, CUHP, STP and CTP milestone achievement.

For further information on our strategic objectives see our Strategic and Operational Plans submitted to NHS Improvement: <https://improvement.nhs.uk/about-us/corporate-publications/publications/Royal-Papworth-Hospital-NHS-Foundation-Trust/>

The key risks for 2019/20 are:

Risk Description	Mitigation
<p>Workforce Recruitment and Retention The inability to recruit and retain mission critical staff (including registered nurses, other professional staff and all non-medical staff groups) resulting in an impact on clinical services, maintaining capacity, pressure on existing staff and failure to meet NHSI agency ceiling and safer staffing levels. Whilst vacancy levels have reduced over the last year there remain high vacancy rates in some areas that impact on the provision of required activity levels. The significant organisational change, primarily the increase in travel time for staff, as a result of the relocation of the hospital has had a negative impact on retention of staff. The national shortages of key professional groups such as nursing means that there will be a continuing impact on the ability of the Trust to recruit staff.</p>	<p>The Trust has a Recruitment and Retention Strategy which includes overseas recruitment campaigns and a programme for assisting overseas nurses to gain registration, proactive social media campaign, engagement with HEIs across the country and regular recruitment events including some jointly with CUH, promotion of return to practice option. The Recruitment and Retention Strategy addresses how we seek to retain staff by supporting and developing them. In addition we have taken specific actions to mitigate the impact of the relocation of the hospital including : an excess daily travel allowance to support staff travelling to the new site, working with campus partners to commission a new bus routes from the west of Cambridge to the new site, a free bus service from the new staff accommodation in Waterbeach to the existing site to support staff in remaining with the Trust during the delays to the relocation.</p>
<p>New Royal Papworth Hospital (including Hospital Move ‘cut over’) Affordability; construction, equipping, Cambridge Transition Programme, ICT and telecoms and cut over planning; construction delays; future</p>	<p>Risk documentation and tracking; Standalone solutions where appropriate; Significant internal audit work performed during 2018/19 (see later in Annual Governance Statement for more detail); Review by the Project Board and Strategic Projects Committee, including ‘Go or No Go Decision’); Escalation process to the Board of Directors.</p>
<p>Cambridge Transition Programme (part of New Royal Papworth Hospital move) Failure to secure mission critical services prior to move to NPH.</p>	<p>CEOs and Teams at Royal Papworth and CUH are working together to resolve mission critical services with agreement that NPH is a joint endeavour. Alternative plans to joint working are being developed where these are more appropriate.</p>
<p>Finances The Trust’s financial position due to national NHS financial pressures, risks to delivery of activity, or change in casemix, the move to the new hospital and the need to identify cost improvements have potential risks to impact on quality. The conclusion of the disposal of residual estate (impact on the cash position Q1 & Q2 2019/20); Delay in implementation of changes in the national tariff for transplantation.</p>	<p>Quality Impact assessments for all CIP/SIP. Continually reviewing environment through CQC matron ward rounds (weekly) and PLACE inspection (1 per year). Escalation to Nursing advisory group and Quality and Risk Committee. Maintenance work plan from estates. Weekly review of Family and Friends feedback escalated to estates if patient environment needs addressing. On-going discussions with Commissioners and Regulators.</p>

Other factors not discussed within this summary could also impact on the Trust and accordingly, this summary should not be considered to represent an exhaustive list of all the potential risks and uncertainties, both positive and negative that may affect the Trust.

Further information on the principal risks to the Trust and internal controls are included in the Annual Governance Statement (AGS) section of the Annual Report.

Going Concern

There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

The Trust is required by the Group Accounting Manual (GAM) to prepare accounts on a going concern basis. The GAM states: *4.11 The FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.*

4.12. For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.13. Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.14. Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.15. Where a DHSC group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved.

4.16. Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible.'

After making enquiries, the Directors have a reasonable expectation that Royal Papworth Hospital NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Further information is available in the Annual Accounts – Accounting Policies.

1.2 Performance Analysis

The purpose of the “Performance analysis” is to provide a detailed performance summary of how Royal Papworth Hospital measures its performance, more detailed integrated performance analysis and long term trends.

Meeting Specialist Healthcare Needs – Treating More Patients

2018/19 has been another busy year for Royal Papworth Hospital and the specialist services provided by our dedicated staff. The number of patient episodes seen at the hospital was 116,647 (2017/18: 116,536) and the tables below provide a breakdown of this demand across our services.

Inpatients and day cases

	2018/19	2017/18	2016/17	2015/16	2014/15
Cardiology	8,318	8,213	8,843	8,548	8,118
Cardiac Surgery	2,252	2,235	2,418	2,561	2,613
Thoracic Surgery (incl PTE)	933	887	888	907	918
Respiratory Support and Sleep Centre	6,064	7,631	7,096	6,901	6,975
Transplant/Ventricular Assist Devices	673	698	885	949	913
Thoracic Medicine	4,555	4,627	5,081	4,809	4,427
Total	22,795	24,291	25,211	24,675	23,964

Outpatients

	2018/19	2017/18	2016/17	2015/16	2014/15
Cardiology	39,812	37,141	37,122	34,416	31,681
Cardiac Surgery	3,604	4,727	5,557	6,139	4,657
Thoracic Surgery	1,266	1,393	1,367	1,510	1,270
Respiratory Support and Sleep Centre	23,632	23,724	24,614	22,161	21,039
Transplant/Ventricular Assist Devices	4,168	3,820	3,435	3,476	3,442
Thoracic Medicine	21,370	21,440	20,491	19,264	19,105
Total	93,852	92,245	92,586	86,966	81,194

Control of Infection

MRSA bacteraemia and C. difficile infection rates*

Goals 2016/17	Outcome 2016/17	Goals 2017/18	Outcome 2017/18	Goals 2018/19	Outcome 2018/19	Goals 2019/20
No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	3 MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia
No more than 5 C. difficile cases *	Total for year = 0	No more than 5 C. difficile cases *	Total for the year= 3	No more than 4 C. difficile	Total for the year 2	No more than 11 C.difficile
Achieve 100% MRSA screening of patients according to agreed screening risk assessment	98%	Achieve 100% MRSA screening of patients according to agreed screening risk assessment	98.7%	Achieve 100% MRSA screening of patients according to agreed screening risk assessment	97% data collected between April 18 – February 19 Q4 data is not currently available	Achieve 100% MRSA screening of patients according to agreed screening risk

Data Source: Mandatory Enhanced Surveillance System (MESS) and PHE Health Care Associated Infection Data Capture System

***Please note: The figures reported in the table are the number of C.difficile cases and MRSA bacteraemias attributed to the Trust and added to our trajectory ceiling targets.**

* Sanctioned cases are those that occur more than two days after admission to Royal Papworth Hospital NHS Foundation Trust and which, after discussion at a scrutiny panel meeting, are deemed to be placed on our trajectory by the Clinical Commissioning Group (CCG) Matrons.

For further information see Part 3 of the Quality Report – other information.

Performance of Trust against selected metrics

Throughout 2018/19 we have continued to measure our quality performance against a number of metrics. The Table below sets out our performance against the national operational metrics identified in Appendix 3 to NHS Improvement's (NHSI's) Single Oversight Framework which are applicable to Royal Papworth Hospital.

Operational performance Metrics

Indicator	Target pa	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-17	Jan-19	Feb-19	Mar-19	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	83.38%	83.62%	83.82%	84.52%	85.65%	87.31%	88.45%	89.49%	90.49%	90.91%	90.35%	90.30%	87.41%
62 day cancer wait *	>85%	100.00%	100.00%	92.90%	78.6%	71.4%	100.00%	100.00%	71.4%	71.4%	100.00%	100.00%	80.00%	88.3%
31 day cancer wait	>96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.1%	100.00%	100.00%	100.00%	100.00%	99.3%
6 week wait for diagnostic	>99%	99.59%	99.14%	99.55%	99.60%	99.50%	99.23%	99.08%	99.18%	99.36%	99.42%	99.28%	99.31%	99.35%
C. difficile (sanctioned)	Less than 5	1	1	0	0	0	0	0	0	0	0	0	0	2
Number of patients assessed for VTE on admission	>95%	94.00%	94.00%	94.33%	94.33%	94.50%	94.24%	92.04%	92.00%	86.64%	86.66%	96.66%	93.33%	92.64%

*These indicators have been subject to independent assurance. KPMG's assurance report can be found in Annex 3 to the Quality Report. The definition of this indicator can be found in Annex 4 to the Quality Report.

Care Quality Commission (CQC)

The last CQC inspection was undertaken in December 2014. Overall the CQC found that the hospital provided highly effective care with outcomes comparable with or above expected standards. The service was delivered by highly skilled, committed, caring staff and patients were overwhelmingly positive about the care they received at the hospital. However, there were areas in which Royal Papworth Hospital could improve and action plans were put in place to address these. The Trust received an overall rating of Good with areas of outstanding practice.

The ratings for Royal Papworth Hospital against the five key questions used by the CQC in their inspections of services are shown in the following table below

Ratings	
Overall rating for this trust	Good 
Are services at this trust safe?	Good 
Are services at this trust effective?	Outstanding 
Are services at this trust caring?	Outstanding 
Are services at this trust responsive?	Good 
Are services at this trust well-led?	Good 

For further information see Part 3 of the Quality Report – other information.

Patient Safety Incident Trends and Actions

There were a total of 2,628 patient incidents reported during the financial year compared to 2,499 in the previous year; an increase of 129 reports. In 2018/19 there were 2,278 actual incidents reported (2,208 in 2017/18) and 350 near miss incidents (291 in 2017/18).

Those graded as near miss (13%) and no/low harm over the last 12 months (80%) demonstrates a continuous readiness to report and learn from all types of incidents. There has been a request for staff to report incidents in order to demonstrate an open and fair culture of learning and no blame. This process also captures the clinical consideration given to all types of incidents, with moderate harm incidents and above being reviewed at the Trust's new Serious Incident Executive Review Panel (SIERP).

All moderate harm incidents and above have investigations and associated action plans, which are managed by the relevant business unit and monitored by the Quality and Risk Management Group (QRMG). Lessons learnt are shared across the organisation via the quarterly Lessons Learnt report on the intranet, Grand Round presentations and local dissemination via Business Units and specialist meetings.

For further information see Part 3 of the Quality Report – other information.

2018 National Adult Inpatient Survey

Royal Papworth Hospital performed very well in the latest National Inpatient Survey and improving our overall response rate from 59% to a 63% (against an average of a 43% response rate for similar organisations included in the Picker Average who undertook the survey on our behalf).

For further information see Part 3 of the Quality Report – other information.

Oncology/62 day cancer waits

Like all other hospital trusts, Royal Papworth Hospital is expected to treat 85% of patients referred on a 'fast track' pathway with suspected lung cancer within 62 days of referral. As Royal Papworth only treats lung cancer and is never the first hospital on a patient's pathway the achievement of the 85% single cancer site-specific target continued to be challenging in 2018/19 but was achieved.

For further information see Part 3 of the Quality Report – clinical effectiveness.

Financial Review 2018/19

This part of the Annual Report provides a review of the financial performance for the year ending 31 March 2019.

Summary of financial performance

As at 31 March 2019, the Trust had delivered the following performance:

	Plan	Year end
EBITDA *	£(0.60)m	£0.19m
Year-end deficit	£(17.02)m	£(10.23)m
Cash Balance	£4.60m	£22.72m
Use of resources rating	3	3

*Earnings Before Interest, Tax and Amortisation

- The year-end deficit of £(10.23)m included an impairment relating to the old hospital site of £1.56m;
- The capital programme was underspent by £3.53m due to the delay in the hospital move compared to the original plan and a capital contingency that was not utilised;
- The cash balance of £22.72m was favourable to plan by £18.12m due to an improved working capital position driven from the trading position and the delays to the capital equipping programme following the move delay.

2018/19 Income by Commissioner and Service

The following two tables show total income for the year broken down by Commissioner and Service.

2018/19 Income by Commissioner

	£'000
NHS England	98,473
Cambridgeshire and Peterborough CCG	13,070
West Suffolk CCG	4,126
West Norfolk CCG	2,841
Ipswich & East Suffolk CCG	1,606
Bedfordshire CCG	2,194
East and North Hertfordshire CCG	1,165
South Lincolnshire CCG	1,348
West Essex CCG	1,223
Other CCGs	4,459
Other NHS	3,485
Private patients	8,115
Other non-NHS	12
Total patient service income	142,117

2018/19 Income by Service

	£000's
Admitted patient care	
Cardiology	31,594
Cardiac surgery	24,488
Thoracic surgery	11,399
Respiratory Support and Sleep Centre	7,070
Transplant/Ventricular Assist Devices	18,387
Thoracic Medicine	11,749
Clinical and diagnostics	15,171
Total Admitted Patients	119,858
Outpatients	
Cardiology	5,362
Cardiac surgery	635
Thoracic surgery	212
Respiratory Support and Sleep Centre	3,898
Thoracic Medicine	2,876
Diagnostics	2,404
Total Outpatients	15,387
Agenda for Change (pay award central funding)	1,153
MFF (inpatients and outpatients)	5,719
Grand total (Inpatients and Outpatients)	142,117

Looking Ahead

Financial Plan 2019/20

Royal Papworth Hospital has a track record of successfully meeting the demand for specialist cardiac services, adapting to local and national changes in the healthcare system whilst pioneering and establishing new treatments and procedures to provide the best possible level of patient care to patients. The Trust is going through a significant period of change with the relocation of the hospital to the Cambridge Biomedical Campus in May 2019 and together with the financial challenges in the NHS both locally and nationally, it is increasingly imperative that the Trust deliver clinical excellence whilst maintaining financial stability.

Royal Papworth Hospital is fully engaged in the system wide transformation programme that is underway with our five neighbouring NHS providers, the Clinical Commissioning Group and local authority partners. Locally the Trust is also actively involved with Cambridge University Hospitals (CUH) in the Cambridge Transition Programme (CTP) in line with the move to the new hospital site on the Cambridge Biomedical Campus in May 2019. The impacts of this move have been reflected in the Operational Plan submissions.

In addition, the Trust agreed Strategic Objectives for 2019/20 as have been set out above.

The Trust is planning to deliver a £15.5m deficit on a Control Total basis – pre Financial Recovery Funding (FRF) / Prover Sustainability Funding (PSF) in 2019/20, a £nil (break-even) position on a Control Total basis post FRF/PSF and a bottom line surplus of £11.6m (post profit on sale of assets).

This Operational Plan reflects the impact of the agreed contracts with the Trust's largest commissioners, NHS England - Specialised Commissioning Midlands and East (East of England) and Cambridgeshire & Peterborough Clinical Commissioning Group.

Environmental matters

See sustainability section of Annual Report.

Social, community and human rights matters

See Staff Report and Sustainability Report.

Policies to Counter Fraud and Corruption

In common with all NHS organisations, Royal Papworth Hospital takes a very robust approach to fraud and bribery. Trust policies provide details of the points of contact for any members of staff who suspect fraud and bribery is taking place. The Trust has a dedicated counter fraud officer who, amongst other areas of counter fraud work, works on behalf of the Board to inform and involve staff of the Trust's anti-fraud stance as well as seeking the prevention and detection of fraud. Any concerns reported are investigated at the earliest opportunity by the Local Counter Fraud Specialist (LCFS), in conjunction with the Trust Management. The LCFS provides reports to the Audit Committee on the concerns raised and the action taken.

Operations outside of the United Kingdom (UK)

Royal Papworth Hospital NHS Foundation Trust has no branches outside the UK.

Any important events since end of the financial year affecting Royal Papworth Hospital

There have been no important events since the end of the financial year affecting Royal Papworth Hospital.

A handwritten signature in black ink, appearing to read 'S. Posey', with a stylized flourish at the end.

Stephen Posey
Chief Executive and Accounting Officer
23 May 2019

2. Accountability Report

2.1 Director's Report

Composition of the Board

The Board consists of seven Non-executive Directors (NEDs), one of whom is the Non-executive Chairman, and six Executive Directors (EDs), one of whom is the Chief Executive. During the year due to changes ten individuals served as NEDs.

Non-executive Directors

The Council of Governors has responsibility for appointing the Chairman and NEDs. One of the NEDs is a clinical representative nominated by the University of Cambridge.

Register of Interests

At the time of their appointment, all Directors are asked to declare any interests on the Register of Directors' Interests. There is a standing item on all Board of Directors and Committee meetings to confirm/update declarations of interest. The register is held by the Trust Secretary and updated annually or as required during the year and interests are recorded in the minutes of the Board. The register is available to the public and published on the Trust website. Anyone who wishes to see the Register of Directors' Interests should make enquiries to the Trust Secretary at the following address: The Trust Secretary, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

Political Donations

No political donations have been made by Royal Papworth Hospital NHS Foundation Trust in the 2018/19 financial year. No political donations were made in previous years.

Cost allocation and charging

During the year 2018/19, the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within thirty days of receipt of goods or a valid invoice, whichever is later. Furthermore, the Trust has made efforts to play its part in assisting small and medium sized enterprises in these more challenging financial times through aiming to make payment within ten days where possible.

The Trust endeavours to make payments within the timescales required by the Code and aims to pay 95% of invoices within 30 days or within agreed contract terms. In 2018/19 86.6% (2017/18: 79.0%) of non-NHS invoices were settled within 30 days of invoice date and 69.9% (2017/18: 60.2%) of NHS invoices. The Trust paid £0 (2017/18: £0) of interest under the Late Payment of Commercial Debts (Interest) Act 1998 during.

Statement of Directors' Responsibilities in respect of the Annual Report and Accounts

Under the NHS Foundation Trust Code of Governance the Directors of Royal Papworth Hospital NHS Foundation Trust are required to prepare financial statements for each financial year. The Directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

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

The income from the provision of goods and services for the purposes of the health service in England during 2018/19 was greater than the income from the provision of goods and

services for any other purposes. Private patient income was £8.12m (£8.15m 2017/18) or 5.4% (6.1% 2017/18) of total patient income.

Quality and Risk

Quality Strategy

Our Quality Strategy has been reviewed and refreshed in 2018 and builds on the foundations and achievements of previous Trust strategies. We have made excellent progress over the past three years and our new strategy provides the opportunity to reflect on our achievements and journey so far, and to refresh our Quality Ambitions and Objectives for the next 3 years. Our Strategy is aligned to and takes into account of the National Quality Improvement (QI) agenda, current QI research, and National QI leadership programmes. This includes the Trust Board endorsement to implement the Culture and Leadership Programme co-designed between NHS Improvement and the Kings Fund, which will start in 2019 and support the delivery of our Quality Strategy.

At Royal Papworth Hospital we pride ourselves on our ability to deliver state-of-the art medicine with excellent patient outcomes. However it is important to always strive for improvement in the care which is given to our patients and look at new and innovative ways to do this. We believe that high quality care is only achieved when safety, clinical effectiveness and positive patient experience are present; not just one or two of them.

For further information see Quality Report.

Quality Governance

The Trust has a Quality and Risk Management Group (QRMG) as part of its framework to ensure that it has in place a system to support the continuous improvement in the quality of care. The Group approves and monitors policies and procedures to safeguard patient care and promotes an organisational culture that encourages patients, visitors and staff to report any concerns they may have or make suggestions for improvement. The QRMG meets every four weeks and is chaired by a Consultant Anaesthetist (Clinical Governance Lead). A quarterly Quality and Risk report is published on the Trust's public website. The objective of this document is to ensure that the Trust can demonstrate a robust system for the analysis and communication of clinical governance activity across the whole organisation. This includes a systematic approach to the analysis of incidents, complaints, claims and resulting actions.

Approach to Quality Improvement

Quality Improvement Capability is described in the Quality Strategy, the Trust intends to build quality improvement capability from novice to expert. This is a continuation of the work already underway to improve the safety and continuous improvement culture within the Trust. Our Strategy is aligned to and takes into account the National Quality Improvement (QI) agenda, current QI research and National QI leadership programmes. This includes the Trust Board endorsement to implement the Culture and Leadership Programme co-designed between NHS Improvement and the Kings Fund, which will start in 2019 and support the delivery of our Quality Strategy.

For further information see the Quality and Risk Quarterly and Annual Reports on our web site <https://royalpapworth.nhs.uk/our-hospital/information-we-publish>

Commissioning quality priorities 2018/19

The Commissioning Quality Priorities for 2018/19 are set out below. Monitoring of the quality priorities continued through the year using the quality dashboard and quality accounts, overseen by the Quality and Risk Committee. Quarterly quality reviews were undertaken with lead commissioners. The Trust continues to aim to align its quality priorities with those set by the national agenda, and those agreed with commissioners through the contracting process and as part of the Commissioning for Quality and Innovation (CQUIN) programme.

The National and Local CQUINs for Royal Papworth Hospital in 2018/19 were as follows:

National CQUINs
GE3: Hospital Medicines Optimisation
IM2: Cystic Fibrosis Adherence
NSTEMI Pathway
NSTEAC pilot
Cardiac Clinical Network
CCG CQUINs
1a: Improvement of Health and Wellbeing of NHS Staff
1b: Healthy food for NHS staff, visitors and patients
1c: Improving the uptake of flu vaccinations for front line clinical staff
2a: Timely identification of sepsis in acute inpatient settings
2b: Timely treatment of sepsis in acute inpatient settings
2c: Antibiotic review
2d: Reduction in antibiotic consumption
6: Offering advice and guidance
7: NHS e-Referrals
9a: Tobacco screening
9b: Tobacco brief advice
9d: Alcohol screening
9e: Alcohol brief advice or referral
Engagement in STP process

The Trust received 99.6% of its CQUIN funding for 2018/19. For further information on CQUINs see the Quality Report.

Commissioning quality priorities 2019/20

For 2019/20 the NHSE specialised 2019/20 CQUIN schemes and non-specialised CCG CQUIN schemes have been agreed and are set out below:

Specialised CQUIN Schemes:
GE3 Hospital Medicines Optimisation
Rethinking conversations/Shared decision making
NSTEMI Pathway
Cardiac Clinical Network
Non Specialised CQIN Schemes:
CCG 2 Staff Flu Vaccinations
CCG 3a Alcohol & Tobacco - Screening
CCG 3b Tobacco Brief Advice
CCG 3c Alcohol Brief Advice
CCG 7 Three High Impact Actions to Prevent Falls

Royal Papworth Hospital's Quality Account Priorities 2018/19

- Quality Improvement/Patient Safety
- Improve communication with our patients
- Recruitment and Retention
- Well Led
- Safely move the Hospital

For further information see the Quality Report - Part 2.

The Trust's quality priorities 2019/20

To determine priorities for 2019/20 the Trust reviewed its clinical performance indicators for the year and the feedback from on-going consultation with service users on the range and quality of services provided. A wide range of methods are used to gather information, including national patient surveys, real-time patient feedback from the Trust-wide patient experience data collection tool, concerns, compliments and complaints. Having identified potential priorities, the Trust consulted with clinical teams, Governors, Quality and Risk Committee and Patient & Public Involvement Committee before final priorities were selected. Our priorities for 2019/20 reflect the three domains of quality, patient safety and clinical effectiveness & patient experience. They are:

- Quality Improvement
- A safe Hospital Move
- Optimise Lorenzo
- Leadership and Culture

For further information see the Quality Report - Part 2.1 Priorities for improvement

NHS Improvement's well-led framework

The NHSI Well Led Framework focuses on ensuring that Trusts have strong integrated governance and leadership across quality, finance and operations, and in line with the changing operating environment and Developing People - Improving Care, an emphasis on organisational culture, improvement and system working. The annual governance statement, corporate governance statement and the quality report detail the Trusts approach to governance and leadership across quality, finance and operations. They detail the governance and performance framework against which the Board and leadership team assures itself that risks are appropriately identified, escalated and mitigated.

Utilising the NHSI guidance we have undertaken a developmental self-assessment of our leadership and governance using the framework as part of our continuous improvement. This self-assessment has been used to identify areas where we need to improve. A Fundamentals of Care Board has been established which is overseeing the implementation of improvements. We have worked at a directorate level to improve the governance and support structures. We have worked with our bookings teams to develop KPIs and delivered training across a range of staff. This has been a significant piece of work which looked at cultural change and a movement towards a responsive and professional business support function.

The performance review cycle for the Board has been reviewed and improvements made which ensure that all Executives and Non-Executive Directors have performance reviews completed by the end of the financial year and objectives set for the coming year in line with the Corporate Objectives. These objectives are then cascaded to individual Executive Directors teams. The performance review process includes individual 360 feedback.

Patient Experience

Patient Led Assessments of the Care Environment (PLACE) Programme

This is an assessment of how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. The latest published assessment was held in August 2018.

Further information is available in the Quality Report - Part 3.

Patient and Public Involvement

Royal Papworth Hospital has a Patient and Public Involvement Committee (PPI) of the Council of Governors which monitors patient experience, and is involved in setting the priorities for the Quality Accounts for the year. The Trust established a Patient and Carer Experience Group in year (formerly the PEP) with extended membership and including patient and support group representatives and representation from Healthwatch. The PEP and the PCEG group met on several occasions during the year and are represented on the PPI Committee.

The Trust continues to have strong relationships with The British Cardiac Patients Association (BCPA) and the Norfolk Zipper Club. Other patient support groups include:

- Pulmonary Hypertension;
- Mesothelioma;
- Pulmonary Fibrosis
- Transplant Patient Support Group.

Further information is available in the Quality Report - Part 3.

Complaints Handling

Listening to the patient experience and taking action following investigation of complaints is an important part of our quality improvement framework. In 2018/19 Royal Papworth Hospital received 54 formal complaints from patients. Of the 54 complaints reported (24 inpatient and 30 outpatient complaints) 53 were relating to NHS provided services with 1 complaint relating to private patient services at Royal Papworth Hospital. The overall numbers of complaints received is decreased on the number received during the previous year when 70 complaints were received (23% decrease). All formal complaints received have been subject to a full investigation, and throughout the year service improvements have been made as a result of analysing and responding to complaints. Communication /Information and Delay in Diagnosis/ Treatment or Referral categories were the highest reason for complaints in 2018/19.

Trends and data collected on formal complaints received by the Trust are reported to the Quality and Risk Management Group on a quarterly basis via the quarterly Quality and Risk report. Lessons learnt and actions taken following investigation of formal complaints are detailed in the report, which also includes Patient Advice and Liaison Service (PALs) feedback and patient incidents. The quarterly Quality and Risk report is presented to the Quality and Risk Committee (acting as a Committee of the Board of Directors) and to all clinical management groups. It is available on the Trust intranet for staff to access and is also on the public website.

Further Information on listening to the patient experience and complaints is available in the Quality Report Part 3.

Other Highlights of 2019-20

Student Nursing Times Awards

Royal Papworth Hospital's Critical Care Team was shortlisted for two categories at this year's Student Nursing Times Awards. The team was highly-commended for the Student Placement of the Year and Partnership of the Year awards – the latter with our partner, Anglia Ruskin University.

NHS Heroes Awards

On Monday 14 May, Royal Papworth surgeons Mr Stephen Large and Mr Steven Tsui received the 'Hero Pioneer Award' at the ITV and Daily Mirror NHS Heroes Awards. The award recognises their work to establish the DCD heart transplantation programme at Royal Papworth Hospital. The event was broadcast on ITV1 on Monday 21 May and covered in a wide range of national and local media outlets, helping to raise awareness of this innovative procedure which had already saved more than 40 lives.

Strategic partnership with Philips Electronics UK Limited

On Monday 11 June, Royal Papworth Hospital signed up to a strategic partnership with Philips Electronics UK Limited to explore new healthcare innovations. As part of the hospital's commitment to working with industry to tackle major heart and lung conditions, the two organisations agreed to team up on a number of projects that have the potential to transform patient care.

Celebrating 100 years at Papworth

On Wednesday 27 June we held a thanksgiving service at 6pm in Papworth Village Hall, conducted by the Bishop of Ely. The service, which was part of our centenary celebrations, was a chance to give thanks for everything the hospital has achieved over the last 100 years and the many people whose lives have been changed as a result of the hospital's work.

We also held a summer fete here in Papworth Everard to recognise 100 years of partnership with the village. The event, which raised funds for Royal Papworth Hospital, featured a huge range of traditional fete activities as well as stalls about our history, the work of our Research and Development team and our wards.

On 5 July, the 70th anniversary of the NHS, we held a screening of our new documentary 'Papworth: A Moving Story' at Cambridge Arts Picturehouse. The film had been made to celebrate our centenary thanks to support from the Heritage Lottery Fund and Papworth Hospital Charity. Further screenings took place in Papworth Everard and Saffron Walden later in the year.

New offices at Royal Papworth House in Huntingdon

On Monday 25 June, we opened our new office at Royal Papworth House in Huntingdon. Up to 200 staff members from departments including Workforce, Research and Development and the Booking team are now based in the new office, all making a vital contribution to our services.

New staff accommodation opened

On Monday 25 June, we accepted handover of our new staff accommodation at Waterbeach. This is a significant project which enables us to provide 230 new units of high quality staff accommodation to current and future staff members.

'How the NHS Changed our World' documentary

On Monday 25 June, BBC2 broadcast a documentary about Royal Papworth Hospital as part of a series called 'How the NHS Changed our World'. The documentary, which was part of the channel's NHS 70th anniversary programming, looked at the history of heart and lung transplantation at the hospital.

Annual Members' Meeting

On Wednesday 19 September, we held our Annual Members' Meeting for Foundation Trust Members in Papworth Village Hall. Our Foundation Trust Members heard updates on the hospital's performance over the past year, as well the latest on the hospital move and some excellent clinical presentations from some of our consultants. Many of the questions raised by those at the event echo the discussions we have been having internally regarding travel and parking at the Cambridge Biomedical Campus, how we plan to work with our partners at CUH and other hospitals in the future and our progress with implementing our Electronic Patient Record.

Celebrating Organ Donation Week

In September, to mark Organ Donation Week, we reunited five patients transplant patients who had received their transplants in 36 hours to help raise awareness of the need for more organ donors and for more families to have the discussion about organ donation at home.

DCD Heart Transplant Programme

Royal Papworth Hospital's pioneering donation after circulatory death (DCD) heart transplant programme reached a significant milestone when clinicians used the new life-saving technique on the 50th patient. The transplant took place in October, and since then surgeons and physicians have added to the figure – taking the total number of non-beating heart transplants to 64.

40 years since Papworth Hospital carried out its first ever heart transplant.

On Monday 14 January we marked 40 years since Papworth Hospital carried out its first ever heart transplant. On 14 January 1979, a 44-year-old patient underwent the operation, which was overseen by surgeon Sir Terence English, having spent a prolonged time in hospital with advanced heart disease. The recipient died 17 days later after developing a brain injury, but the dramatic effect of providing a patient in terminal heart failure with a normal functioning heart had been shown. The operation which is considered the UK's first successful heart transplant was carried out at Papworth Hospital in the August of the same year.

Pulmonary endarterectomy

Royal Papworth Hospital has performed its 2,000th pulmonary endarterectomy (PTE) procedure, 23 years after the hospital's first in 1996. This is the second biggest PTE series in the world and is one of the most active currently, with nearly 200 operations carried out each year. Royal Papworth remains the only centre in the UK offering the service with some of the best long-term outcomes internationally. I would like to congratulate the whole team involved in reaching this significant milestone.

Excellence in Organ Retrieval Award

Royal Papworth Hospital won a top transplant award at the British Transplantation Society Annual Congress 2019 in March. Our Transplant team picked up the accolade for 'Excellence in Organ Retrieval' at the 'Inaugural UK Awards for Excellence in Organ Donation and Retrieval'. Transplant Consultant Dr Jas Parmar collected the award, with judges praising the 'entire hospital staff for a number of reasons, not least completing five transplants in 36 hours' last year. Other achievements during the year included a world record in the number of adult donation after circulatory death (DCD) heart retrievals, resulting in a 40% increase in the number of patients who have benefitted from transplantation, leading to a significant reduction in the hospital's heart transplant waiting list.

Disclosures to Auditors

So far as the Directors are aware, there is no relevant audit information of which the Trust's auditor is unaware and each Director has taken all of the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

The Directors' Report is presented in the name of the following directors who occupied Board positions during the year 2018/19:

Name	Title
John Wallwork	Chairman
Michael Blastland	Non-Executive Director (from 22 March 2019)
Karen Caddick	Non-executive Director (to 31 October 2018)
Cynthia Conquest	Non-executive Director (from 1 January 2019)
David Dean	Non-executive Director (from 1 November 2018 & Designate NED from 1 August 2018)
David Hughes	Non-executive Director and Deputy Chairman
Susan Lintott	Non-executive Director and Senior Independent Director
Mark Millar	Non-executive Director (to 31 October 2018)
Nick Morrell	Non-executive Director
Ron Zimmern	Non-executive Director (to 28 February 2019)
Stephen Posey	Chief Executive
Roy Clarke	Chief Finance Officer
Roger Hall	Medical Director
Eilish Midlane	Chief Operating Officer (from 24 April 2017)
Oonagh Monkhouse	Director of Workforce and OD (from 1 October 2017)
Josie Rudman	Chief Nurse
Andrew Raynes	Director of Digital and Chief Information Officer



Stephen Posey
 Chief Executive and Accounting Officer
 23 May 2019

2.2 Remuneration Report

During 2018/19 there were a number of changes to the Non-executive Directors (NEDs) on the Board. Two NEDs came to the end of their terms of office; one NED resigned from the Board and three NEDs were appointed to the Board. One NED had their third term extended from three to eleven months (from February 2019 to October 2019) to provide continuity during the hospital move.

The Trust has also made two NED designate appointments to replace two NEDs whose terms of office come to an end in October 2019.

All appointments are subject to open advertisement.

The Trust has two Committees contributing to the process of remuneration of members of the Board of Directors:

- Executive Remuneration and Nominations Committee of the Board of Directors, comprising the Chairman and all the Non-Executive Directors (NEDs). This Committee is responsible for Executive Director performance and remuneration;
- Appointments (NED Nomination and Remuneration) Committee of the Council of Governors, comprising elected Governors. This Committee is responsible for NED, including the Chairman, performance and remuneration.

Annual Statement on Remuneration from the Chair of the Executive Remuneration Committee

Major decisions on senior managers' remuneration

Remuneration and performance appraisal for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Executive Remuneration and Nominations Committee. The only non-cash element of senior managers' remuneration packages are pension related benefits accrued under the NHS Pensions Scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which applies to all NHS staff in the scheme. The Trust's strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and ongoing appraisal process.

Senior managers are employed on contracts of employment and are substantive employees of the Trust. Their contracts are open ended and can be terminated by either party with six months' notice. The Trust's normal disciplinary policies apply to senior managers, including the sanction of summary dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff.

Senior Managers' remuneration policy (Executive Directors who are Board members)

Future Policy Table – Executive Directors

The table below summarises each of the components of the remuneration package for senior managers which comprise the senior managers' remuneration policy.

Remuneration component	Applicable to	Jurisdiction	Relevance to Trust's long and short term objectives	Amount payable
Basic salary	All senior managers	Remuneration Committee	Recommendations in respect of basic salary are made to the Remuneration Committee by the Chief Executive (for Executive Directors) and the Chairman (for the Chief Executive) on the basis of internal and external relativities, the scope of responsibilities, where appropriate performance and the annual cost of living assessment.	Any increases are agreed with reference to external benchmarks and advice as required. No Executive Director has been released for Board duties at another trust for which they have received an additional payment.
Payments over £150,000	Two Senior Managers	Remuneration Committee. NHSI approval where above £150k National Terms and Conditions – Consultants (England) 2003	When determining salary levels, an individual's role, and experience together with independently sourced data are considered. For medical staff National terms and conditions for Consultants apply.	See table 1- Remuneration to March 2019.
Pension	All senior managers	Terms of membership as specified by the NHS Pension Scheme administered by the NHS Pensions Agency	Not Applicable	Existing Executive Directors are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions .
Clinical Excellence Award Scheme	Medical Director	Determined by Local and National Awards Committees in accordance with medical employment contracts; these are not awarded by Remuneration Committee	Awards are determined by the Local and National Awards Committees in accordance with an agreed scheme that recognises clinical excellence. Analysis of the scheme demonstrates a linkage to the Trust's strategic objectives including the leadership and delivery of clinical services, teaching, training and research.	Level 9 award is the maximum that can be awarded locally.

Accompanying notes:

- (1) There have been no additions or changes to the components of the remuneration package paid during 2018/19
- (2) There are no significant differences in 2018/19 between the remuneration policy for senior managers and the general policy for employees' remuneration
- (3) The remuneration policy for 2018/19 does not include provision for performance-related bonuses or other such schemes.
- (4) There is provision for the recovery of performance sums paid to directors

Non-executive director remuneration policy

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	The remuneration and expenses for the Trust Chairman and Non-Executive Directors are determined by the Council of Governors, taking account of the guidance and advice issued by organisations such as the NHS Confederation and the NHS Appointments Commission.
Appointment		The Council of Governors appoints the Non-Executive Directors for an initial term of office of 3 years, with the opportunity to be reappointed subject to satisfactory performance and the Council of Governors' approval.

Terms of Office of members of the Board of Directors during 2018/19

		First Appointed	Re-appointed From	Expiry/End of Term of Office
John Wallwork	Chairman	1 Feb 2014	1 Feb 2017	31 Jan 2020
Michael Blastland	Non-executive Director	22 Mar 2019	-	31 Mar 2022
Karen Caddick	Non-executive Director	1 Nov 2013	1 Nov 2016	31 Oct 2018
Cynthia Conquest	Non-executive Director	1 Jan 2019	-	31 Dec 2020
David Dean	Non-executive Director	1 Nov 2018	-	31 Oct 2021
David Hughes	Non-executive Director	1 Nov 2013	1 Nov 2016	31 Oct 2019
Susan Lintott	Non-executive Director	1 Dec 2012	1 Dec 2015 1 Dec 2018	31 Oct 2019
Mark Millar	Non-executive Director	1 Nov 2011	1 Nov 2014 1 Nov 2017	31 Oct 2018
Nick Morrell	Non-executive Director	1 Jan 2014	1 Jan 2017	31 Dec 2019
Ron Zimmern	Non-executive Director	1 Dec 2012	1 Dec 2015	28 Feb 2019
Stephen Posey	Chief Executive	14 Nov 2016	Not Applicable	6 month notice period
Roy Clarke	Director of Finance	30 Nov 2015	Not Applicable	6 month notice period
Roger Hall	Medical Director	22 May 2015	Not Applicable	6 month notice period
Eilish Midlane	Chief Operating Officer	24 Apr 2017	Not Applicable	6 month notice period
Oonagh Monkhouse	Director of Workforce and OD	1 Oct 2017	Not Applicable	6 month notice period
Josie Rudman	Chief Nurse/Interim COO	18 Mar 2014	Not Applicable	6 month notice period
Andrew Raynes (Advisory Non-Voting Member)	Director of Digital and Chief Information Officer	01 April 2018	Not Applicable	6 month notice period

Attendance of Non-executive Directors at Executive Remuneration Committee Meetings

Name		03-May-18	08-Aug-18
John Wallwork	Chairman	✓	✓
Michael Blastland	Non-executive Director		
Karen Caddick	Non-executive Director	x	x
Cynthia Conquest	Non-executive Director		
David Dean	Non-executive Director		
Dave Hughes	Non-executive Director	✓	✓
Susan Lintott	Non-executive Director	✓	✓
Mark Millar	Non-executive Director	✓	✓
Nick Morrell	Non-executive Director	✓	✓
Ron Zimmern	Non-executive Director	✓	x

✓ Attended meeting x Apologies received Not a member

The Committee was advised by the Interim Director of Workforce and OD

Attendance of Governors at Appointments Committee Meetings

Governor Members	Category	09-May-18	21-Nov-18	20-Mar-19
Janet Atkins	Public	x	x	x
Barry Crabtree-Taylor	Public	x	x	✓
Richard Hodder (Chair and Lead Governor)	Public	✓	✓	✓
Glenn Edge	Public	✓	x	✓
Rob Graham	Public	x	✓	✓
Keith Jackson	Public	✓	✓	✓
Graham Jagger	Public	x	x	✓
Cheryl Riotto	Staff	✓	x	✓
Alessandro Ruggiero	Staff	✓	x	✓

✓ Attended meeting x Apologies received

The Trust Secretary and Director of Workforce and OD were in attendance at these meetings

NEDs also receive work mileage expenses. For values see Remuneration table.

Disclosures required by the Health and Social Care Act 2012

Directors received expenses for 2018/19 of £19,550 (2017/18: £14,000). Expenses to the value of £14,477 (2017/18: £8,669) are a reimbursement of amounts directly incurred in the performance of an individual Director's duties. They also include an element of tax on some of these payments. In the Remuneration Report tables on remuneration for Directors, note 3 states that benefits in kind also include this taxable benefit on mileage.

The Board consists of 14 Directors (including one non-voting Director), due to changes in the year there were a total of 17 (2017/18: 15) serving Directors. 8 (2017/18: 12) Directors received expenses.

Governors received expenses for 2018/19 of £3,260 (2017/18: £4,969). Expenses are a reimbursement of amounts directly incurred in the performance of an individual Governor's duties.

At March 2019 the Council consisted of 26 (2017/18: 28) Governors and due to changes in the year there were a total of 31 (2017/18: 35) serving Governors. 7 Governors received expenses (2017/18: 9)

Remuneration Report (Audited Information)

Table 1: Year ended 31 March 2019 (audited information):

Name and Title	Salary and Fees ¹	Taxable Benefits ²	All Pension-related Benefits	Total
	(bands of £5,000)	(total to the nearest £100)	(bands of £2,500)	(bands of £5,000)
	£'000	£	£'000	£'000
Prof. J Wallwork – Chairman	40 - 45	1,200	-	40 – 45
Mr M Blastland – Non-executive Director (started 22 March 19)	-	-	-	-
Mrs K Caddick – Non-executive Director	5 - 10	-	-	5 – 10
Mrs C Conquest – Non-executive Director	0 - 5	-	-	0 - 5
Mr D Dean – Non-executive Director	5 -10	1,100	-	5 -10
Mr D Hughes – Non-executive Director	10 - 15	2,400	-	10 – 15
Dr S Lintott – Non-executive Director	10 - 15	-	-	10 – 15
Mr M Millar – Non-executive Director	0 - 5	1,500	-	5 - 10
Prof. N Morrell – Non-executive Director	10 - 15	-	-	10 – 15
Dr R Zimmern – Non-executive Director	10 - 15	-	-	10 – 15
Mr S Posey – Chief Executive ⁸	155 - 160	-	57.5 - 60.0	215 – 220
Mr R Clarke – Chief Finance Officer	130 - 135	-	10.0 – 12.5	140 – 145
Dr R Hall – Medical Director ⁶	165 - 170	-	-	165 – 170
Mrs E Midlane – Chief Operating officer	95 - 100	-	112.5 – 115.0	210 - 215
Mrs O Monkhouse – Director of Workforce and OD	105 - 110	-	12.5 – 15.0	120 - 125
Mrs J Rudman – Chief Nurse	105 - 110	-	62.5 – 65.0	170 – 175
*Mr A Raynes (Advisory non-voting member)	95 - 100	-	50.0 – 52.5	145 - 150

Remuneration received

The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only. The report includes a non-voting Director (*) who has served in year in an advisory capacity to the Board.

Notes to Tables 1 and 2

- Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts;
- Taxable Benefits relate to a taxable benefit on mileage;
- No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus;
- No compensation payments were made to past Executive or Non-executive Directors;
- No Executive Director served as a Non-executive Director elsewhere;
- Salary and Fees includes £34,755 relating to clinical duties and £36,192 relating to a Clinical Excellence Award;
- No performance related remuneration was paid in 2018/19;
- Includes a 10% non-consolidated/non pensionable element at risk of claw-back.

Table 2: Year ended 31 March 2018 (audited information):

Name and Title	Salary and Fees ¹	Taxable Benefits ²	All Pension-related Benefits	Total
	(bands of £5,000)	(total to the nearest £100)	(bands of £2,500)	(bands of £5,000)
	£'000	£	£'000	£'000
Prof. J Wallwork – Chairman	40 - 45	1,900	-	40 – 45
Mrs K Caddick – Non-executive Director	10 - 15	-	-	10 – 15
Mr D Hughes – Non-executive Director	10 - 15	1,400	-	10 – 15
Dr S Lintott – Non-executive Director	10 - 15	100	-	10 – 15
Mr M Millar – Non-executive Director	10 - 15	1,900	-	10 – 15
Prof. N Morrell – Non-executive Director	10 - 15	-	-	10 – 15
Dr R Zimmern – Non-executive Director	10 - 15	-	-	10 – 15
Mr S Posey – Chief Executive ⁸	155 - 160	-	42.5 - 45.0	195 – 200
Mr R Clarke – Director of Finance	115 - 120	-	57.5 - 60.0	175 – 180
Dr R Hall – Medical Director ⁶	165 - 170	-	35.0 - 37.5	200 – 205
Miss E Horne – Director of Human Resource (Board Member to 16/5/17 remuneration includes project role to 31/01/18)	125 - 130	-	22.5 - 25.0	150 – 155
Mrs E Midlane – Chief Operating officer (from 24/4/17)	95 - 100	-	17.5 – 20.0	110 - 115
Mrs O Monkhouse – Director of Workforce and OD (from 1/10/17)	50 - 55	-	22.5 – 25.0	75 - 80
Mrs C Tripp – Deputy Chief Executive (to 22/9/17)	115 – 120	-	n/a	115 - 120
Mrs J Rudman – Director of Nursing (2017/18) Director of Nursing/Interim Chief Operating Officer (to 23/4/17)	105 - 110	-	50.0 - 52.5	155 – 160
*Mr A Raynes (Advisory non-voting member)	45 - 50	-	35.0 – 37.5	80 - 85
*Ms R McAll (Advisory non-voting member)	30 - 35	-	n/a	30 - 35

Notes to Tables 1 and 2

- Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts;
- Taxable Benefits relate to a taxable benefit on mileage;
- No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus;
- No compensation payments were made to past Executive or Non-executive Directors;
- No Executive Director served as a Non-executive Director elsewhere;
- Salary and Fees includes £34,525 relating to clinical duties and 36,192 relating to a Clinical Excellence Award;
- No performance related remuneration was paid in 2017/18;
- Includes a 10% non-consolidated/non pensionable element at risk of claw-back.

Table 3: Pension Entitlements of Senior Managers 31 March 2019 (audited information):

Name and Title	Real Increase in Pension at pension age	Real Increase in Pension Lump Sum at pension age	Total Accrued Pension at pension age at 31 March 2018	Lump Sum at pension age Related to Accrued Pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr S Posey – Chief Executive	2.5 – 5.0	0.0 – 2.5	40 – 45	90 – 95	501	113	630
Mr R Clarke – Chief Finance Officer	0 – 2.5	0.0	35 – 40	75 – 80	399	69	497
Dr R Hall – Medical Director	-	-	-	-	-	-	-
Mrs E Midlane – Chief Operating officer	5.0 – 7.5	10.0 – 12.5	35 - 40	95 - 100	566	166	762
Mrs O Monkhouse – Director of Workforce and OD	0.0 – 2.5	0.0	35 - 40	80 - 85	581	73	686
Mrs J Rudman – Chief Nurse	2.5 – 5.0	2.5 – 5.0	40 – 45	105 – 110	595	127	755
Mr A Raynes (Advisory non-voting member)	2.5 – 5.0	2.5 – 5.0	10 - 15	15 - 20	148	33	198

- 1 Non-executive Directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-executive Directors;
- 2 Information contained within this note is based on figures provided by the NHS Pension Agency. The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time;
- 3 The benefits valued are the members' accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries;
- 4 The current inflation rate applied to pensions by the NHS Pension Agency is 3.0%;
- 5 In calculating the actuarial value of the CETV as at 31 March 2019 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010.
- 6 The factors used to calculate a CETV increased on 29 October 2018. This has affected the calculation of the real increase in CETV. CETVs are calculated in accordance with SI 2008 No 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008; Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.
- 7 There are no employers' contributions to stakeholder pensions.

Table 4: Pension Entitlements of Senior Managers 31 March 2018 (audited information):

Name and Title	Real Increase in Pension at pension age	Real Increase in Pension Lump Sum at pension age	Total Accrued Pension at pension age at 31 March 2017	Lump Sum at pension age Related to Accrued Pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mr S Posey – Chief Executive	2.5 – 5.0	0.0 – 2.5	35 – 40	90 – 95	431	65	501
Mr R Clarke – Director of Finance	2.5 – 5.0	2.5 – 5.0	30 – 35	75 – 80	334	62	399
Dr R Hall – Medical Director	0.0 – 2.5	7.0 – 7.5	35 – 40	115 – 120	795	92	895
Miss E Horne – Director of Human Resource (to 31/01/2018)	0.0 – 2.5	2.5 – 5.0	40 – 45	115 – 120	709	72	788
Mrs E Midlane – Chief Operating officer (from 24/4/17)	0.0 – 2.5	0.0	30 - 35	80 - 85	533	27	566
Mrs O Monkhouse – Director of Workforce and OD (from 1/10/17)	0.0 – 2.5	0.0	30 - 35	80 - 85	529	46	581
Mrs J Rudman – Director of Nursing (2017/18) - Director of Nursing/Interim Chief Operating Officer (to 17/4/17)	2.5 – 5.0	2.5 – 5.0	35 – 40	95 – 100	516	74	595
Mrs C Tripp - Deputy Chief Executive (to 22/9/17)	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mr A Raynes (Advisory non-voting member)	0.0 – 2.5	0.0	10 - 15	10 - 15	122	25	148
Ms R McAll (Advisory non-voting member)	n/a	n/a	n/a	n/a	n/a	n/a	n/a

- 1 Non-executive Directors do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-executive Directors;
- 2 Information contained within this note is based on figures provided by the NHS Pension Agency. The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time;
- 3 The benefits valued are the members' accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries;
- 4 The current inflation rate applied to pensions by the NHS Pension Agency is 1.0%;
- 5 In calculating the actuarial value of the CETV as at 31 March 2018 the NHS Pensions Agency has used factors which include the indexation of pension benefits in line with the Consumer Price Index (CPI) and not the Retail Price Index (RPI). This follows the Government announcement in July 2010 that pension benefits from 2011 will be indexed in line with CPI and not RPI. The change in inflation assumption led to a decrease in the CETV value as at 31 March 2011 compared with the CETV as at 31 March 2010.
- 6 Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pension Scheme.
- 7 There are no employers contributions to stakeholder pensions.

Fair Pay Multiple

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

	2018/19		2017/18
Band of Highest Paid Director's Total Remuneration (£'000)	165-170	Band of Highest Paid Director's Total Remuneration (£'000)	165-170
Median Total Remuneration	29,608	Median Total Remuneration	28,913
Ratio	5.66	Ratio	5.79

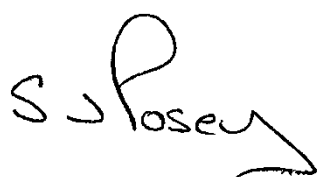
The mid-point of the banded remuneration of the highest paid Director in the Foundation Trust in the financial year 2018/19 was £167,500 (2017/18: £167,500). This was 5.66 times (2017/18: 5.79 times) the median remuneration of the workforce, which was £29,608 (2017/18: £28,913). 19 employees in 2018/19 (2017/18: 18) received remuneration in excess of the highest paid Director. Remuneration ranged from £168,954 to £264,965 (2017/18: £168,949 to £252,401).

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

The median full time equivalent remuneration of the workforce has been calculated based on those receiving remuneration in March 2019. The remuneration received in March has been annualised and excludes the highest paid director. Included within the figures to calculate the median full time equivalent remuneration is the annualised remuneration of agency staff working at the Trust at 31 March 2019. The annualised remuneration of agency staff has been calculated after deduction of an average commission rate, removing employers NI and excluding those only working a single shift.

Expenditure on bank staff has been included in the calculation of the median full time equivalent remuneration figure.

Approved by the Board and signed by the Chief Executive



Stephen Posey
Chief Executive
23 May 2019

2.3 Staff Report

Recruitment and Retention

One of the Trust's most significant risks is recruiting and retaining staff, particularly during this period of major organisational change. There are local and national skills shortages, particularly in key groups such as registered nurses and cardiac physiologists. The recruitment market is extremely competitive in Cambridge and it is a high cost of living area which will particularly impact on staff in AfC Pay Bands 2-4. In addition the Trust is undergoing the most significant organisational change in its history as a result of the move to our new sites. This inevitably impacts on staff engagement and retention. In 2018/19 we have continued to implement our Recruitment and Retention Strategy with the aim of addressing the Trust's challenges with recruitment and retention, thereby ensuring the Trust is an organisation where staff are expert in what they do, appropriately trained and qualified and feel supported, empowered and enabled to deliver high quality care, first time, every time.

The three goals articulated in the Strategy are:

To **retain** a compassionate, expert workforce that is proud to work at Royal Papworth Hospital NHS Foundation Trust and feels developed and supported to make decisions, innovate and improve the lives of our patients.

To **attract** a diverse and skilled candidate pool across all staff groups by developing a strong employment brand through the use of social media and expanding the geographical area of advertising campaigns. Promotion of the Trust's unique selling point 'fantastic reputation'.

To **recruit** staff that share the Trust values ensuring that vacancies are filled in a timely manner. To have efficient recruitment processes and a strong corporate induction that supports the Royal Papworth Hospital brand.

During 2019/20 we will be seeking to maximise the opportunities presented by our new state of the art hospital and the media interest connected to the move to attract staff. We have started to build effective working relationships with Cambridge University Hospital and are planning joint recruitment events on the campus. There is a risk that for a period of time following the move our turnover remains unstable as staff adapt to new travel arrangements and, for many, extended travel time. We will continue to support staff with travel arrangements, for example relocation allowance, discounted bus and train fares, flexible working.

We will work to develop links with our new local communities. The Trust offers a range of schemes to promote the NHS and the Trust with the local community: work experience, traineeships, voluntary worker schemes and apprenticeships and we will continue this work following our move. We will collaborate with our partners on the campus to ensure effective joint working and maximising the benefits of our co-location.

Staff Engagement, Consultation and Involvement

In 2018/19 we undertook the most significant organisational change in the Trust's history. In moving to our new facilities we not only moved location but also, in many areas, fundamentally changed our ways of working. Effectively involving, consulting and engaging our staff during the move process was crucial to staff engagement and retention. We implemented a monthly staff survey to track staff views and feedback on the issues that were concerning them. In 2019/20 we will transition this to a quarterly staff survey that will seek staff feedback as they adapt to their new working environment and

arrangements. We introduced a weekly managers stand up briefing (Our Big Move Briefing) ahead of the move and will continue with this post move as it has proved a popular and effective channel for two way communication.

The Joint Staff Council (JSC) provides the formal management/staff interface for staff, via the recognised Trade Unions and Professional Organisations, enabling consultation on employment policies and procedures and discussion about the implications of organisational change. The JSC meetings include Staff Governors and this provides a means to ensure that the voice of all staff is heard, not just those who are members of a Trade Union. Staff representatives are also included in a range of work streams which will impact on staff, including Service Improvement Programmes, the Cambridge Transition Programme, and the New Hospital.

Our 'staff engagement champions' continue to play a significant role in communication between senior management and staff. Their role 'is to ensure that key messages are spread through all areas in the Trust, principally by word of mouth, and that feedback is facilitated: the key requirements for staff engagement champions are the ability to *connect* with their teams, an interest in *influencing* the way we work, and confidence in *sharing* updates.

The champions' role supplements the range of traditional channels of communication used by the Trust which include a quarterly staff newsletter, a weekly electronic information/news update bulletin, and extensive information about the Trust and its activities which can be accessed on the Trust's Intranet site.

Valuing Staff/Celebrating Success

Demonstrating that the contribution of staff is recognised and valued is an important element of staff engagement. We hosted the Royal Papworth 100 Staff Awards in March 2019 ahead of our move in April. It was an opportunity to recognise and celebrate the contribution of staff from across the Trust to deliver excellent services and outcomes to our patients. A total of thirteen staff and two Trust teams were presented with awards at a special evening ceremony celebrating individual achievement and team success supported by sponsors and Royal Papworth Hospital Charity. The new hospital was a great backdrop for the awards and made it a very special occasion for the staff nominated.

We use our weekly and monthly newsletters and our social media platforms to celebrate the achievement of individual staff and teams. The Trust Board receive information on the number of compliments received on a monthly basis.

Staff Survey

As stated previously staff engagement is an important issue for the Trust. We undertake a monthly staff survey (moving to quarterly post-move) as well as participating in the NHS national staff survey. These surveys help the Trust measure staff engagement and develop plans to address key themes. In 2018 the response rate from the Trust staff was 54%, 985 responses, which was slightly above the average response rate of 53% for our peer group and an improvement on the 2017 response rate of 46%. We carried out a full census this year and moved to electronic distribution only.

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Scores for each indicator together with that of the survey benchmarking group, Acute Specialist Trusts, are presented below.

	2018/19	2018/19	2017/18	2017/18	2016/17	2016/17
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.1	9.3	9.3	9.3	9.3	9.3
Health and wellbeing	6.0	6.3	6.3	6.3	6.3	6.3
Immediate managers	7.0	7.0	7.1	6.9	6.8	6.9
Morale	5.8	6.3	na	na	na	na
Quality of appraisals	5.4	5.7	7.4	7.7	7.8	7.8
Quality of care	7.4	7.8	7.4	7.7	7.8	7.8
Safe environment – bullying and harassment	8.2	8.2	8.4	8.4	8.3	8.3
Safe environment – violence	9.7	9.7	9.7	9.7	9.6	9.7
Safety culture	6.8	6.9	6.9	6.9	6.8	6.9
Staff engagement	7.2	7.4	7.3	7.4	7.2	7.5

Comparison of our results with our peer benchmark group is as follows:

In 2018 our scores were average compared to our peer group in the following 3 themes:

- Immediate manager
- Safe environment: bullying and harassment
- Safe environment: violence

We are below average compared to our peer group in 7 themes:

- Equality, diversity and inclusivity
- Health and welfare
- Morale
- Quality of appraisals
- Quality of care
- Safety culture
- Staff engagement

Compared to the NHS national results our scores are above the average in all the themes with the exception of Quality of Care where our score is the same as the national average and the following where we are below the average:

- Morale
- Quality of appraisals

The comparison of our 2018 results with our results in 2017 is as follows:

There was a statistically significant reduction in our scores from last year in 2 themes:

- Equality, diversity and inclusivity
- Health and well-being

There were 2 themes with no reduction in scores from last year:

- Quality of care
- Safe environment: violence

In 6 themes our score reduced from last year but it was not a statistically significant change.

- Immediate manager
- Safe environment: bullying and harassment
- Morale
- Quality of appraisals
- Safety culture
- Staff engagement

Future priorities and targets

Analysis of the results to identify key trends and interactions and review the results broken down by staff group and Directorate has been undertaken. In particular we have focused on analysing the themes of Equality, Diversity and Inclusivity and Health and Wellbeing to understand the drivers for the reduction in our results and to ensure that we take targeted action to improve the experience of staff in these areas. There is no doubt that the very significant organisational change impacted on staff health and wellbeing.

Providing feedback to managers and staff on the outcome of the survey and the actions taken by the Trust in response is very important. They have been provided with analysis of their directorates results which they have cascaded and discussed with their teams to identify areas for improvement within their departments that they wish to focus on. We have also reviewed and discussed the results with key groups such as the Joint Staff Council, Staff Engagement Representatives, the BAME Network, the Equality, Diversity and Inclusivity Steering Group and Staff Governors. In particular we will review and refresh the WRES action plan. The results will be an important part of the diagnostic phase of the Culture and Leadership Programme that is in development.

We will monitor implementation of directorate action via the monthly Directorate Performance Meetings and a learning event that will be held in Autumn 19. The quarterly Trust Staff Survey will gather feedback directly from staff on their experience of working for the Trust.

Disability Information

We are recognised by the Government's Department for Work and Pensions as a 'Disability Confident' employer. The 'Disability Confident' scheme aims to help employers make the most of the opportunities provided by employing disabled people.

For staff who become disabled whilst in work, either temporarily or permanently, we have proactive, supportive policies and procedures in place to enable their skills and experience to be retained within the Trust. These include the use of external organisations to undertake detailed workplace assessments and, where appropriate, to advise on specialist equipment to facilitate adjustments to working practices.

The number of staff who reported themselves as having a disability at the end of 2018/19 was 64 (3.28%) of the workforce. Further information in connection with Equality and Diversity can be found in the Equality and Diversity section of the Annual Report.

Occupational Health Services

Royal Papworth Hospital's Occupational Health Service is delivered by Cambridge Health at Work (CHaW). CHaW are SEQOHS (Safe Effective Quality Occupational Health Service) accredited. They provide a full range of occupational health services to staff and are integral to the pro-active management of sickness absence and in the promotion of health and well-being initiatives.

As a result of a proactive campaign 84% of front line staff received flu vaccinations, which was an improvement from the previous year (78%). This is an important patient and staff safety measure.

Employee Assistance Programme

Managers have an important role to play in ensuring our staff feel supported and valued in the workplace. By taking a proactive approach, managers help to ensure that staff have access to advice and support through occupational health at the earliest opportunity. The Trust's Management of Sickness Absence Procedure requires managers to refer all cases of anxiety, stress and depression to Occupational Health to ensure early intervention: evidence suggests that early intervention is important for preventing acute situations becoming chronic.

Employee counselling contributes to a positive, productive and healthy workforce. Face-to-face counselling is provided through Cambridge Consultancy in Counselling and members of staff are referred via Occupational Health if it is thought that this will be beneficial and the correct treatment option. Individuals have an initial assessment followed by up to four counselling sessions. In addition, our staff continue to utilise the services of other support agencies which are freely available through signposting and recommendation from Occupational Health.

Breakdown at the year end of the number of male and female Directors, other senior managers and employees

We remain committed to having a diverse Board in terms of gender as well as diversity of experience, skills, knowledge and background. There were 14 members of the Trust Board at the end of March 2019, of whom nine were male and five were female.

	Female	Male	Total
Directors (includes Non-executive Directors)	5	9	14
Senior Managers (as per occupation codes)	20	10	30
Other Employees	1,420	496	1,916

Total	1,445	515	1,960
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Notes: 1. National occupation code used to define senior managers (non-clinical).
2. Non-executive Directors are included in totals but are not defined as employees.
3. Executive Directors includes one non-voting Board member.

Sickness absence rate of staff

It is a Treasury FReM requirement that all public bodies report their sickness absence rate. This must be reported for the calendar year to allow reconciliation with already published data.

Figures Converted by DHSC to Best Estimates of Required Data Items			Figures Converted by DHSC to Best Estimates of Required Data Items	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE - Days Available	FTE - Days Lost to Sickness Absence
1736	13,355	7.69	633,592	21,665

Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse
Period covered: January to December 2018
FTE = Full Time Equivalent

Reduction of sickness absence remains a key performance target. The Trust continues to work towards improving the health and wellbeing of our staff, reducing sickness absence levels and improving line manager capability, together with delivering improved patient care and outcomes

Expenditure on consultancy

During 2018/19 The Trust engaged Consultants to undertake work on a number of projects including: New Royal Papworth Hospital, implementation of the LORENZO Electronic Patient Record (EPR) system and development of the Trust's five year strategy.

Staff Exit Packages

Foundation trusts are required to disclose summary information of their use of exit packages agreed in the year, as required by the *FReM* (paragraph 5.3.27(h)). There were no exit packages agreed in 2018/19.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	0	0
£10,00 – £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	0	0
£100,000 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
>£200,001	0	0	0
Total number of exit packages by type	0	0	0
Total resource cost	0	£0	£0

Exit packages: non-compulsory departure payments

	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	0 (2017/18:2)	0 (2017/18:97)
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

Reporting high paid off-payroll arrangements

Table 1: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2018	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The Trust engaged with all off payroll contractors in light of the new IR35 arrangements to ensure an assessment of their role was undertaken and if necessary arrangements for deducting tax and NI put in place from 6th April 2017.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
No. for whom assurance has been requested	0
Of which...	0
No. for whom assurance has been received	0
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received.	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0 (2017/18: 0)
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

Table 4: Staff costs

	Group			
	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	73,050	1,675	74,725	69,633
Social security costs	7,159	-	7,159	6,753
Employer's contributions to NHS pensions	8,274	-	8,274	7,902
Apprenticeship levy	347	-	347	325
Agency/contract staff	-	4,837	4,837	3,211
Total gross staff costs	88,830	6,512	95,342	87,824
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	88,830	6,512	95,342	87,824
Of which Costs capitalised as part of assets	83	247	330	170

Table 5: Average number of employees (WTE basis)

	Group					
	Permanent Number	Other Number	2018/19 Total Number	Permanent Number	Other Number	2017/18 Total Number
Medical and dental	211	6	217	206	9	215
Administration and estates	371	35	406	374	39	413
Healthcare assistants and other support staff	349	31	380	340	16	356
Nursing, midwifery and health visiting staff	576	34	610	561	33	594
Scientific, therapeutic and technical staff	147	10	157	141	7	148
Healthcare science staff	75	7	82	74	8	82
Other	1		1	2		2
Total average numbers	1,731	123	1,854	1,698	112	1,810
Of which Number of employees (WTE) engaged on capital projects	0	0	0	1	1.6	2.6

2.4 Disclosures required under the NHS Foundation Trust Code of Governance

NHS Improvement's Code of Governance

In late December 2013, Monitor published a revised *NHS Foundation Trust Code of Governance* (the Code). The revised Code applied from 1 January 2014.

Directors

The Board of Directors is responsible for ensuring proper standards of corporate governance are maintained. The Board, since January 2008, is made up of the Chairman, six Executive Directors and six independent Non-executive Directors (NEDS) and is collectively responsible for the success of the Trust. The Board of Directors considers all of the current Non-executive Directors (NEDs), including the Chairman, to be independent. All appointments to the Board are the result of open competition.

Details of the composition of the Board and the experience of the Directors are contained within the Board of Directors section of the Annual Report which also includes information about the standing Committees of the Board, the membership of those Committees, and attendance.

The Board considers strategic issues. The Board meets regularly and has a formal schedule of matters specifically reserved for its decision. The Board delegates other matters to the Executive Directors and other senior management. The Board had seventeen formal meetings in 2018/19. The Chairman of the Trust is Chairman of the Board of Directors and Council of Governors and leads both groups on strategy and monitoring. The Chief Executive has responsibility for the implementation of strategy and the day to day operations of the Trust.

The Directors are given accurate, timely and clear information so that they can maintain full and effective control over strategic, financial, operational, compliance and governance issues. The Directors have a range of skills and experience and each brings independent judgement and knowledge to the Board's discussions and determinations.

The Trust has arranged appropriate insurance cover in respect of legal proceedings and other claims against its Directors. Independent professional advice is available as required to the Board or its standing committees.

Board Independence

The Board considers that the Chairman satisfied the independence criteria of the Code on his appointment. The Interview Panel and Appointments Committee of the Council of Governors had noted that whilst Professor Wallwork had continued to be associated with the hospital the conclusion was this enhanced the strategic vision of the hospital in terms of the relocation to the Cambridge Biomedical Campus and strengthened the alliance with the University of Cambridge to build a joint heart and lung research institute (HLRI) adjacent to the new Royal Papworth Hospital. Together with his other interests external to the Trust, the panel had concluded that he was sufficiently removed from the day-to-day operational activity of the hospital to enable him to remain independent.

All the Non-executive Directors who have served during the year are considered to be independent according to the principles of the Code. During 2009, the Trust became a partner in one of the first Academic Health Science Centres designated by the Department of Health. The Chairman, Chief Executive and the Non-executive Director

nominated by the University of Cambridge are members of the Board of this separate legal entity as part of their Royal Papworth roles. The Board of Directors does not consider this to affect the independence of these Directors.

Independence is kept under review and is based on whether each Director is independent in character, judgement and behaviour. Also considered are factors such as participation and performance on both the Board and Board Committees. Non-executive Directors (NEDs), including the Chairman, are not NHS employees and do not contribute to the NHS pension scheme in their NED role. Non-executive Directors have confirmed their willingness to provide the necessary time for their duties. The Chairman and NED terms of office are subject to approval by the Council of Governors. The Board is satisfied that no individual or group has unfettered powers or unequal access to information. The Board has received confirmation from all Directors that no conflicts of interest exist with their duties as Directors.

The Chairman holds meetings with the Non-executive Directors without the Executive Directors being present. The Senior Independent Director (SID) also holds meetings with the other Non-executive Directors without the Chairman being present.

Policy for Raising Matters of Concern

Arrangements have been put in place by which the Trust's employees may in confidence raise matters of concern. These arrangements are covered in the Trust's "Policy for Raising Matters of Concern" commonly known as a "Whistle-blowing Policy".

Governors

The general duties of the Council of Governors are:

- 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 the Trust's members as a whole and the interests of the public.

Since April 2013, the Council of Governors consists of 18 elected public members, seven elected staff members and four appointed stakeholder representatives. The Council of Governors meets formally four times a year and has a nominated Lead Governor. Details of the composition of the Council of Governors and attendance at meetings are contained within the Council of Governors section of the Annual Report.

Board Performance Evaluation

The process for Board members appraisal is that the appraisal of NEDs is carried out by the Trust Chairman for report to the Appointments [NED Nomination and Remuneration] Committee of the Council of Governors. The appraisal of the Chairman is co-ordinated by the Senior Independent Director using input from the Lead Governor and Chairs of Governor Committees and the Chief Executive along with input through a 360 degree review process. The Lead Governor is also the Chair of the Appointments Committee of the Council of Governors. Board meetings are open to the public and Governor attendance is encouraged.

The last external review of governance against NHS Improvement's framework was undertaken during 2015/16 by Deloitte. Deloitte has no other connection with the Trust. An internal audit – Well-led Governance Follow Up Review – was undertaken in 2016/17 which resulted in a substantial assurance opinion. A further Well-led review is planned for 2018.

Compliance Statement

Royal Papworth Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, revised in July 2014, was based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors considers that it complies with the main and supporting principles of the Code of Governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B.1.1. In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

B.1.3 The Royal Papworth Chief Nurse is a Partner Governor on the Council of Governors of Cambridge University Hospitals NHS Foundation Trust (CUH). NHS Improvement has been advised of this arrangement and considers it acceptable due to the proposals for the relocation of Royal Papworth Hospital to the Cambridge Biomedical Campus.

D.2.2 The Chief Executive has determined that the definition of “senior management” for the purposes of the Remuneration Report should be limited to Board members only.

D.2.3 Recommendations made to the Council of Governors on remuneration levels of the Chairman and other Non-executive Directors are based on annual benchmarking information obtained from NHS Providers and other national surveys. The Council of Governors does not consult external professional advisers to market test at least once every three years. See the Remuneration Report for more detail.

The following provisions require a supporting explanation, even in the case that the NHS Foundation Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is provided to avoid unnecessary duplication.

Table of supporting explanation for required disclosures

Code of Governance reference	Summary of requirement	Disclosure
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	The schedule contains a statement on separate roles. The Council of Governors and Board of Directors have an agreed interaction process that describes how disagreements would be resolved.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See Directors' Report.

A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Council of Governors section.
Additional requirement of FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	See Council of Governors section.
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	See earlier in this section.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors section.
Additional requirement of FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	See Remuneration Report section.
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See Remuneration Report section.
Additional requirement of FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Open advertisement for Chairman and Non-executive Directors.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See earlier in this section.
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	See Governors and Foundation Trust sections and latest information on new Royal Papworth Hospital on our website
Additional requirement of FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012 "	Governors have not exercised this power.
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See Remuneration Report section.
B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	External review 2015/16. See earlier in this section.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and	See Director's Report See Annual Governance Statement.

	provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See Audit Committee section and Annual Governance Statement.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See Audit Committee section.
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Council of Governors accepted recommendation to appoint new External Auditor from 2015/16 audit.
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: <ul style="list-style-type: none"> the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. 	See Audit Committee section
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	No Director was released in 2018/19.
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	See Council of Governor section.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See Foundation Trust Membership section.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	See Board of Director section and Council of Governors section

Additional requirement of FT ARM	<p>The annual report should include:</p> <ul style="list-style-type: none"> • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members. 	See Foundation Trust Membership section.
Additional requirement of FT ARM	<p>The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.'</p>	There is a standing item on all agendas for the Board of Directors and Council of Governors and their Committees. The register is held by the Trust Secretary.

2.5 NHS Improvement's Single Oversight Framework

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

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

Segmentation

Royal Papworth Hospital NHS Foundation Trust is in Segment 2: *Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.* Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website: <https://improvement.nhs.uk/resources/single-oversight-framework-segmentation>

Finance and use of resources

The finance and use of resources theme 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	2018/19				2017/18			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	2	1	1	1	1	1	1
Financial efficiency	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	4	4	4	4
	Agency spend	4	4	4	4	3	2	2	2
Overall scoring		3	3	3	3	3	3	3	3

The Trust's deficit position results in a score of 3 across each quarter in 2018/19. For more information on our financial performance during 2018/19 see the Performance Report section of the Annual Report.

2.6 Board of Directors

The Board of Directors

The Board's responsibilities are as follows:

- setting the overall strategic direction of the Trust, within the context of NHS priorities and taking into account views of the Council of Governors and other key stakeholders;
- to set strategic objectives;
- to provide high quality, effective and patient focused healthcare services required under its contracts with commissioners and other organisations;
- to ensure appropriate governance and performance arrangements are in place to deliver the Trust's strategic objectives;
- to ensure the quality and safety of all healthcare services, research and development, education and training;
- promoting effective dialogue between the Trust and the communities it serves;
- ensuring high standards of corporate governance and personal conduct; and
- ensuring that the Trust complies with the terms of its licence from the Regulator, its constitution, relevant legislation, mandatory guidance and other relevant obligations.

The licence from NHS Improvement and the constitution govern the operation of the Trust. The schedule of decisions reserved for the Board and scheme of delegation set out the types of decisions that must be taken by the Board of Directors and those which can be delegated to management. The constitution defines which decisions must be taken by the Council of Governors and the standing orders of the Board of Directors describe how disagreements between the Board and the Council should be resolved.

Further information on Royal Papworth Hospital services can be obtained from our website <https://www.royalpapworth.nhs.uk/>

Professor John Wallwork, Chairman

Professor Wallwork was appointed as Chairman in February 2014 and re-appointed for a further three years in 2017. He returned to Royal Papworth Hospital as Chairman after spending thirty years at the forefront of transplant surgery and research at the Trust. Professor Wallwork is Emeritus Professor of Cardiothoracic Surgery. He was a consultant based at Royal Papworth Hospital in Cambridge until his retirement in July 2011.

Before being appointed as a Consultant in 1981, he was Chief Resident at Stanford University Hospital in California for nearly two years, where he first became involved in heart and heart-lung transplantation and played a major role in the development of heart-lung transplantation at Royal Papworth Hospital. He performed Europe's first successful heart-lung transplant in 1984 and in 1986 he performed the world's first heart-lung and liver transplant with Professor Sir Roy Calne.

He succeeded Sir Terence English as Director of the Transplant Service from 1989 to 2006, chaired the UK Transplant Cardiothoracic Advisory Group from 1994 to 2006 and was Medical Director of Royal Papworth Hospital from 1997 to 2002. He was also Director of Research and Development at Royal Papworth Hospital until his retirement.

On 1 October 2002 the University of Cambridge awarded him an honorary Chair in Cardiothoracic Surgery.

In January 2012 Professor Wallwork was recognised in Her Majesty the Queen's New Year's Honours list and was awarded a CBE for services to health.

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

Michael Blastland (from 22 March 2019)

Michael is a writer and broadcaster. For nearly twenty years, he was a BBC current-affairs presenter and producer, devising programmes including *More or Less* on Radio 4 – about numbers in public argument - of which he was also the first producer (with Andrew Dilnot the original presenter). He can still be heard as an occasional presenter on BBC Radio 4 and the BBC World Service.

He has written four books, including *The Tiger that Isn't*, a guide to numbers in the news and politics. His other books are about risk, about his son's autism, and, most recently, *The Hidden Half – How the World Conceals its Secrets*, about uncertainty.

He teaches, advises and presents widely, in schools, to business, government and academia. Current health-related roles include advisor to a large meta-analysis of the potential adverse effects of statins, and to the 'Behaviour Change By Design' research programme into nudge-type interventions for public health. He is also a board member of the Cambridge-based Winton Centre for Risk and Evidence Communication.

Mrs Karen Caddick, Non-Executive Director (to 31 October 2018)

Karen Caddick left the Trust on 31 October 2018. Further details of her expertise and experience can be found in our annual report for 2017/18.

Mrs Cynthia Conquest (from 1 January 2019)

Cynthia is an experienced ex NHS Director of Finance with a wide portfolio of NHS experience covering 39 years. She has worked in all aspects of financial services and in all types of healthcare settings; large acute teaching hospitals, specialist hospitals, mental health and community services. She has a high level of experience in all financial and healthcare processes with a specialty in financial management and transformation. Cynthia's diverse experience includes the education sector either through charity work or paid employment as an interim or consultant and the hospice sector through her voluntary work. Cynthia is currently the Chair of the Audit Committee for a GP Confederation in London and was until the end of December 2018, the Chair of the Patients & Family Committee at a Hospice in Suffolk. She has a master's degree in Business Administration (MBA) from Warwick University and is a Fellow Member of the professional body the Chartered Institute of Public Finance & Accountancy (CIPFA).

**Mr David Dean Non-Executive Director from 1 November 2018
(designate NED from 1 August 2018)**

David has experience both at Executive and Non-Executive level within the NHS. From 2007 to 2014 he was a Non-Executive Director at Guy's and St Thomas NHS Foundation Trust where he served as Audit Chair and later as Vice Chairman of the Trust. From 2013-2014 he was also Chairman of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. From 2014 to 2017 David was a Senior Director at NHS Improvement (formerly Monitor) joining initially to lead the Enforcement and later the Transformation and Turnaround teams. Prior to his NHS career David was an Investment Banker in London and Hong Kong for 17 years and following his retirement from banking, a part-time concert pianist. He is currently Chairman of Essentia Trading Limited, a wholly-owned commercial subsidiary of Guy's and St Thomas NHS Foundation Trust. David is

an active distance runner and completed the 250 mile Cape Wrath Ultra marathon across North West Scotland, in May 2018.

Mr David Hughes, Non-Executive Director

Dave holds a number of consulting, Non- executive and Executive roles. He is strategy Director for Mentor Europe, a Telecommunications specialist consultancy; Director of Castle Crag Communications and Director of Paradigm Academy Trust which owns five schools in Tower Hamlets and Ipswich. Prior to this he held a range of Executive roles at BT over a 35 year career.

Dave was appointed as a Non-Executive Director of the Foundation Trust Board in November 2013 for a term of three years and re-appointed in 2016 for a further three years.

Dave is Deputy Chairman of the Board, Chair of the Performance Committee and Strategic Projects Committee and member of the Charitable Funds Committee.

Dr Susan Lintott, Non-Executive Director

Susan was appointed as a Non-executive Director of the Foundation Trust Board in December 2012 for a term of three years. In December 2015, she was reappointed for a further three years and this appointment has been extended to October 2019. She is Senior Bursar of Downing College, University of Cambridge, a position she has held for the last eighteen years after retiring from a career as an investment banker, first at The Chase Manhattan Bank in New York and then at the Chase Investment Bank in London. She has previously been on the Board of Cambridge in America, where she held the position of Treasurer. She has also chaired the University's Board of Scrutiny, served as a member of its Audit Committee, and was Chairman of the Cambridge Colleges' Bursars' Committee. She is currently a member of the Gates Cambridge Trust Investment Committee.

Susan has extensive experience in a non-executive capacity, having served several terms on the Board of the Christ's Hospital Foundation and chaired its Securities Investment Committee; she also has experience in estate development, fundraising, and corporate finance. She holds a PhD, and was educated at Girton College, Cambridge, the University of Kent at Canterbury, and the New York University Stern School of Business Administration.

Susan is Chair of the Charitable Funds Committee, a member of the Audit Committee and Senior Independent Director.

Mr Mark Millar, Non-Executive Director (to 31 October 2018)

Mark Millar left the Trust on 31 October. Further details of his expertise and experience can be found in our annual report for 2017/18.

Professor Nicholas Morrell, Non-Executive Director

Nick was appointed as a Non-executive Director of the Foundation Trust Board in January 2014 for a term of three years and was re-appointed for a further three years from January 2017. Nick qualified in Medicine (MB BS) from Charing Cross and Westminster Medical School (now Imperial College) in 1987. He undertook his research MD at Charing Cross and then spent two years in Denver, Colorado, as a British Heart Foundation Fellow before returning as a Lecturer to complete training in General and Respiratory Medicine at the Royal Postgraduate Medical School, Hammersmith Hospital. He was appointed Senior Lecturer and Honorary Consultant at Hammersmith Hospital, Imperial College in 1998 and was awarded an MRC Clinician Scientist Fellowship.

He moved to Cambridge in 2000 as University Lecturer and Honorary Consultant at Addenbrooke's and Royal Papworth Hospitals, and was appointed Professor of Cardiopulmonary Medicine in 2007. In 2009, he was awarded a British Heart Foundation Professorship and was elected to the Fellowship of the Academy of Medical Sciences in 2011. He has chaired the programme committees of the British and American Thoracic Societies. He has served as a member of the MRC Clinical Fellowships Committee. Nick is the Director of Studies in Clinical Medicine at St Catharine's College, Cambridge. He is Director of the BHF Cambridge Centre for Cardiovascular Research Excellence and leads the Cardiovascular Theme of the NIHR Cambridge Biomedical Research Centre. Nick is the Research Director of the Pulmonary Vascular Diseases Unit at Royal Papworth Hospital and is an NIHR Senior Investigator. His research focuses on understanding genetic causes of cardiovascular disease, particularly pulmonary arterial hypertension, and developing new treatments for these conditions.

Nick is a member of the Quality and Risk Committee and a Director of Cambridge University Health Partners (CUHP). He is also the interim Director of the planned Heart and Lung Research Institute to be built alongside the new Royal Papworth Hospital.

Dr Ron Zimmern, Non-Executive Director (to 28 February 2019)

Ron Zimmern left the Trust on 28 February 2019. Further details of his expertise and experience can be found in our annual report for 2017/18.

Mr Stephen Posey, Chief Executive

Stephen joined the Trust as its Chief Executive in November 2016. Previously Stephen was the Deputy Chief Executive and Director of Strategy at East and North Hertfordshire NHS Trust where he led the delivery of Hertfordshire's acute consolidation programme, which completed in 2014. A £150 million investment programme to reconfigure the Trust's acute services across east and north Hertfordshire to improve clinical outcomes and enable the development of specialist services.

This role builds on more than 20 years' experience in the health service, spanning commissioning, provider and strategic roles.

Mr Roy Clarke, Chief Finance Officer

Roy was appointed Chief Finance Officer in November 2015 and is responsible for Finance, Procurement, Commercial Services and Estates & Facilities. He joined the Trust from Norfolk Community Health and Care NHS Trust where he was the Chief Finance Officer responsible for leading on all aspects of Finance, IM&T, Estates & Facilities, Procurement and Commercial Services. Previous to this role, Roy held senior roles in general acute and specialist NHS hospital services. Roy is a Chartered Management Accountant and has particular experience in developing and implementing organisational strategy, financial recovery and large scale estate development. He is motivated by developing healthcare organisations to deliver the best possible care to patients.

Dr Roger Hall, Medical Director

Roger was appointed as Interim Medical Director in November 2014 and to the substantive post of Medical Director in May 2015. Roger is a consultant cardiothoracic anaesthetist and Intensivist. He studied medicine at Otago University in New Zealand and completed his specialist training in the UK, New Zealand and Australia. From 1991 to 2002 he was a consultant at Green Lane Hospital in Auckland, New Zealand practicing both paediatric and adult cardiac anaesthesia and intensive care before moving to Royal Papworth Hospital.

Mrs Eilish Midlane, Chief Operating Officer

Eilish was appointed as Chief Operating officer in April 2017 joining the Trust from East and North Hertfordshire NHS Trust, where she was the Divisional Director of Clinical Support Services. Eilish is a biomedical scientist by background and holds a wealth of experience spanning strategy, operational leadership and delivery and hospital and clinical services reconfiguration.

Eilish has worked in the NHS for 30 years and has considerable expertise in patient safety, clinical governance and service improvement planning.

Mrs Oonagh Monkhouse, Director of Workforce and OD

Oonagh was appointed as Director of Workforce and Organisational Development in October 2017 having held the same role at Bedford Hospitals NHS Foundation Trust. Oonagh worked previously at Cambridge University Teaching Hospitals, where she undertook a number of senior human resources roles including Deputy Director of Workforce.

Oonagh is originally from Northern Ireland and worked in a number of NHS organisations in Belfast before moving to Cambridge in 1993.

Mrs Josie Rudman, Chief Nurse

Josie was appointed as Director of Nursing in March 2014. Josie first came to Royal Papworth in 2008 as Deputy Director of Nursing and was involved in introducing the Productive Ward, E-rostering and ALERT Service. Josie worked previously at Peterborough District Hospital as Lead Practice Development Nurse, is a Registered Nurse tutor and has a BSc in Oncology Nursing and MSc in Nursing Practice. Josie was appointed as acting Director of Nursing in July 2013. Josie is a CQC inspector as an expert advisor.

Josie is the professional lead for nursing, Allied Health Professionals (AHPs) and Scientists, is the Director of Infection Prevention and Control and is the Caldicott Guardian for the Trust. She is also the executive lead for clinical quality including patient experience and patient safety, safeguarding vulnerable people including dementia services, clinical governance and risk management, emergency planning, and clinical education.

Mr Andrew Raynes Director of Digital and Chief Information Officer

Andrew is Chief Information Officer and Director of Digital at Royal Papworth Hospital NHS Foundation Trust. Andrew joined the Trust in September 2017 following his former role as IT Programme Director at Barking, Havering and Redbridge University Hospitals NHS Trust. Andrew has over 19 years' experience working in the health and private sectors including overseas. He has led a number of high profile projects including the implementation of a GP-led practice at HMP Thameside on the Belmarsh Estate and the implementation of Liquidlogic, a children and adult social care system while at Leicester City Council. Andrew has a Masters degree in Healthcare Informatics specialising in Education and is a member of the National GS1 UK Advisory Board and is a Fellow of the British Computer Society (BCS).

Andrew is a non-voting member of the Board.

Table of Attendance at Board and Committee Meetings

The following table shows the number of Board of Director and Committee meetings held during the year and the attendance of individual Non-executive Directors (NEDs) where they were members.

	Board ^A	Audit ^B	Performance ^C	Quality & Risk ^D	Strategic Projects Committee	Executive Remuneration ^E
Number of meetings 2018/19	17	5	12	5	12	2
M Blastland¹	1/1		1		1	
K Caddick¹	7/10	2/3	1	3/3	4	0/2
R Clarke	16/17	5	11/12		11/12	
C Conquest¹	4/4	1/2			3/3	
D Dean¹	6/7	2/2	5/5		5/5	
R Hall	15/17		10	3/5	10/12	
D Hughes	16/17	3	11/12		11/12	2/2
S Lintott	13/17	4/5				2/2
E Midlane	16/17		11/12	1	11/12	
M Millar¹	7/10	2/3	5/7		5/7	2/2
O Monkhouse	15/17	3	11/12	1	11/12	2
N Morrell	9/17			1/5		2/2
S Posey	15/17	1	11/12	1	10/12	2
A Raynes	15/17		12	2	12	
J Rudman	14/17	2	10	5/5	10/12	
J Wallwork	16/17		1		3	2/2
R Zimmern¹	10/15	2	5/11	5/5		1/2

Not members of the Committee, however Directors attend meetings of committees of which they are not members either as regular attendees or as required.
¹ Part year membership.

^A All Directors are members.
^B 3 NEDs members. See Audit Committee section of Annual Report.
^C Membership 3 NEDs plus Medical Director and Chief Nurse.
^D Membership 3 NEDs plus Chief Executive, Chief Finance Officer, Director of Human Resources, Deputy Chief Executive and Chief Operating Officer.
^E Membership only Chairman and NEDs. See Remuneration section of Annual Report.

The dates of the Board of Directors' meetings in 2018/19 were:

5 Apr 2018	3 May 2018	24 May 2018	7 June 2018	21 June 2018	5 July 2018
2 Aug 2018	6 Sep 2018	27 Sep 2018	4 Oct 2018	1 Nov 2018	6 Dec 2018
10 Dec 2018	03 Jan 2019	07 Feb 2019	07 Mar 2019	28 Mar 2019	

Contacting the Directors

Directors can be contacted through the Trust Secretary at the Chief Executive's Office.
Tel: 01223 638064

2.7 Audit Committee

Composition of the Audit Committee

As required under NHS Improvement's Code of Governance the membership of this Committee is three independent Non-executive Directors. For the purposes of NHS Improvement's Code Mark Millar, David Dean and Cynthia Conquest are considered by the Board of Directors to have recent and relevant financial experience as detailed in the biographies in the Board of Directors section of this report. The membership of the Committee during 2018/19 was:

Mark Millar (Chair) to 31 October 2018

David Dean (Chair) from 1 November 2018 (designate NED from 1 August 2018)

Cynthia Conquest from 1 January 2019

Karen Caddick to 31 October 2018

Susan Lintott

Meetings and Attendance of Members

Name	24 May 18	11 Jul 18	10 Oct 18	23 Jan 19	14 Mar 19
Mark Millar (Chair)	x	✓	✓		
Karen Caddick	✓	✓	x		
Susan Lintott	✓	x	✓	✓	✓
David Dean (Chair)			✓ ¹	✓	✓
Cynthia Conquest				x	✓

✓ Attended meeting

x Apologies were received

✓¹ Attended as Designate NED

To assist the Audit Committee in fulfilling its role the following are in attendance at all meetings: The Director of Finance, the Trust Secretary, representatives from the External Auditors, representatives from the Internal Auditors and the Local Counter Fraud Specialist. Two Governors also attend the Audit Committee and contribute to discussions. Executive Directors attend during the year as business requires. Members of the Audit Committee meet separately with the External and Internal Auditors.

Role of the Audit Committee

The Audit Committee's role is to review the adequacy of the Trust's risk and control environment, particularly in relation to:

- Internal Audit, including reports and audit plans;
- External Audit and annual financial statements; and
- Counter Fraud Services.

The Committee also receives/reviews assurance that the Trust's overall governance and assurance frameworks are robust and that there are appropriate structures, processes and responsibilities for identifying and managing key risks facing the organisation.

The Audit Committee undertook a self-assessment of its performance against its delegated responsibilities as set out in its terms of reference. The Committee, supported by the Board, has considered its role in relation to risk with that of the Quality and Risk Committee, the Performance Committee and the Strategic Projects Committee.

The conclusions of finalised Internal Audit reports are reported to the Audit Committee. The Committee can, and does, challenge assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee. A system whereby Internal

Audit recommendations are followed-up is in place. Progress towards the implementation of agreed recommendations is reported (including details of all outstanding recommendations).

The Audit Committee is responsible for considering the appointment of the Internal Audit service and Counter Fraud service and reviewing their audit fees. In 2017/18 the contract for Internal Audit and Counter Fraud services was renewed for a further three years being awarded to RSM following a formal tendering process under the Crown Commercial Services Framework (RM3745). RSM was also appointed to provide Counter Fraud services.

The Audit Committee also reviews the External Audit service and makes recommendations to the Council of Governors on the appointment and re-appointment of the External Auditor. To aid assurance two Governors are attendees at Audit Committee. In 2015 a formal mini competition was undertaken against the regional framework developed by the East of England Procurement Hub for the appointment of External Auditors. The contract was to cover services for the NHS Statutory Audit and Annual Report and the Charity Annual Report and Accounts. In September 2015 the Council of Governors was asked to approve the appointment of KPMG LLP as External Auditor for an initial period of three years starting with the 2015/16 Statutory Audit, with an option to extend for a further two years which was exercised in 2018/19. A Governor was a member of the interview panel for the appointment of the External Auditor.

Annual Governance Statement (AGS)

The AGS provides information on the Trust's system of internal control and the risk and control framework. The AGS can be found in the last section of the Annual Report. Both the Audit Committee and the Quality and Risk (Q&R) Committee considered the Trust's draft AGS for 2018/19. Audit Committee members, Q&R Committee members together with the Trust's External and Internal Auditors, had the opportunity to provide comments on the draft statement. The final AGS was approved by the Audit Committee and Board of Directors on the 23 May 2019.

In the opinion of the Audit Committee the AGS is fair and provides assurance to the Accounting Officer that there were no unmanaged risks to the Trust during the year.

Specific Audit Committee Issues – 2018/19

During 2018/19, the Audit Committee received regular reports from Internal Auditors, External Auditors and Local Counter Fraud Specialist and reviewed their annual work plans and strategies as appropriate.

Principal matters considered were:

- The draft Annual Report and Accounts (including Quality Accounts) and the External Auditors' ISA 260 (including letter of representation and formal independence letter);
- The Annual Governance Statement (AGS);
- The Internal Audit Annual Report and Head of Internal Audit Opinion;
- The External Audit Plan for the Foundation Trust, including requirements for Quality Accounts;
- External Audit Plan, engagement letter and ISA 260 for the Charity Annual Report and Accounts;
- Reports as required on losses and special payments, waived tender schedule and bad debts;
- The Internal Audit Plan and progress report, including log of audit actions;
- Counter Fraud Annual Report, progress report and benchmark report;

- Anti-Fraud & Bribery Policy update and policy;
- Board Assurance Framework;
- Waiver to Standing Financial Instructions report;
- Managing conflicts of interest policy;
- Sanctions and Financial Re-dress Policy;
- Contract for Internal Audit and Counter Fraud Services;
- Annual review of Standing Financial Instructions, Standing Orders and Scheme of Delegation;
- Reports from Committee Chairs;
- CTP Post Submission Assurance Report;
- Annual review of the Audit Committee's terms of reference, Annual Self-Assessment and Committee forward Planner.

Information on internal audit reviews undertaken by the Internal Auditors for 2018/19 can be found in the Annual Governance Statement section of the Annual Report.

Action plans to address recommendations have been drawn up and will be subject to review as part of the Audit Committee standard review of the audit action log.

Whistle-blowing

The Trust has a Whistleblower's Procedure (Raising Issues of Concern) which explains how members of staff should raise any matters of concern which may impact adversely on the safety and/or well-being of our patients/our staff or the public at large, or may be detrimental to the Trust as a whole. It is consistent with the 'Freedom to Speak Up' Report published by Sir Robert Francis QC. Any concern raised is treated seriously and investigated thoroughly. Every effort is made to ensure confidentiality and feedback is provided to the person who raised the issue. As part of the process, individuals have the right to contact our Freedom to Speak Up Guardian, senior Trust officers of the Trust as listed in the Procedure, and identified Executive and Non-Executive Director leads. In addition our policy provides information on how staff can raise concerns with NHSI, CQC, NHSE and HEE. The Procedure is agreed with the Trust's recognised Trade Unions. The Trust's Freedom to Speak up Guardian proactively promotes his role across the Trust by meeting all new starters in the Trust and by undertaking regular walkabouts both in the Hospital site and at Royal Papworth House. He meets regularly with the Director of Workforce and the Chief Executive Officer to discuss themes emerging from the concerns raised with him and the number of hours he has to undertake the role was increased in 2018/19, in recognition of the importance of the role and the need to ensure that there was sufficient time for it to be undertaken effectively. The Guardian is required to report all concerns raised with him to the National Guardian's Office on a quarterly basis. Since his appointment in August 2018 the Guardian has reported 30 concerns. The concerns raised with him have been exclusively about staff relationships rather than about patient care. In 2019/20 we are looking to introduce Speaking Up ambassadors who will work with the Guardian to ensure staff are encouraged and know how to raise concerns. We will also be improving the feedback to managers and staff about the themes emerging from the concerns raised to ensure that we learn from them.

External Auditors

The External Auditors of Royal Papworth Hospital NHS Foundation Trust are: KPMG LLP Botanic House, 100 Hills Road, Cambridge, CB2 1AR. They report to the Council of Governors through the Audit Committee. Non-audit work may be performed by the Trust's external auditors where the work is clearly audit-related and external auditors are best placed to do that work. For such assignments Audit Committee approval ensures that auditor objectivity and independence is safeguarded. The total cost of audit services for the year was £47,500 (2017/18: £52,100), excluding VAT. This is the fee for an audit in

accordance with the Audit Code issued by Monitor in March 2011 and includes a non-recurrent fee in respect of PFI accounting. A further £7,400 (2017/18: £7,400) has been paid for other services in relation to the Quality Report opinion.

As part of reviewing the content of the proposed external audit plan for each year, the Audit Committee satisfies itself that the auditors' independence has not been compromised.

The Foundation Trust is responsible for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts ("NHS Improvement") under the National Health Service Act 2006.

The External Auditors' accompanying opinion on the financial statements is based on their audit conducted under the National Health Service Act 2006 and in accordance with NHS Improvement's Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland), and sets out their reporting responsibilities.

2.8 Council of Governors

As an NHS Foundation Trust, Royal Papworth has a Council of Governors as required by legislation. The Council comprises 18 public and seven staff members, all elected from the membership, together with four representatives nominated from local organisations. The responsibility for the operational and financial management of the Trust on a day-to-day basis rests with the Board of Directors, and all the powers of the Trust are vested in them. In accordance with the National Health Service Acts the specific responsibilities of the Governors at a General Meeting are to:

- Appoint or remove the Chairman and the other Non-executive Directors;
- Approve the appointment (by the Non-Executive Directors) of the Chief Executive;
- Decide the remuneration and the other terms and conditions of office of the Chairman and Non-executive Directors; and
- Appoint or remove the External Auditor.

They must also be presented with:

- the annual financial accounts;
- any report of the auditor on them;
- the annual report; and
- the quality accounts.

Other statutory roles and responsibilities of the Council of Governors are to:

- Hold the non-executive directors, individually and collectively, to account for the performance of the board of directors;
- Represent the interests of the members of the Trust as a whole and the interests of the public;
- Approve “significant transactions”;
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;
- Decide whether the Trust’s non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions, and
- Approve amendments to the trust’s constitution in consultation with the Board of Directors.

As required under NHS Improvement’s code there is an agreed interaction process for dealing with any conflict, should this arise, between the Board of Directors and the Council of Governors. This states that the normal channels of communication via the Chairman, Trust Secretary, Lead Governor or Senior Independent Director would be used in the first instance. There has never been any occasion for the process to be used.

The Council of Governors supports the work of the Trust outside of its formal meetings, advised by the Chairman and Executive Directors. Council of Governors’ Committees play an important role, with the skills and experience of individual Governors providing a valuable asset to the Trust. Through the Committees, Governors have the opportunity to concentrate on specific issues in greater detail than is possible at a full meeting of the Council of Governors.

The Council of Governors has the following Committees:

- Forward Planning, which reviews forward planning (including the Operational and Strategic Plans submitted to NHS Improvement) and the New Royal Papworth Hospital project;
- Appointments [Non-executive Director Nomination and Remuneration], which leads on the appointment, re-appointment and remuneration of NEDs. The Committee is chaired by the Lead Governor;
- Patient and Public Involvement (PPI), which considers patient and public involvement matters and Staff Awards ;
- Governors' Assurance, a 'task and finish' group;
- Access and Facilities Group; and
- Fundraising Group.

Members of the Council of Governors as at 31 March 2018:

Cambridgeshire

Stephen Brown

I have lived in Cambridgeshire for 34 years with my wife, we have 3 children and 5 grandchildren. Following open heart surgery at Papworth in 2007 I became a volunteer ward visitor, a worthwhile and rewarding role. In my long career as a senior manager within the construction industry I have contributed to a number of NHS projects. I am a fellow of the CIOB and past chair of the Cambridge centre and contribute to the government CIC

Glen Edge

Having retired from the RAF in 2006, Glenn is a full time arable farmer and businessman. He is a Papworth patient and in addition to being a Public Governor, is a patient representative on the Anglia Lung Network Cancer Group. He has assisted in a recent Peer Review and is also a member of the Patient Advisory Board of the local Cancer Alliance.

Gillian Francis

After bringing up her family Gillian started nursing in her early 40's, retiring as the 'Modern Matron' in Neuroscience at Addenbrookes' in 2004. The next year she became a Public Governor for Addenbrooke's. Gillian took a particular interest in the patient's experience which she continues as a Governor for Papworth.

Graham Jagger

Graham is a Cambridge University graduate and professional HR manager and consultant with wide public and private sector experience, the last 20 years of which have been in various roles in the NHS. He joined Papworth in 1994 as Director of Corporate Development and retired in 2009 on being appointed to the NHS Pay Review Body. Currently he is a Director of Healthwatch Cambridgeshire and Peterborough CIC and also works with HEE and CQC and chairs the East of England ACCEA and other remuneration committees; previously he was Chair and Lead Trustee of the Cambridge Community Mediation Service from 2006 to 2011.

Dr Richard Hodder (Lead Governor)

Richard's medical career included hospitals, the RAF, research and general practice. After retiring he has maintained an active interest in health issues as well as voluntary work at Papworth and Addenbrooke's. In late 2012 he underwent a successful pulmonary endarterectomy at Papworth. As a Governor his main interest is in the quality of care and patient safety/dignity

Suffolk

Barry Crabtree-Taylor

Barry has been with his firm of Solicitors in Newmarket since 1976. He commenced his working life as a trainee Legal Executive, qualified as a Legal Executive, then qualified as a Solicitor. He is and has been for some years an Equity Partner of the firm and its current Chairman.

Julia Dunicliffe (to 19 September 2019)

Julia is a retired NHS oncology and research nurse and has since then been working as a private secretary.

Trevor McLeese

Trevor retired as an equity partner due to ill health from an accountancy practice in 2014. He suffers from Muscular Dystrophy and Asthma and is a patient of Papworth Hospital. Trevor has been fitted with a defibrillator and has also experienced treatment in the Sleep Study Centre. Trevor uses an electric wheelchair and understands the issues and needs of the less able.

Norfolk

John Fiddy MBE

John has been closely associated with Papworth Hospital since his first bypass operation in 1984. He then joined the Norfolk Zipper Club and has been actively involved ever since. In 2008 John was awarded an MBE for services to fundraising for cardiac patients. John was Chairman of the Norfolk Zipper Club from 1995 until 2010. John joined the Council of Governors in 2004.

Tony Moodey

Tony recently retired from a hectic career undertaking roles in both engineering and sales and marketing working for a number of international companies. Throughout his career, he has travelled and lived in the Americas and in South East Asia. Originally from Hertfordshire, Tony has lived in Norfolk with his family for over 30 years. Keen to support the Royal Papworth Hospital Trust, he was appointed to the Council of Governors in 2017.

Peter Munday

Peter is a retired director of his own building firm and lives in Cringleford. In 2009 Peter underwent a triple bypass operation at Papworth Hospital after which he joined the Norfolk Zipper Club to be able to give something back in recognition of the care he received. He now serves as an active committee member of the Norfolk Zipper Club raising funds for Papworth Hospital.

Bob Spinks

Bob is a businessman who runs his own 4x4 car dealership having worked in the motoring industry for his entire career. He has witnessed first-hand the services provided at Papworth Hospital after he underwent a potentially life-saving quadruple heart bypass 15 years ago. This spurred him on to join the Norfolk Zipper Club to give something back to the staff that cared for him. He has recently become the club's chairman and decided he wanted to further support Papworth Hospital by becoming a governor.

Rest of England and Wales

Janet Atkins

Janet has been a member of the Patient Experience Panel since 2003 and was joint chair in 2006. She is actively involved in various committees with the hospital concerning patient issues. Janet is herself a Papworth Hospital patient.

Rob Graham

Rob has been the Co-Chair of the NHSBT Cardiothoracic Transplant Patient Group since 2015 and is also a committee member of the Papworth Transplant Patient Group. Rob's wife, Kathryn, received a heart/lung transplant at Papworth in 2013.

Keith Jackson

Keith has a professional background as Faculty Director (Technology) at Cambridge Regional College. He has been Cambridge Community Health Council Chairman and held representative appointments on both Addenbrooke's Hospital and East Anglian Ambulance Boards. His long association with Papworth Hospital is as Chairman of the British Cardiac Patients Association and a trustee of Heart Valve Voice. Keith is also actively involved in various committees within the Hospital.

Simon Marnier

Simon qualified as a Doctor in 1979 at King's College Hospital in London. After working at King's Westminster and Charing Cross Hospitals specialising in ENT surgery, he transferred to General Practice. He became a partner at a surgery in 1992 and retired 22 years later as the Senior Partner in 2014. He continues to work as a locum GP for a few sessions per week. He became a patient at Papworth Hospital in 2015 and was appointed to the Council of Governors in September 2017.

Harvey Perkins

Harvey is a retired business consultant and professional engineer and brings to the Council of Governors a wide range of general management, commercial, and financial skills. Harvey previously served as a Governor from 2004 to 2014, during which time he held a number of positions including Chair of the Forward Planning Committee, Chair of the Appointments Committee and Lead Governor.

Staff Governors

Penny Martin, Allied Health Professionals

I have been elected as Staff governor for Royal Papworth hospital representing the Allied Health Professionals. I am a qualified and registered social worker and have worked at Papworth since 2007, initially as a part time social worker before being appointed as team leader in 2009.

Prior to working at Papworth I had worked in a variety of roles in social care, as a child protection social worker, managing a unit for people with severe dementia, as well as a variety of posts in residential and day care for the elderly. I also have experience of working with young people who are homeless.

I love working at Royal Papworth hospital as it allows me to use the skills that I have developed over my career and I enjoy the daily challenges it brings. I am proud to act as a staff governor.

Helen Munday, Nurses (to 11 November 2018)

Helen left the Trust on 11 November 2018. Further details of her expertise and experience can be found in our annual report for 2017/18.

Katrina Oates, Scientific & Technical

Katrina has worked in Respiratory Physiology at Papworth since 2002. Her role is primarily in education and research but she also has a clinical workload and leads the exercise physiology service. Fifty percent of her time is seconded to Anglia Ruskin University, where she teaches and develops degrees in clinical physiology.

Cheryl Riotto, Nursing

Cheryl is the Head of Nursing for Clinical and Diagnostic Services. She has worked at Papworth Hospital since 1994 having started working within the Critical Care Unit before progressing to Sister and Transplant Coordinator within the Transplant Unit. In 2013 she progressed to be part of the Matron team working within the Transplant unit and Ambulatory Care. Since January 2018 Cheryl has been working in the Head of Nursing role and her role encompasses responsibility for Critical Care, Theatres, Cath Lab and Diagnostics alongside Ambulatory care and Private Patients. She is serving a third term as a Staff Governor representing Nursing

Helen Rodriguez, Administrative, Clerical & Manager

Helen has worked at Royal Papworth Hospital since 1992 in a variety of administrative roles across a number of departments. Her current role is Service Manager for Booking. This team is now a centralised service covering in-patient and out-patient bookings for the organisation and is based within the administration hub in Huntingdon. This role ensures that the booking team delivers activity which is booked to capacity whilst helping the organisation meet their waiting times.

Alessandro Ruggiero, Doctors

Dr Alessandro Ruggiero qualified as a doctor at the University of Rome and trained in radiology in Rome. He undertook the Molecular Imaging for Oncology Fellowship at Memorial Sloan-Kettering Cancer Center (New York, USA) and then he moved to the Erasmus University Medical Center in Rotterdam (The Netherlands). He was awarded a PhD from Erasmus University in 2012. He completed his subspecialty training in Cambridge (UK) at Addenbrooke's hospital (cross sectional radiology), Papworth Hospital (cardio-thoracic radiology) and Southampton University hospital (cardiac MR). He was appointed consultant cardio-thoracic radiologist at Royal Papworth Hospital in 2015.

He is a staff governor representing doctors since 2017.

Tony Williams, Ancillary, Estates & Others

Tony is a member of the Estates Team. Tony is a Porter at Papworth Hospital and says we are undergoing a change that is both exciting and challenging for members of staff. He feels it is of the utmost importance to keep staff informed of all the latest developments and to listen to what they are saying.

Appointed Governors

Ann-Marie Ingle (to August 2018)

Chief Nurse, Cambridge University Hospitals.

Lorraine Szeremeta (from October 2018)

Chief Nurse, Cambridge University Hospitals.

Cllr Susan Ellington (to Jun 2018)

Cambridgeshire County Council

Cllr Linda Jones (from Sept 2018)

Cambridgeshire County Council

Caroline Edmonds

Secretary of the School of Clinical Medicine, University of Cambridge

Cllr Nick Wright (to Jun 2018)

South Cambridgeshire District Council

Cllr Alex Malyon (from Jun 2018)

South Cambridgeshire District Council (SCDC covers Papworth Everard).

Terms of Office of Governors as at 31 March 2019

Elected Public Constituency	Name	First Elected	Re-Elected	End of Current Term of office
Cambridgeshire *served from Sept 2014 to Sept 2017 in another constituency	Stephen Brown	Sept 2017	n/a	Sept 2020
	Glenn Edge*	Sept 2014	Sept 2017	Sept 2020
	Gill Francis	Sept 2014	Sept 2017	Sept 2020
	Richard Hodder	Sept 2014	Sept 2017	Sept 2020
	Graham Jagger	Sept 2013	Sept 2016	Sept 2019
Suffolk *served from Sept 2010 to Sept 2013 in another constituency	Barry Crabtree-Taylor*	Sept 2013	Sept 2016	Sept 2019
	Trevor McLeese	Sept 2017	n/a	Sept 2020
	Vacancy	-	-	-
	Vacancy	-	-	-
Rest of England and Wales	Rob Graham	Sept 2016	n/a	Sept 2019
	Keith Jackson	Sept 2011	Sept 2014 Sept 2017	Sept 2020
	Janet Atkins	Sept 2017	n/a	Sept 2020
	Harvey Perkins	Sept 2016	n/a	Sept 2019
	Simon Marnier	Sept 2017	n/a	Sept 2020
Norfolk	John Fiddy MBE	Sept 2014	Sept 2017	Sept 2020
	Tony Moody	Sept 2017	n/a	Sept 2020
	Peter Munday	Sept 2014	Sept 2017	Sept 2020
	Bob Spinks	Sept 2013	Sept 2016	Sept 2019
Elected Staff Constituency	Name	First Elected	Re-Elected	End of Current Term of office
Doctors	Alessandro Ruggiero	Sept 2017	n/a	Sept 2020
Nurses	Cheryl Riotto	Sept 2011	Sept 2014 Sept 2017	Sept 2020
	Vacancy (from Nov 18)	-	-	-
Allied Health Professionals	Penny Martin	Sept 2017	n/a	Sept 2020
Scientific & Technical	Katrina Oates	Sept 2011	Sept 2014 Sept 2017	Sept 2020
Administrative, Clerical & Management	Helen Rodriguez	Sept 2013	Sept 2016	Sept 2019
Ancillary, Estates and Others	Tony Williams	Sept 2016	n/a	Sept 2019
Appointed Governor	Name	Start of Term of Office	Re-elected	End of Current Term of office
University of Cambridge	Caroline Edmonds	Oct 2016	n/a	As agreed between organisations
Cambridge University Hospitals NHS FT	Lorraine Szeremeta	Oct 2018	n/a	As agreed between organisations
Cambridgeshire County Council	Cllr Linda Jones	Sept 2018	n/a	As agreed between organisations
South Cambridgeshire District Council	Cllr Alex Malyon	June 2018	n/a	As agreed between organisations

Register of Interests

The Trust's Constitution requires the Trust to maintain a register of Governors' interests. All Governors are asked to declare any interests at the time of their appointment and annually thereafter. There is a standing item on all Council of Governors and Committee meetings to confirm/update declarations of interest. The register is held by the Trust Secretary. The register is available to the public on request. Anyone who wishes to see the Register of Governors' Interests should make enquiries to the Trust Secretary at the following address: The Trust Secretary, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

Contacting the Governors

Governors can be contacted via the Chairman's Office, by telephoning 01223 639833 or by writing to: The Chairman's Office, Royal Papworth Hospital, Papworth Road, Cambridge Biomedical Campus Cambridge, CB2 0AY.

Governor Election Results

Electoral Reform Services Limited (ERS) acted as the returning officer and independent scrutineer for the election process during 2018.

There were vacancies for Governors in one of our public constituencies, Suffolk. No nominations were received from this constituency.

Information on election results:

Cambridgeshire – no election in 2018/19

Suffolk - uncontested election: no nominations – two vacancies

Norfolk - no election in 2018/19;

Rest of England and Wales - no election in 2018/19;

Doctors - no election in 2018/19;

Scientific and Technical - no election in 2018/19;

Allied Health Professionals - no election in 2018/19;

Nurses - no election in 2018/19 – one vacancy

Involving and Understanding the views of the Governors and Members

The Board of Directors welcomes all opportunities to involve and listen to the views of Governors and Members. Listed below are some of the activities that demonstrate this commitment:

- Members voting (and standing for election) in elections for the Council of Governors;
- Presentations for Governors on subjects including clinical leadership and optimisation of our Electronic Patient Record; Patient Stories;
- Six main Governor/Director Committees: Forward Planning, Appointments [Non-executive Director Nomination & Remuneration], Patient/Public Involvement (PPI), Governors' Assurance, Access and Facilities and Fundraising Group;
- Governor attendance at Audit Committee, Quality and Risk Committee and Open Board meetings;
- Governors' attendance at events such as the Annual Members' Meeting and annual Staff Awards Ceremony;
- Norfolk Governors have leading roles in Norfolk Zipper Club, which supports patients and their families and actively fundraises for the Trust;
- Governor membership on the Patient and Carer Experience Group (PCEG), Reading Panel and HealthWatch;
- Member engagement with the Trust through PALS (Patient Liaison and Advice Service);
- Active Volunteer structure.

Table of Attendance of Directors at Council of Governors' Meetings

Council of Governors	20-Jun-18	19-Sep-18	21-Nov-18	20-Mar-19
John Wallwork (Chairman)	✓	✓	✓	✓
Stephen Posey	x	✓	✓	✓
Michael Blastland				
Karen Caddick	x	x		
Roy Clarke	✓	✓	x	✓
Cynthia Conquest				x
David Dean		✓	x	x
Roger Hall	✓	x	✓	x
David Hughes	x	x	x	x
Susan Lintott	x	x	x	✓
Eilish Midlane	x	✓	✓	✓
Mark Millar	x	x		
Oonagh Monkhouse ¹	✓	✓	✓	✓
Nick Morrell	x	x	x	x
Andy Raynes	x	x	x	✓
Josie Rudman	x	✓	✓	✓
Ron Zimmern	x	x	x	

✓ Indicates attendance at meeting.

x Indicates did not attend.

¹ Part year membership

Royal Papworth Hospital is a Trust with a small management team. Whilst Executive and Non-Executive Directors are keen to understand the views of Governors they rationalise attendance at all Trust meetings based on the content of the agenda. Governors attend public Board meetings as observers and are invited to attend Board Committee meetings as attendees, where they contribute to discussions.

Table of Governor Attendance at Council of Governors' Meetings 2018/19

Council of Governors	20-Jun-18	19-Sep-18	21-Nov-18	20-Mar-19
Atkins, Janet	x	✓	x	x
Brown, Stephen	✓	✓	✓	✓
Crabtree-Taylor, Barry	✓	✓	x	✓
Dunncliffe, Julia	x	✓		
Edge, Glen	✓	✓	x	✓
Fiddy, John	x	✓	✓	✓
Francis, Gill	✓	✓	✓	✓
Graham, Robert	✓	✓	✓	✓
Hodder, Richard (Lead)	✓	✓	✓	✓
Jackson, Keith	x	✓	✓	✓
Jagger, Graham	✓	✓	✓	✓
Marner, Simon	✓	x	✓	✓
McLeese, Trevor	✓	x	✓	✓
Moodey, Tony	✓	✓	✓	✓
Munday, Peter	✓	x	x	✓
Perkins, Harvey	✓	x	✓	✓
Spinks, Bob	✓	x	✓	✓
Martin, Penny	✓	x	✓	✓
Munday, Helen	x	✓		
Oats, Katrina	x	x	✓	✓
Riotto, Cheryl	✓	✓	✓	✓
Rodriquez, Helen	✓	✓	✓	✓
Ruggiero, Alessandro	✓	✓	✓	✓
Williams, Tony	✓	x	✓	x
Edmonds, Caroline	✓	x	✓	✓
Ellington, Sue	✓			
Ingle, Anne-Marie	✓			
Jones, Linda			x	✓
Malyon, Alex		x	x	x
Szeremeta, Lorraine			x	x

Not a Governor
 ✓ In attendance
 x Apologies received

2.9 Foundation Trust Membership

Royal Papworth Hospital has always been a patient-centred organisation and as an NHS foundation trust strongly believes that greater public participation in the affairs of the hospital combined with the freedoms afforded to foundation trusts will help to deliver even better services to patients. In creating a membership the Trust was clear that it was more important to build an active and engaged membership rather than merely adding numbers.

Public and Staff constituencies

Following changes to its Constitution agreed by Members at our Annual Members' Meeting in September 2007, the Trust's public constituencies cover the whole of England and Wales allowing anyone over the age of 16 to join. Constituencies have been split to reflect Royal Papworth's regional and national catchment areas. No changes have been made to the constituencies for membership since 2007. The Trust has no patient constituency. Public Constituencies are: Cambridgeshire; Norfolk; Suffolk; and The Rest of England and Wales. Staff constituencies reflect professional groupings using the old Whitley Council classifications: Doctors, Nurses, Allied Health Professionals, Scientific and Technical, Administrative, Clerical and Managers, Ancillary, Estates and Others.

Membership by constituency as at 31 March 2019:

Membership by constituency as at 31 March 2019		
Public Membership Profile	Number of Members	% of total
Cambridgeshire	2,372	36.60%
Norfolk	1,106	17.07%
Suffolk	957	14.77%
Rest of England & Wales	2,046	31.57%
Sub-total	6,481	100.00%
Constituencies – Staff*	Number of Members	% of total
Nurses	842	37.26%
Doctors	368	16.28%
Allied Health Professionals	258	11.42%
Scientific & Technical	118	5.22%
Ancillary, Estates & Others	156	6.90%
Administrative, Clerical & Management	518	22.92%
Sub-total	2,260	100.00%
Total Membership	8,741	100.00%
*Note: Numbers are individual members of staff, not whole time equivalent		

Membership Plans

The Membership Strategy was reviewed with Governors in November 2018 is to be refreshed and re-launched following the move to the new hospital. The strategy underpins the Trust's membership model of governance. It sets out how the Council of Governors discharges its role and responsibilities with particular reference to the Governors' role of being responsible for representing the interests of the membership. The strategy includes direction on how Governors could provide regular and effective communication with members, to keep them informed about what is happening at the Trust and, crucially, improve engagement with stakeholders. Membership recruitment continues using the website, leaflets, and posters.

Annual Members' Meeting

The Trust held its Annual Members' Meeting (AMM) on Wednesday 19 September. Our Foundation Trust Members heard updates on the hospital's performance over the past year, as well the latest on the hospital move and some excellent clinical presentations from our consultant staff.

Presentations included the Lead Governor speaking on the role of Governors, performance updates from our Chief Executive, Chief Nurse and Chief Finance Officer, as well as an update on our new hospital and clinical presentations covering Thoracic surgery: now and in the future; Cardiac sarcoidosis: combining research in lung and heart disease and the launch of new Rapid NSTEMI pathway.

The meeting was well attended with much interest in clinical developments and questions answered around travel and parking at the Cambridge Biomedical Campus, how we plan to work with our partners at CUH and other hospitals in the future, and our progress with implementing our Electronic Patient Record.

Thanking our volunteers

In December 2018 we hosted a Christmas Afternoon Tea to say thank you to our volunteers who have supported the work of the hospital throughout the last year. Every day, our volunteers provide invaluable support to our staff and patients in a wide variety of roles and in this year they provided tremendous support for staff and patients throughout the hospital move period. Our volunteers acted as wayfinding champions for our new patients, as runners for our Command and Control centre as well as helping with packing and making beds, which all supported the successful move into the new hospital.

We have launched our Volunteer Strategy in this year and this will support the development of a volunteer service that brings added value to our patients, promotes and gives opportunities for people to volunteer and develops partnership and networking with national, charitable and third sector organisations including volunteer support groups. Since our move to the new site we have seen increase in interest in becoming a volunteer with the Trust.

If you are interested in hearing more about the work of Royal Papworth's volunteers please contact the PALS team via the PALS Office, by emailing papworth.pals@nhs.net or by telephoning 01223 638896.

2.10 Sustainability Report

It is widely acknowledged that climate changes have a significant impact on health and wellbeing, as well as being one of the most serious global environmental threats. The commitment to sustainability and carbon reduction with respective targets are the norm in most large organisations. In addition, the Climate Change Act sets target reductions of 30% by 2030 and 80% by 2050 against a 1990 baseline.

Revenue investments have continued to be made over the previous year to improve the Trust's performance in sustainability and carbon reduction, however with the impending move to new Royal Papworth Hospital there is minimal opportunity for further "spend to save" investment, due to the limited payback period. The concentration has therefore been on behavioural changes within the Trust around informing and educating staff members on best practices to reduce our carbon footprint and reduce our energy usage, engaging with staff members by means of Quiz's, posters and drop in sessions. This can have a significant impact on the targets, and the need for wider engagement and collaboration in supporting the Trust to achieve these targets continues to be a priority for the coming years, especially when we move into the new Royal Papworth Hospital.

The Trust continually monitors its performance and electrical consumption against the carbon credit limits assessing whether its electricity consumption has increased sufficiently to require the Trust to purchase carbon credits. The annual CREES (Carbon Reduction Energy Efficiency Scheme) statement received from EDF indicates that the Hospital is again under the 6 million kwh target (Actual to be provided). This has been achieved against a background of increasing activity and a consequential increase in energy consumption.

From 19 February 2018 onwards aggregated data from the 2 sites will need to be provided until sale of the current site. The increases reported in 2018/19 reflect the impact of dual running across two sites, and some exceptional use relating to the commissioning of the new site.

Future Projects

The Trust continues to be represented at meetings of the Cambridge Biomedical Campus (CBC) as part of a Travel and Transport, and Sustainability working group. The group has been looking at ways to improve travel onto the CBC site prior to the move in 2019 whilst still maintaining a "green" travel plan along with exploring culture change for sustainability focusing on energy, waste and water across the whole campus.

The Trust is working with Mott Macdonald to undertake a forensic review of energy consumption at the new hospital site to ensure this is in line with both the design specification and is delivering the required savings.

SUMMARY OF COMPARATIVE DATA

Area	Type	Non-Financial data						Financial Data £000's					
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19*
Greenhouse Gas Emissions	Direct GHG Emissions												
	Electricity (GJ)	21,149	20,904	20,235	20,383	21,400	42,214	653,089	667,874	677,343	677,737	786,572	1,551,787
	Gas (GJ)	44,580	36,608	35,881	36,481	37,183	77,406	400,135	321,557	280,616	247,988	245,194	510,107
	Oil (GJ)	698	635	554	588	1,215	1,469.55	9,424	9,684	6,406	7,940	19,357	23,410
	Total	66,427	58,147	57,816	57,452	57,798	116,043	1,062,688	999,115	964,365	933,665	1,038,495	2,085,304
Waste Minimisation and Management	Clinical Waste for Incineration (Tonnes)	296	311	318	306	300	261	121,596	128,314	142,036	143,666	141,110	122,910
	General Waste (Tonnes)	322	320	345	331	362	567	43,078	38,019	42,122	45,755	40,371	63,304
Finite Resources	Water (M ³)	62,010	50,294	55,289	54,552	63,984	167,911	123,691	107,389	112,377	109,098	130,561	342,539

* 2018/19 figures reflect dual running and some exceptional use due to the commissioning of the new site.

For information on 2008/09 to 2012/13 see previous Trust Annual Reports

<https://royalpapworth.nhs.uk/our-hospital/information-we-publish/annual-reports>

In 2012 the Trust changed their utility procurement with a greater focus on Gas than Oil for cost and energy efficiency reasons.

2.11 Equality and Diversity Report

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

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations between persons who share a relevant characteristic and those who do not.

The nine protected characteristics are:

- Age
- Disability
- Ethnicity
- Gender
- gender reassignment
- marriage & civil partnership
- pregnancy & maternity
- religion or belief
- sexual orientation

We publish information to demonstrate compliance with the general duty at least annually and prepare and publish equality objectives every 4 years.

The Trust takes due regard for equality by undertaking equality impact assessments for equality analysis when reviewing policies or when planning changes to services as part of organisational change processes to ensure our functions and services are not discriminatory. The Trust recognises that a richly diverse workforce, representative of the population we serve, will better identify the needs both of our staff and patients and that staff perform best at work when they can be themselves. This report sets out profile of our workforce and the actions we take to promote workforce and service equality and diversity across the Trust.

Workforce Profile – 31 March 2019

The following overview of the profile of our workforce is taken from data held on the Electronic Staff Record and is self-declared by the member of staff.

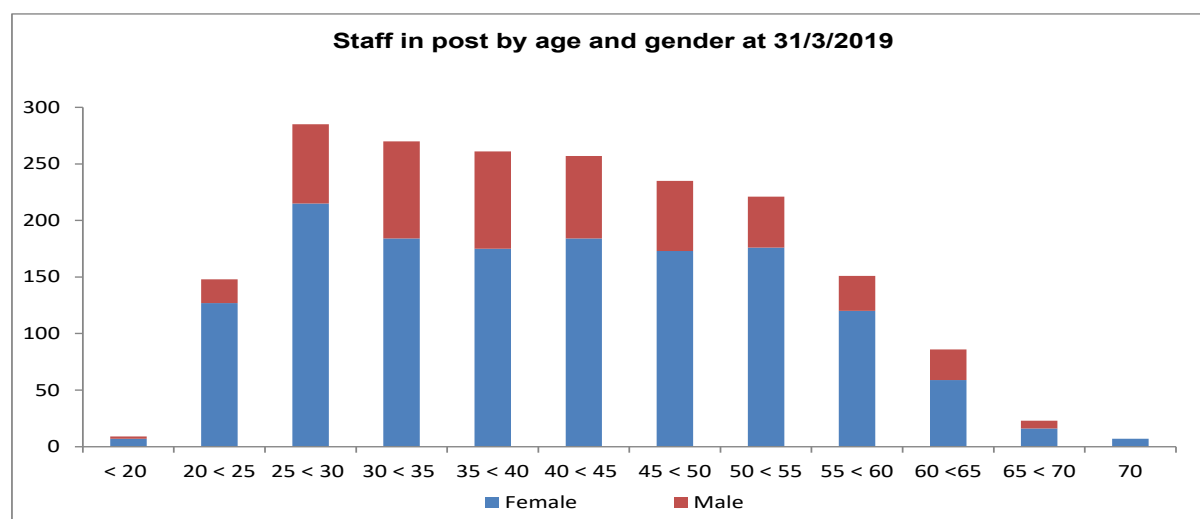
Gender

The Hospital had 1953 employees at 31st March 2019, excluding hosted services, of which, 1400 were full time employees and 553 were part time.

Gender	Full Time		Part Time		Total Workforce	
	Wofkforce	% of Full time	Wofkforce	% of part-time	Wofkforce	% of workforce
Female	942	67.29%	501	90.60%	1443	73.89%
Male	458	32.71%	52	9.40%	510	26.11%
Grand Total	1400	100.00%	553	100.00%	1953	100.00%

Age by Gender

The age profile of the workforce gender is as follows:



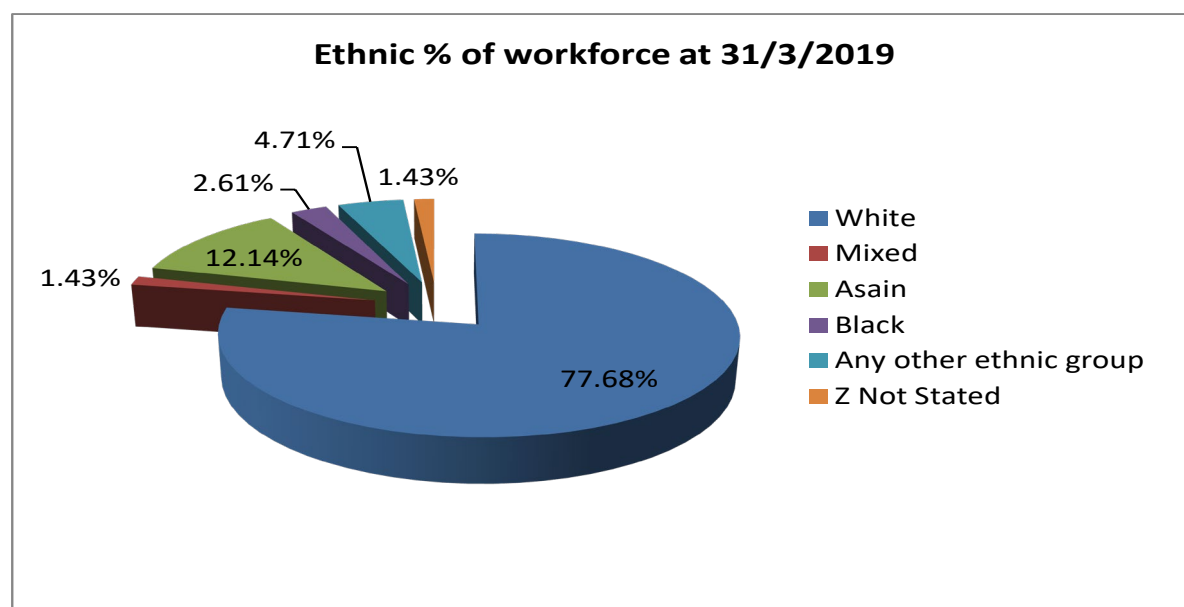
Age band	Female	Male	Total	% of staff
< 20 years	7	2	9	0.46%
20 < 25 years	127	21	148	7.58%
25 < 30 years	215	70	285	14.59%
30 < 35 years	184	86	270	13.82%
35 < 40 years	175	86	261	13.36%
40 < 45 years	184	73	257	13.16%
45 < 50 years	173	62	235	12.03%
50 < 55 years	176	45	221	11.32%
55 < 60 years	120	31	151	7.73%
60 < 65 years	59	27	86	4.40%
65 < 70 years	16	7	23	1.18%
70 years and over	7	0	7	0.36%
Grand Total	1443	510	1953	100.00%

Gender Pay Gap

The Trust has complied with the new reporting requirements in relation to the gender pay gap and have developed an action plan to ensure that we better understand historical reasons for the gender balance in particular areas, that we share data with our staff and that we put in place measures, including training and support, that will allow us to address issues that are identified.

Gender pay published for 31/3/2018														
Royal Papworth Hospital NHS FT	ORDINARY PAY										BONUS PAY			
	Mean pay gap %	Median Pay gap %	Quartile 4 (Top quartile)		Quartile 3 (Upper Middle Quartile)		Quartile 2 (lower middle quartile)		Quartile 1 (Lower quartile)		Mean Bonus pay gap %	Median Bonus Pay gap %	Proportion of males and females receiving a bonus payment	
			Men	Women	Men	Women	Men	Women	Men	Women			Men	Women
	25.96%	10.25%	40.42%	59.58%	18.38%	81.62%	23.79%	76.21%	25.95%	74.05%	46.21%	78.86%	7.39%	0.72%

Ethnicity



Sexual Orientation

Sexual orientation	Total	% of workforce
Bisexual	16	0.82%
Gay or Lesbian	12	0.61%
Heterosexual or Straight	1341	68.66%
Not stated (person asked but declined to provide a response)	360	18.43%
Other sexual orientation not listed	2	0.10%
Undecided	1	0.05%
Undefined	221	11.32%
Grand Total	1953	100.00%

Disability

Disabled	Female		Male		Grand Total	
	Wofkforce	% of workforce	Wofkforce	% of workforce	Wofkforce	% of workforce
No	938	48.03%	328	16.79%	1266	64.82%
Not Declared	126	6.45%	76	3.89%	202	10.34%
Prefer Not To Answer	3	0.15%		0.00%	3	0.15%
Undefined	324	16.59%	94	4.81%	418	21.40%
Yes	52	2.66%	12	0.61%	64	3.28%
Grand Total	1443	73.89%	510	26.11%	1953	100.00%

Religious belief

Religious belief	Total	% of workforce
Christianity	886	45.37%
I do not wish to disclose my religion/belief	396	20.28%
Atheism	251	12.85%
Undefined	220	11.26%
Other	129	6.61%
Islam	31	1.59%
Hinduism	30	1.54%
Buddhism	9	0.46%
Judaism	1	0.05%
Grand Total	1953	100.00%

NHS equality delivery system (EDS)

The EDS has been developed by the NHS England Equality and Diversity Council to improve equality and diversity practice in the NHS as a tool to embed equality and diversity practice to meet the public sector equality duty. The EDS contains 18 outcomes grouped under four goals. The four goals are:

- Better health outcomes for all
- Improved patient access and experience
- Workforce – the NHS as a fair employer
- Inclusive leadership at all levels

Continuous improvement is prompted by a grading system. The grading system is red (underdeveloped), amber (developing), green (achieving) and purple (excelling) RAGP rating system. A core part of the EDS is engagement with local interest groups. It is these local interests that grade how well they think the Trust is doing as an organisation. These grades are then published on the Trust website.

The Trust uses the NHS Equality Delivery System (EDS) as a tool to drive equality improvements to engage with patients, staff and the community to review our service and employment equality performance and to identify future priorities and actions for

the Trust's equality objectives. The outcome of our 2017 EDS rating was also reported by the CEO to the Board in November 2017. The Trust's EDS rating reporting template and annual equality objectives to address the gaps are published on the Trust website.

Workforce Race Equality Standard

The WRES was introduced into the NHS in April 2015 to tackle the '...consistently less favourable treatment of the Black and Ethnic Minority (BME) workforce...'. Its main purpose is to help NHS organisations, locally and nationally, to review their data against nine WRES indicators, to produce action plans to close gaps in workplace experience between White and Black Ethnic Minority (BME) staff, and to improve BME representation at Board level in organisations.

The Trust publishes our annual WRES review and our action plan to address issues identified in the review on our Website. The implementation of the action plan is overseen by the Equality, Diversity and Inclusivity Committee. Key activity on the WRES action plan are:

- Improving the diversity of our Board
- Introducing unconscious bias training for line managers
- Refreshing the governance for WRES
- Setting up a BME Staff Network to improve engagement with BME staff

Equality monitoring

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

This includes:

- the profile of our staff by age band, disability, race, religion, sex, sexual orientation and marital status
- ethnic profile of our staff compared to the local population
- recruitment data by age band, disability, race, religion, sex, sexual orientation and marital status (those applying, shortlisted and appointed)
- staff in post by pay band by age, disability, race, sex and sexual orientation
- the number attending training courses by age band, disability, race and sex
- the number of leavers by age band, disability, race and sex
- employee relations cases (disciplinary, capability, performance and sickness bullying and harassment) cases by age band, disability, race and sex

<https://royalpapworth.nhs.uk/our-hospital/information-we-publish/equality-diversity-and-inclusion>

Trade Union Facility Time Publication Requirements

The Trust has complied with the Disclosure of Trade Union Facility Time set out in The Trade Union (Facility Time Publication Requirements) Regulations 2017. The following data was published as required in 2018/19.

Seven employees were Relevant Union Officials during the relevant period (2017/18) and this equated to 6.4 FTE employees.

The percentage of time spent on facility time was:

a	0%	0
b	1%-50%	7
c	51%-99%	0
d	100%	0

The percentage of pay bill spent on facility time during the relevant period

a	Total cost of pay bill on facility time	£15,523
b	Total pay bill	£82,732,000
c	Total pay bill spent on facility time	0.02%
d	Time spent on paid trade union activities as a percentage of total paid facility time hours	75.29%

2.12 Statement of Accounting Officer's responsibilities

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] 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 Royal Papworth Hospital NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

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

taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed:

A handwritten signature in black ink that reads "S. Posey". The signature is written in a cursive style with a large, looped 'P' and a trailing flourish.

Stephen Posey
Chief Executive
Date: 23 May 2019

2.13 Annual Governance Statement

Executive summary

My annual governance review of 2018/19 confirms that Royal Papworth Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust has a programme that regularly monitors and tests various aspects of its governance and risk management structures to ensure they remain fit for purpose. Overall, no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2019/20. The document below summarises the key areas that informed this opinion.

Scope of Responsibility

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

In undertaking this role I, and my team, have developed and maintained strong links with NHS Improvement, NHS England, clinical commissioning groups, and partner organisations both in the local health economy and nationwide.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Royal Papworth Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Royal Papworth Hospital NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Board of Directors leads the management of risk within the Trust. The Trust has in place a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to Executive Directors. The Operational Plan sets out the Trust's principal aims for the year ahead. Executive Directors have the responsibility for identifying any risks that could compromise the Trust from achieving these aims.

All new staff joining the Trust are required to attend Corporate induction which covers clinical governance and risk management, including use of the Datix Incident Reporting System. The Trust learns from good practice through a range of mechanisms including root cause analysis of identified incidents, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidenced based practice. All relevant

policies are available on the Trust intranet.

Accountability arrangements of the Chief Executive include a requirement to provide regular corporate performance reports to the Board of Directors and the Council of Governors on the Trust's performance against key national and local quality targets and on the Trust's financial status. The Royal Papworth Integrated Performance Report (PIPR) allows for triangulation of quality, operational activity and finances. Scrutiny of quality metrics takes place at the Executive Committee, Clinical Professional Advisory Committee and Quality and Risk Committee and the external Commissioning Quality Monitoring meeting occurs regularly during the year and once a year there is an annual deep dive which includes staffing establishments and quality indicators.

The risk and control framework

Quality governance and risk management is central to the effective running of the organisation. The Risk Management Strategy and supporting procedure set out the key responsibilities for managing risk within the organisation, including ways in which risk is identified, evaluated and controlled. The overall aim of the Risk Management Strategy is to achieve a Trust wide corporate approach to risk management supported by effective and efficient systems and processes which ensure the organisation is one which:

- Recognises that risk is present in all activities both clinical and non-clinical and is fully aware of its risks – where risk management is embedded within our culture and integrated into the working practices of all grades and disciplines of staff;
- Encourages the open reporting of accidents, concerns, incidents and near miss events by fostering a fair and just culture that learns from such events, puts actions into place to prevent recurrence, recognises the effects of Human Factors, provides feedback to staff and offers sensitive and fair investigation of the organisation and individuals' contribution to the event;
- Accepts that risk management is everyone's responsibility;
- Achieves organisation wide understanding of the challenges arising from the implementation of Clinical and Quality Governance;
- Facilitates change through multidisciplinary ownership of identified plans and work streams;
- Ensures the Trust achieves set targets relating to clinical quality and safety;
- Adopts a pro-active approach to risk management and endeavours to identify opportunities and risks for all projects and tasks;
- Ensures by pro-active management that effective action plans are in place to mitigate risks which will minimise any actual harm or loss;
- Anticipates the effect of change on all activities and transformation to New Royal Papworth Hospital;
- Advocates honesty and transparency in its communications with patients, staff, contractors and visitors and acknowledges our liability for harm or loss in any instance where we have been negligent in our duties.

The Board of Directors is responsible for identifying and assessing the Trust's principal risks (i.e. those that threaten the achievement of the Trust's corporate objectives). A risk management matrix is used to support a consistent approach to assessing and responding to clinical and non-clinical risks and incidents.

Risk assessment information is held in an organisation wide risk register (Datix Risk Management system). There are regular Corporate and Board Assurance Framework (BAF) risk reports to the Executive Directors; which includes a BAF tracker dashboard. All Serious Incidents (SIs) are reported to the Board via the Chief Nurse, Medical Director or Chief Operating Officer. All staff are responsible for responding to incidents, risks,

complaints and near misses in accordance with the appropriate policies. Incident reporting is co-ordinated by the Department of Clinical Governance and Risk Management. Staff are encouraged to report incidents and there continues to be a healthy incident reporting culture which is demonstrated by the percentage of near miss reports against actual incidents with the majority of incidents graded as low or no harm. Information on patient safety incident trends and actions are discussed in the monthly Quality and Risk Management Group (QRMG) which is chaired by the Clinical Governance Lead – a Consultant Anaesthetist, who is a member of the Board’s Quality and Risk (Q&R) Committee. Information on staff, visitor and organisational incidents and risks are shared at the Health and Safety Committee and disseminated across the Committee structure. Information on patient safety incident trends and actions are also placed on the Trust’s external website in the quarterly Quality and Risk Report. The QRMG reports to the Q&R Committee.

Board of Director Committees consisted in the year of:

- Audit Committee;
- Quality and Risk (Q&R) Committee;
- Performance Committee;
- Strategic Projects Committee;
- Executive Remuneration Committee;
- Charitable Funds Committee (Board of Trustees);

Membership of the Q&R Committee, Performance Committee and Strategic Projects Committee consists of Non-executive Directors (NEDs) and Executive Directors, the Chairs are NEDs. Other Executive Directors, attend as business requires. Two Governors are also in attendance at the Q&R Committee and Audit Committee. During the year the Q&R Committee met five times, the Performance Committee and Strategic Projects Committee met twelve times, all Committees report to the Board through minutes and written Chair’s reports.

During 2018/19 the Q&R Committee was delegated with providing assurance to the Board that there is an effective structure, process and system of control for:

- Clinical Governance;
- Information Governance;
- Non-financial Resource Governance;
- Risk Management;
- Quality Reporting to support assurance for the annual Quality Report/Accounts; and
- Board Assurance Framework (BAF) to support the Annual Governance Statement.

The role of the Performance Committee is to provide assurance, overview and monitoring for the Board on financial governance and reporting, including the cost improvement programme/service improvement programme (CIP/SIP). The Performance Committee provides in year scrutiny for matters affecting the overall business, performance and reputation of the Trust, including:

- In-Year Performance (financial and service performance);
- Capital Investment, supported by the Investment Group;

- Planning and Service Development, including CIP/SIP.

The Investment Group, chaired by the Chief Finance Officer, supports the Performance Committee and has the remit of ensuring that all major investment, disinvestment and development decisions (both revenue and capital) receive appropriate overview and scrutiny. The Key aims of the Group are to establish the overall methodology and controls which govern the Trust's investment and development decisions; ensure that robust processes are followed (e.g. evaluation of fit with the Trust strategy); and evaluate, recommend/approve, scrutinise and monitor investments and developments.

The role of the Strategic Projects Committee is to provide assurance on the Trust's strategic projects/transformation plans in respect of the following programmes: New Royal Papworth Hospital (NPH), Cambridge Transition Programme (CTP), E-Health – Lorenzo Electronic Patient Record (EPR) and the Heart and Lung Research Institute (HLRI).

For information on the Audit Committee see the Audit Committee section of this Annual Report. For information on the Executive Remuneration Committee see the Remuneration section of this Annual Report. For information on the Charitable Funds Committee see the Charity Annual Report and Accounts, published separately – see Charity website <https://www.papworthhospitalcharity.org.uk/governance>

The Trust is a patient centered organisation and places a high priority on the quality of its clinical outcomes, patient safety and patient experience and abides by the principles outlined in NHS Improvement's quality governance framework and/or Well-led, as follows:

- Quality Strategy: Every patient has the right to feel safe and cared for whilst accessing services at Royal Papworth Hospital NHS Foundation Trust. The Trust has refreshed its Quality Strategy 2019-22 building on its achievements and aligned to, and taking into account the national Quality Improvement agenda, current QI research and National QI leadership programmes. This includes implementation of the Culture and Leadership Programme co-designed between NHS Improvement and the Kings Fund, which will be undertaken in 2019 and support the delivery of our Quality Strategy. The Trust's Quality strategy sets out three ambitions:
 1. Safe: Provide a safe system of care thereby reduce avoidable harm;
 2. Effective and Responsive Care: Achieve excellent patient outcomes and enable a culture of continuous improvement;
 3. Patient experience and engagement: We will further build on our reputation for putting patient care at the heart of everything we do.
- Risks to quality are listed in the Board Assurance Framework (BAF) and in the risk register. The Medical Director and Chief Nurse review the Quality impact assessments for all new Service Improvement (CIP/SIP) projects;
- Capabilities and culture: The Trust has achieved Non-executive Director (NED) engagement in quality through the Quality and Risk Committee (Q&R) and Governor engagement through the Patient and Public Involvement (PPI) Committee and Q&R Committee. The Board of Directors and Council of Governors receive and review the PIPR, including patient safety and patient experience at every meeting. The last external Well-led Review was carried out during 2015/16.
- Structures and processes: Quality, in the form of patient quality and safety, and patient experience are standing items for all meetings of the Board of Directors and Council of

Governors. The Q&R Committee reviews actions to address quality performance issues. The Trust has engaged with its key external stakeholders on quality through the quality reporting process and has requested input from system partners including our NHS Commissioners, Cambridgeshire County Council Health Committee and Healthwatch Cambridgeshire and Peterborough. There is a Guardian of Safe Working Hours and a Lead Healthcare Scientist role established; in the last year the Trust has established a network for Black and Minority Ethnic Staff and has established the role of Freedom to Speak Up Guardian who reporting directly to the Board.

- **Measurement:** The Board reviews its performance metrics through the PIPR and these are linked to the Trust's strategic objectives, national priority indicators, NHS Improvement (NHSI) governance ratings, Commissioning for Quality and Innovation (CQUIN) and local priorities. The PIPR is used to report on quality to the Board on a monthly basis alongside operational and finance performance. The quality elements are informed from the directorate quality reports and the Matrons monthly ward and departmental score card. The Trust has worked with Commissioners on quality matters and meets with the Commissioner's quality team to review the Commissioning Quality dashboard. There have been no quality derogations recorded. The Trust has submitted and will continue to submit evidence for the NHS Quality Surveillance Program and the Specialised services quality dashboard (SSQD). The Trust has a SSQD gatekeeper (Assistant Director Quality and Risk) and Executive lead (Chief Nurse) sign off for the QST portal.

Risk

The risk management function is managed by the department of Clinical Governance and Risk Management, which reports to the Chief Nurse. The Chief Nurse is the Caldicott Guardian. The department of Clinical Governance and Risk Management is supported by a number of Committees which report through the Quality and Risk Management Group (QRMG) to the Quality & Risk (Q&R) Committee of the Board. There are a range of policies in place to describe the roles and responsibilities of staff in identifying and managing risk and these policies set out clear lines of responsibility and accountability. All relevant policies are available for viewing on the intranet and are regularly updated. Over the previous couple of years the Trust has successfully embraced and continues to improve electronic reporting of all risks. The continued development of senior staff risk skills has enhanced the awareness of the need to record issues and formally bring them to the attention of senior management.

All new risks are identified in-year and escalated to the risk register and reported via the Board Assurance Framework (BAF) where the residual risk rating is extreme, and the risk cannot be controlled to an acceptable level. Once identified, all risks are assessed with a consistent approach utilising the Trust 5x5 severity and likelihood matrix. During the review process, all risks (financial, safety, clinical project & management) are afforded the correct level of priority dependent on the Residual Risk Rating (RRR) following any recognised control measures which have been identified. Risks confirmed with a RRR of between 1 and 12 are managed by the responsible Directorate. Risks, resulting in a RRR of 15 or more are reviewed by the Lead Executive to provide assurance that the control measures put in place, are effective and that actions are developed to reduce the risk. Where the risk remains high, it is considered for escalation to the BAF for review by the appropriate Board Committee. All risks are also reviewed by the respective directorate management groups, with the Risk Management Group continuing to monitor the process via the dashboard on a quarterly basis.

In addition all organisational strategic risks irrespective of score are added to the BAF to ensure the Board receives full evidence of strategic risk assurance e.g. financial risks and strategies.

The Risk Strategy describes the reporting and role responsibilities from department to the Board. Open risks are discussed at departmental and directorate meetings, the corporate risk register and the BAF are considered by the Executive Team and Board Committees, with a report going to Audit Committee at each meeting.

The Trust's top principal risks (in-year and future) are summarised below together with mitigations.

Risk Description	Mitigation
<p>Workforce Recruitment and Retention The inability to recruit and retain mission critical staff (including registered nurses, other professional staff and all non-medical staff groups) resulting in an impact on clinical services, maintaining capacity, pressure on existing staff and failure to meet NHSI agency ceiling and safer staffing levels. Whilst vacancy levels have reduced over the last year there remains high vacancy rates in some areas that impacts on the provision of required activity levels. The significant organisational change as a result of the relocation of the hospital has had a negative impact on retention of staff. The national shortages of key professional groups, such as nursing, means that there will be a continuing impact on the ability of the Trust to recruit staff and an ongoing impact on staff at new Royal Papworth Hospital.</p>	<p>The Trust has a Recruitment and Retention Strategy which includes overseas recruitment campaigns and a programme for assisting overseas nurses to gain registration, proactive social media campaign, engagement with HEIs across the country and regular recruitment events including some jointly with CUH, promotion of return to practice option. The Recruitment and Retention Strategy addresses how we seek to retain staff by supporting and developing them. In addition we have taken specific actions to mitigate the impact of the relocation of the hospital including : an excess daily travel allowance to support staff travelling to the new site, working with campus partners to commission a new bus routes from the west of Cambridge to the new site, a free bus service from the new staff accommodation in Waterbeach to the existing site to support staff in remaining with the Trust during the delays to the relocation.</p>
<p>New Royal Papworth Hospital (including Hospital Move 'cut over') Affordability; construction, equipping, Cambridge Transition Programme, ICT and telecoms and cut over planning; construction delays; future</p>	<p>Risk documentation and tracking; Standalone solutions where appropriate; Significant internal audit work performed during 2017/18 (see later in Annual Governance Statement for more detail); Review by the Project Board and Strategic Projects Committee, including 'Go or No Go Decision'); Escalation process to the Board of Directors.</p>
<p>Cambridge Transition Programme (part of New Royal Papworth Hospital move) Failure to secure mission critical services prior to move to NPH.</p>	<p>CEOs and Teams at Royal Papworth and CUH are working together to resolve mission critical services with agreement that NPH is a joint endeavour. Alternative plans to joint working are being developed where these are more appropriate.</p>
<p>Finances Risk to the Trust's financial position due to: national NHS financial pressures, risks to delivery of activity, or change in casemix, the move to the new hospital and the need to identify cost improvements have potential risks to impact on quality. The conclusion of the disposal of residual</p>	<p>Quality Impact assessments for all CIP/SIP. Continually reviewing environment through CQC matron ward rounds (weekly) and PLACE inspection (1 per year). Escalation to Nursing advisory group and Quality and Risk Committee. Maintenance work plan from estates. Weekly review of Family and Friends feedback escalated to estates if patient environment needs addressing. On-going discussions with</p>

estate (impact on the cash position Q1 & Q2 2019/20); Delay in implementation of changes in the national tariff for transplantation.	Commissioners and Regulators.
Activity Recovery	Activity recovery plan in place
EU Exit from the European Union	The Trust has an EU Exit Project Board and has assessed risks across: supply of medicines, vaccines, medical devices and clinical consumables; supply of non-clinical consumables, goods and services; Workforce; Reciprocal healthcare; Research and clinical trials; Data sharing, processing and access

Safer Staffing: Developing Workforce Safeguards

As a key element of the planning for the move to the new hospital the Trust undertook a full workforce planning exercise in 2018/19 to ensure that staffing models, skill mix and numbers aligned with new operational plans. This was a bottom up exercise with close scrutiny by the Executive Team to ensure that workforce plans would deliver safe and cost effective staffing levels. The Trust has used for the last 8 year a Care Hours per Patient Day CHPPD establishment tool which has been adapted from the Nursing Hours Per Patient Day Australian tool. This has been developed for use in a cardiothoracic hospital and benchmarked during it's development with the annual Australian report. This provides the sensitivity required for this group of patients. This was used to set staffing levels and skill mix for the new ward staffing configurations post move.

Each ward has a set average of CHPPD, and we use this to report acuity and identify areas of risk on a daily basis. Royal Papworth Hospital remains compliant against the 2016 NQB guidance and uses a triangulated approach to safer staffing. In the Board Integrated Performance Report safer staffing fill rate and CHPPD is presented alongside safety metrics. This is replicated in detail in the ward score cards, providing ward to Board assurance.

There are two staffing reviews per annum to ensure that changes in activity, acuity etc are identified and where appropriate skill mix and/or staffing numbers are adjusted . The ward acuity is measured 3 times a day and reported at the Trust-wide safety briefing in the morning where safer staffing is discussed and addressed. Professional judgement assisted by an acuity tool is used to ensure the effective deployment of staff to ensure safe staffing levels on a shift by shift basis.

The productive ward series has been embedded and activity audits are carried out quarterly to measure direct care time and reported in Board Integrated Performance Report. Effective rostering for nursing has been reported to the Clinical Professional Advisory Committee, and this next year we will be including the AHP group. Red flags are reviewed and reported. Benchmarking with other Trust's is not available through the model hospital as there is not data available on tertiary hospitals. We do reach out to other specialist tertiary cardio thoracic centres to benchmark CHPPD.

Patient feedback is gathered through the Friends and Family questionnaire and is reviewed on a real time basis weekly at the Matron's meeting, and acted upon. The action taken is feedback on "you said, we did" boards in all areas.

Compliance Statements

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The last CQC announced inspection was in December 2014 and this assessed the overall rating as 'Good', with two of the five overall assessments rated as 'Outstanding' with the other three rated 'Good'. Since completing the action plan from the visit the Trust has undertaken three internal mock CQC inspections all rated the organisation as 'Good'. These were undertaken in May 2016 and November 2016 and in October 2018.

The foundation trust has published an up-to-date register of interests 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 which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust's Operational Plan for 2018/19 was approved by the Board of Directors, supported by the Council of Governors, submitted to and accepted by NHS Improvement (NHSI). The Plan reflected finance and governance requirements (including service and quality aspects), each of which was ascribed a risk rating by NHSI. Achievement of the Plan relied on delivery of cash releasing efficiency savings during the financial year. Progress against delivery of service improvement (CIP/SIP) is monitored throughout the year and updates are presented to the Performance Committee and Board of Directors via reports covering activity, capacity, human resources management, patient safety, patient experience, clinical effectiveness, finance and risk. The process to ensure that resources are used economically, efficiently and effectively across clinical services include directorate and divisional reviews, and the regular monitoring of clinical indicators covering quality and safety. In addition to the agreed annual CIP, further efficiency savings are realised during the year through initiatives, such as on-going tendering and procurement rationalisation. The Trust achieved its key financial targets during 2018/19 (excluding Clinical Income and % Agency spend).

The Trust carried out a refresh of the Financial Strategy via the Financial Recovery Plan which reported to the Board of Directors in October 2017. The monthly review of the risks identified and the progress of initiatives has subsequently continued in 2018/19. This provides a focused strategic risk based assessment of the key financial assumptions inherent to the Trust's strategy and therefore the affordability of the Private Finance Initiative (PFI). These risks and related mitigations were considered as part of the two year Operational Plan review for 2018/19 to 2019/20 and a further refresh is underway. To enable the Trust to meet the challenging targets for 2018/19 to 2019/20, the Trust has and will continue to review its position with regard to Get it Right First Time (GIRFT), Agency,

Procurement and efficiencies highlighted by the Lord Carter review to ensure that the Trust's concentration is on delivering a value for money efficient service as part of the local health economy.

As part of their annual audit, our external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not. Please see the Independent Auditor's Report included within the Annual Accounts for their opinion on the use of resources and a description of the work performed. The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee (see later in this Annual Governance Statement).

Information Governance

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

The Trust annually assesses compliance with the requirements of the NHS Digital Information Governance Toolkit for the management and control of risks to information. The Trust's Director of Digital is the Senior Information Risk Owner (SIRO) and the Chief Nurse is the Caldicott Guardian, both reporting to the Board.

Senior managers across the Trust are information asset owners accountable for a particular group of information assets as part of the Information Governance Management Framework. A regular update on information governance is received by the Quality and Risk (Q&R) Committee of the Board of Directors, which is tasked with providing assurance to the Board. There is an Information Governance Steering Group (IGSG) chaired by the SIRO which reviews/approves policies and procedures/action plans relevant to information governance. The SIRO reports any issues to the Q&R Committee and the Board. The Trust has submitted Data Security and Protection (DS&P) Toolkit, which includes requirements relating to the Statement of Compliance and all standards were declared as met.

In 2018/19 there were no serious incidents relating to information governance, including data loss or confidentiality breach that were classified as Level 2 in the Information Governance Incident Reporting Tool.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Chief Nurse is the nominated Trust Executive for the Quality Report. The Board of Directors has agreed that the Quality Report will be considered and recommended by the Quality and Risk (Q&R) Committee of the Board. The Q&R Committee was also responsible for deliberating on priorities for inclusion in the Quality Report. The quality

priorities were developed in consultation with a range of stakeholders including the Patient and Public Involvement (PPI) Committee of the Council of Governors and clinical colleagues. The Council of Governors endorsed items for inclusion in the report.

Since the go live of the electronic patient record (EPR) system (Lorenzo) the Trust has continued to embed and optimise the EPR system and processes. In 2018 we achieved a bidirectional (two-way) link with the EPIC system and this was a first in this level of system interoperability. Information to support the quality metrics used in the Quality Report are held in a number of trust systems, including Lorenzo and Datix (electronic risk management system).

The assessment of quality indicators is integrated into the Trust's performance management system, and hence they are subject to review by operational and managerial staff on a monthly basis in a structured framework of performance review. The Trust uses the same systems and process to collect, validate, analyse and report on data in the Quality Report as it does for other reporting requirements. Specified indicators are subject to external audit. Reporting in year has also been supported by the PIPR.

The Trust's Quality Report included within the Annual Report contains reported performance against the 2018/19 priorities and provides information on 2019/20 priorities.

There were 14 patient safety incidents reported as serious incidents in 2018/19, one of which was a never event which related to a misplaced nasogastric tube. The Care Quality Commission (CQC) and NHS Improvement (NHSI) were informed immediately. A full root cause analysis investigation took place in each case with learning reported back to staff, full duty of candour was undertaken with the patient and/or family. (For further information see Part 3 of the Quality Report – other information).

The Trust assures the quality of its waiting time data through the validation of the patient tracking list (PTL) which is currently issued weekly. Corrections to Lorenzo are made where required which feed into the following week's PTL. Longer waiting patients are checked on both Lorenzo and other clinical systems to ensure that their waiting time is valid and their treatment expedited if possible. A weekly meeting is held to discuss in detail the longer waiting patients on the PTL and this is further minuted in the Trust's weekly Access meetings.

The Trust has invested in a new validation and reporting system Patient Pathway Plus (PP+) which will enable 'real time' updates to the PTL (updated every 24 hours). PP+ is due to go live in May 2019.

The migration to the Trust's new patient administration system, Lorenzo confirmed that there are a number of areas where data quality can be improved both in timeliness of capture and accuracy. The RTT team and Digital team have worked to develop new training materials and methods. This includes training in the application of Lorenzo specific to staff roles. Individual and group training sessions in RTT are available on a weekly basis and RTT has become part of the induction programme for new starters.

The Trust has not met the overall 92% RTT target for the year in part due to challenges in remaining for an extended period on the old site where we experienced breakdowns in cath lab equipment and operational pressures including ward and critical care bed availability resulting in theatre cancellations, particularly during the ECMO surge and the flu outbreak. The Trust has put in place a remedial action plan and has delivered improvement ahead of trajectory and continues to monitor performance on a monthly

basis. At a specialty level the RTT target was recovered for Cardiology in February 2019 and Cardiac Surgery is ahead of trajectory. The aggregate RTT position is scheduled for recovery in quarter two 2019/20.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the PIPR, the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Risk Committee, the Performance Committee and Strategic Projects Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Work has been commissioned from the Internal Audit service to review the adequacy and effectiveness of the controls and to develop improvements within the governance process. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework on the controls reviewed as part of the internal audit work programme.

The Head of Internal Audit (HOIA) overall opinion for 2018/19 is that:

“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”.

During the year, seven internal audits were conducted: all except one received either a substantial or reasonable assurance opinion which provided assurance over the effectiveness of controls in place for those areas. Full findings of all internal audit reviews undertaken for 2018/19 are given below.

Substantial Assurance:

Financial Forecasting, CIPs and Budgetary Control - Financial Governance
Risk Management and Assurance Framework
Key Financial Controls

Reasonable assurance:

CQC – Governance and Mock Inspection Arrangements:
Financial Forecasting, CIPs and Budgetary Control - CIP Project Management
Business Continuity – Performance Escalation Processes, CADs

Partial assurance (negative) opinion was provided:

Business Continuity – Performance Escalation Processes, Cardiology, Surgery and Transplant

No formal opinion provided

General Data Protection Regulation (GDPR) Governance: no formal opinion provided.
Data Security and Protection Toolkit

Factors and findings which informed the HOIA opinion were they had not issued any ‘no assurance’ (red) opinions to the Trust during the year and they had issued four reports

where a substantial assurance (positive) opinion was provided (see above). They had also issued five audits where a reasonable assurance (positive) opinion was provided (see above).

The internal audit follow up work had also provided assurance on the progress made and the actions taken by management to address the weaknesses found in earlier audit reports and had confirmed that all actions agreed have been implemented.

The Trust's internal audit programme is directed to areas of perceived high risk and where individual weaknesses have been identified the Executive Director lead has ensured action plans have been put in place to address these. Action plans are subject to review as part of the Audit Committee standard review of the audit action log.

My review of effectiveness is also informed in a number of ways, including;

- Head of Internal Audit Opinion – see above;
- Dialogue with Executive Managers within the organisation who have responsibility for the development and maintenance of the system of internal control, the risk management system and the assurance framework;
- The last Care Quality Commission (CQC) Inspection Report dated 27 March 2015 which rated the Trust as “Good”;
- Clinical governance reports, including the quarterly and annual Quality and Risk Report (see public website);
- Clinical audit programme (see Quality Report);
- Consultation with Patient and Public Involvement groups, e.g. Patient Experience Panel, Patient Forum and Patient & Public Involvement Committee of the Council of Governors;
- The results of patient surveys (see Quality Report);
- The results of staff surveys (See Staff Report);
- External Audit management letter and other reports;
- Continued monitoring and reporting on financial performance, including SIP;
- Maintaining cash flow and liquidity;
- Information governance assurance framework including the Information Governance Toolkit;
- Investigation reports and action plans following serious incidents.

Conclusion

The overall opinion is that no significant control issues (i.e. issues where the risk could not be effectively controlled) have been identified that would impact on the delivery of the Trust's strategic and annual objectives.

My review confirms that Royal Papworth Hospital NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its organisational objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2019/20

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

Approved by the Board and signed by the Chief Executive

Signed

A handwritten signature in black ink, appearing to read 'S. Posey', with a stylized flourish at the end.

Stephen Posey
Chief Executive
23 May 2019

**Royal Papworth Hospital
NHS Foundation Trust**

**Group accounts for the
year ended
31 March 2019**

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



Independent auditor's report

to the Council of Governors of Royal Papworth Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Royal Papworth NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2019 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group and Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview

Materiality: £3.1m (2017-18:£2.9m)
Group financial statements as a whole 2.0% (2017-18: 1.9%) of total operating income

Coverage 100% (2017-18:100%) of group total operating income

Risks of material misstatement vs 2017 - 18

Recurring risks	Valuation of land and buildings	◀▶
	Revenue recognition	◀▶
	New: Non-pay expenditure recognition	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
<p>Valuation of Land and buildings</p> <p>Land and buildings (£144 million, including £119 million of buildings in Assets under Construction; 2017/18: £147 million)</p> <p><i>Refer to pages 17 to 21 (accounting policy) and pages 42 to 43 (financial disclosures).</i></p>	<p>Subjective valuation:</p> <p>At 31 March 2019 the Trust was still operating from its existing site in Papworth Everard. Subsequent to the year end the Trust moved to the new PFI hospital at the Cambridge Biomedical Campus.</p> <p>The Trust's existing buildings continues to be valued as an operational asset at 31 March 2019. The carrying value of the buildings is immaterial due to the imminent move.</p> <p>The Trust's new PFI hospital was valued by an external valuer in the prior period and management have asserted that there is no material movement in the 12 months since that valuation. This is because the building was substantially complete at the last valuation date.</p> <p>The value of the new hospital is held in Assets Under Construction due to it not being operational as at 31 March 2019.</p> <p>The valuation of land and buildings relies on the assumption that no material movements in the value of the new hospital have occurred during the 12 months since the 31 March 2018 valuation.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Challenging assumptions: challenging management's assumption that the value of the PFI hospital had not materially changed in the past twelve months. We considered appropriate BCIS property indices to assess whether values had moved materially; — Physical inspection: we physically inspected the PFI hospital to verify that the building design had not materially changed from the prior year, when the full valuation was performed. — Challenging valuation methodology: challenging management's basis for valuing the existing Papworth Everard site as an operational asset, by verifying and evaluating the status of its use and referencing the appropriate valuation methodology against accounting standards.

2. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
<p>Revenue recognition</p> <p>Operating Income (£168 million; 2017/18: £149 million)</p> <p><i>Refer to pages 15 to 16 (accounting policy) and page 30 to 33 (financial disclosures)</i></p>	<p>Subjective estimate:</p> <p>The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners.</p> <p>The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivables and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements.</p> <p>Mis-matches can occur for a number of reasons, but the most significant are due to the Trust and Commissioners recording different accruals for completed periods of healthcare which have not yet been invoiced.</p> <p>Where there is an ongoing lack of agreement between the Trust and its commissioners, mis-matches can also be classified as formal disputes as set out in the relevant contract.</p> <p>The Trust reports patient care revenue of £8.1 million from private and overseas patients and £25.4 million of other operating income. Other operating income includes, amongst others, education and training of £3.5 million and £6.9 million of transitional funding.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Test of detail: obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £300,000 we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable; — Test of detail: obtaining copies of the Trust's most significant contracts by value. Where there were significant variances we sought explanations and supporting evidence to verify the Trust's income balance; — Test of detail: testing a sample of NHS and non-NHS revenue transactions before and after year end to supporting documentation to agree the items were correctly recorded at year end; — Test of detail: Assess the assumptions behind the Trust's bad debt provision for non-NHS receivables and compare those assumptions against our own broader knowledge of the NHS sector, and against the Trust's specific bad debt history.

2. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
<p>Non-pay expenditure recognition</p> <p>Accruals (£11.5 million; 2017/18: £8.7 million)</p> <p><i>Refer to pages 23 - 24 (accounting policy) and page 48 (financial disclosures)</i></p> <p>Provisions (£2.4 million; 2017/18: £1.4 million)</p> <p><i>Refer to pages 25 - 26 (accounting policy) and page 49 (financial disclosures)</i></p>	<p>Effects of irregularities:</p> <p>As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures.</p> <p>This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of accrued non-pay expenditure and provisions at year-end.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> – Segregation of duties: we considered the application of appropriate segregation of duties in the accounts payable process (i.e. the approval of purchase orders and invoices for payment) between those responsible for delivering services and those preparing the financial statements which helps to prevent fraudulent manipulation of expenditure. – Test of detail: we tested payments made and invoices received in April 2019 to identify whether they indicate that an accrual or provision should have been recognised at the balance sheet date. We agreed a sample test of accruals and provisions to supporting evidence to ensure these are accurate and valued appropriately. We critically appraised the basis on which provisions were made and considered the appropriateness of significant estimates supporting the provisions. – Test of detail: we compared provisions and accruals recognised at the previous year-end against actual outturn, to evaluate management’s ability to accurately estimate year-end liabilities and performed a year-on-year review of accruals and provisions, and sought explanation for significant movements;

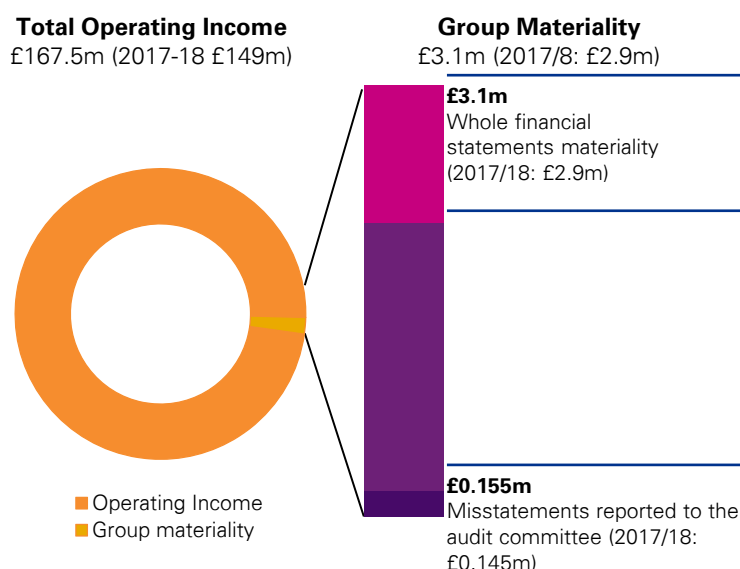
3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £3.1 million (2018: £2.9 million), determined with reference to a benchmark of operating income of which it represents approximately 1.9% (2017/18: 1.9%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust’s financial statements as a whole was set at £3 million (2017/18: £2.8 million), determined with reference to a benchmark of operating income of which it represents approximately 1.8% (2017-18: 1.9%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.155 million (2017/18: (£0.145 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

The Group comprises the Trust and its charity, the Royal Papworth Hospital Charity. In auditing the Group financial statements we have performed procedures on the Charity’s financial information based on a component materiality of £3.0 million (2017/2018: £2.9 million)



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group or the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group or the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Group's and Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Group and Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 88, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources..

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

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

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in 2018/19, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability	Due to a combination of regulatory scrutiny and significant financial challenge in the sector and locally across the health economy, we undertook a detailed review of the Trust's arrangements for planning its finances effectively to support the sustainable delivery of strategic priorities and the maintenance of its statutory functions.	<p>Our work included:</p> <ul style="list-style-type: none"> — Performing an analysis of the Trust's outturn position against plan; — Considering the core assumptions in the Trust's 2019/20 Annual Plan submission; — Considering the extent to which recurrent cost improvement schemes were achieved in 2018/19 and identified for 2019/20; <p>Our findings on this risk area:</p> <p>The Trust's 2018/19 outturn position shows a deficit of £11.5m which is a favourable variance to plan of £4.3m.</p> <p>The 2019/20 Operational Plan shows that the Trust is planning to deliver a breakeven position.</p> <p>We concluded that the Trust had adequate arrangements in place for planning its finances effectively to support the sustainable delivery of its strategic priorities and the maintenance of its statutory functions.</p>

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Royal Papworth NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

S Beavis

Stephanie Beavis

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

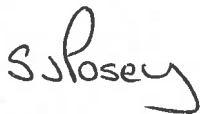
Botanic House
 100 Hills Road
 Cambridge
 CB2 1AR
 23 May 2019

FOREWORD TO THE ACCOUNTS

ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

These accounts for the year ended 31st March 2019 have been prepared by the Royal Papworth Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed:



Stephen Posey
Chief Executive
Date: 23 May 2019

CONSOLIDATED AND TRUST STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 MARCH 2019

		Group 2018/19	Trust 2018/19	Group 2017/18	Trust 2017/18
	NOTE	£000	£000	£000	£000
OPERATING INCOME					
Operating income from patient care activities	2	142,117	142,117	134,191	134,191
Other operating income	3	25,425	25,776	14,628	14,578
TOTAL OPERATING INCOME FROM CONTINUING OPERATIONS		167,542	167,893	148,819	148,769
Operating expenses	4-6	(172,655)	(171,343)	(199,858)	(198,635)
OPERATING SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS		(5,113)	(3,450)	(51,039)	(49,866)
Finance income	7	402	207	246	58
Finance expenses	8	(5,362)	(5,362)	(904)	(904)
Public Dividend Capital dividends payable	23	(1,640)	(1,640)	(2,305)	(2,305)
NET FINANCE COSTS		(6,600)	(6,795)	(2,963)	(3,151)
Gains/(losses) on disposal of non-current assets		(4)	-	(26)	(85)
Movement in fair value of investments	11	267	10	210	-
SURPLUS/(DEFICIT) FOR THE YEAR		(11,450)	(10,235)	(53,818)	(53,102)
OTHER COMPREHENSIVE INCOME					
Impairments	10.1	(1,033)	(1,033)	-	-
Gain on revaluations	10.2	-	-	269	269
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		(12,483)	(11,268)	(53,549)	(52,833)

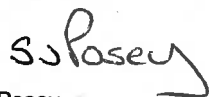
The notes on pages 13 to 59 form part of these accounts.

CONSOLIDATED AND TRUST STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	NOTE	Group 31 March 2019 £000	Trust 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2018 £000
NON-CURRENT ASSETS					
Intangible assets	9	1,700	1,700	611	611
Property, plant and equipment	10	176,613	176,393	161,966	161,742
Investments	11	7,710	-	9,263	-
Trade and other receivables	13	114	114	38	38
Total non-current assets		186,137	178,207	171,878	162,391
CURRENT ASSETS					
Inventories	12	4,531	4,505	3,880	3,862
Trade and other receivables	13	9,473	9,214	9,759	10,714
Cash and cash equivalents	14	23,321	22,719	51,627	50,224
Total current assets		37,325	36,438	65,266	64,800
TOTAL ASSETS		223,462	214,645	237,144	227,191
CURRENT LIABILITIES					
Trade and other payables	15	(35,256)	(35,163)	(36,272)	(36,258)
Other liabilities	16	(248)	(248)	(47)	(47)
Borrowings	17	(2,112)	(2,112)	(2,006)	(2,006)
Provisions	18	(1,568)	(1,568)	(631)	(631)
Total current liabilities		(39,184)	(39,091)	(38,956)	(38,942)
TOTAL ASSETS LESS CURRENT LIABILITIES		184,278	175,554	198,188	188,249
NON-CURRENT LIABILITIES					
Borrowings	17	(94,334)	(94,334)	(96,444)	(96,444)
Provisions	18	(835)	(835)	(742)	(742)
Total non-current liabilities		(95,169)	(95,169)	(97,186)	(97,186)
TOTAL ASSETS EMPLOYED		89,109	80,385	101,002	91,063
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	23	122,053	122,053	121,910	121,910
Revaluation reserve		8,080	8,080	9,113	9,113
Income and expenditure reserve		(49,748)	(49,748)	(39,960)	(39,960)
OTHERS' EQUITY					
Charitable fund reserves	32	8,724	-	9,939	-
TOTAL TAX PAYERS' AND OTHERS EQUITY		89,109	80,385	101,002	91,063

The financial accounts on pages 9 to 59 were approved by the Board on 23 May 2019 and signed on its behalf by:

Signed:



Stephen Posey
Chief Executive
Date: 23 May 2019

**CONSOLIDATED AND TRUST STATEMENT OF CHANGES IN
TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2019**

	Trust			Total Reserves £000	Charitable Fund	Group Total Reserves £000
	Dividend Capital £000	Income and Expenditure Reserve £000	Revaluation Reserve £000		Reserves £000	
Taxpayers' and others' equity at 1 April 2017	76,410	13,142	8,844	98,396	10,655	109,051
Changes in taxpayers' equity for 2017/18						
Total Comprehensive Expense for the year	-	(53,102)	-	(53,102)	(716)	(53,818)
Revaluation - Property, Plant and Equipment	-	-	269	269	-	269
Public dividend capital received	45,500	-	-	45,500	-	45,500
Taxpayers' and others' equity at 31 March 2018	121,910	(39,960)	9,113	91,063	9,939	101,002
Taxpayers' and others' equity at 1 April 2018	121,910	(39,960)	9,113	91,063	9,939	101,002
Changes in taxpayers' equity for 2018/19						
Impact of implementing IFRS 9 on opening reserves	-	447	-	447	-	447
Taxpayers' and others' equity at 1 April 2018 after impact of IFRS 9	121,910	(39,513)	9,113	91,510	9,939	101,449
Total Comprehensive Income for the year	-	(10,235)	-	(10,235)	(1,215)	(11,450)
Impairment - Property, Plant and Equipment	-	-	(1,033)	(1,033)	-	(1,033)
Public dividend capital received	143	-	-	143	-	143
Taxpayers' and others' equity at 31 March 2019	122,053	(49,748)	8,080	80,385	8,724	89,109

The notes on pages 13 to 59 form part of these accounts.

CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 MARCH 2019

	NOTE	Group 2018/19 £000	Group 2017/18 £000	Trust 2018/19 £000	Trust 2017/18 £000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating surplus/(deficit)		(5,113)	(51,039)	(3,450)	(49,866)
NON CASH INCOME AND EXPENSE:					
Depreciation and amortisation	9/10	2,417	3,662	2,413	3,658
Net Impairments	5	1,557	44,698	1,557	44,698
Income recognised in respect of capital donations		-	-	(1,891)	(949)
(Increase)/decrease in inventories		(643)	100	(643)	100
Increase in receivables and other assets		1,570	1,762	2,492	1,039
Increase in trade and other payables		2,987	10,054	2,987	10,054
Increase/(decrease) and other liabilities		201	28	201	28
Increase/(decrease) in provisions		1,030	919	1,030	919
NHS Charitable fund – net movements in working capital, non-cash transactions, non operating cash flows		(111)	(1,095)	-	-
Net cash generated from / (used in) operating activities		3,895	9,089	4,696	9,681
Cash flows from investing activities					
Interest received		202	50	202	50
Payments for land, property, plant and equipment		(20,810)	(16,364)	(20,810)	(16,364)
Proceeds from disposal of property, plant and equipment		10	-	10	-
Payments for intangible assets		(1,225)	(287)	(1,225)	(287)
Prepayment PFI capital contribution cash		-	(20,569)	-	(20,569)
Net cash used in investing activities		(21,823)	(37,170)	(21,823)	(37,170)
Net cash outflow before financing		(17,928)	(28,081)	(17,127)	(27,489)
Cash flows from financing activities					
Public dividend capital received		143	45,500	143	45,500
Other loans received		-	8,250	-	8,250
Other loans repaid		-	(8,250)	-	(8,250)
Capital element of PFI payments		(2,006)	(450)	(2,006)	(450)
Interest paid		(57)	(90)	(57)	(90)
Interest paid on PFI obligations		(5,305)	(812)	(5,305)	(812)
PDC dividends paid		(3,153)	(1,156)	(3,153)	(1,156)
Net cash generated from financing activities		(10,378)	42,992	(10,378)	42,992
Increase / (decrease) in cash and cash equivalents		(28,306)	14,911	(27,505)	15,503
Cash and cash equivalents at 1 April		51,627	36,716	50,224	34,721
Cash and cash equivalents at 31 March	14	23,321	51,627	22,719	50,224

The notes on page 13 to 59 form part of these accounts.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

With effect from 1 January 2018, the name of the Trust was changed from Papworth Hospital NHS Foundation Trust to Royal Papworth Hospital NHS Foundation Trust.

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to NHS foundation trusts, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS Foundation Trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

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

Key matters relating to the Trust's financial position are:

- The Trust reported a financial deficit of £10.23m for the 2018/19 financial year;
- The Trust's Operational Plan for 2019/20 indicates a bottom line surplus of £11.58m this is after profit on asset disposal and receipt of Financial Recovery Funding and Provider Sustainability Funding. Adjusting for these items the Trust is planning a £15.45m deficit;
- To achieve the deficit positions highlighted above the Trust will be required to achieve CIP of £5.0m and achieve its control total in 2019/20;
- The Trust is planning to have cash balances of £9.80m at the end of 2019/20;
- The contract with NHS England has been signed, at 15 May 2019 the CCG contract had not been signed but the Trust had received a letter of comfort, which gives a level of assurance for the expectations of continued service delivery and appropriate cash flows for the Trust during 2019/20;
- The Trust is planning to dispose of the current Papworth Everard site in 2019/20.

Royal Papworth Hospital NHS Foundation Trust's Board of Directors has carefully considered the principle of 'Going Concern', after making enquiries, and considering the uncertainties that are described in the preceding paragraphs, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.1 Consolidation of Subsidiary

The NHS Foundation Trust is the Corporate Trustee of the Royal Papworth Hospital Charitable Fund, a registered charity. The NHS Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the NHS Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the NHS Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Charitable Fund includes all incoming resources in full in the Statement of Financial Activities as soon as the following three factors are met: entitlement, probable receipt and measurement.

Legacy income is accounted for as incoming resources once the receipt of the legacy becomes probable. Receipt is normally probable when:

- there has been a grant of probate;
- the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
- any conditions attached to the legacy are either within the control of the charity or have been met.

The Charitable Fund financial statements are prepared in accordance with the accruals concept. A liability (and consequently, expenditure) is recognised in the financial statements when there is a legal or constructive obligation, capable of reliable measurement, arising from a past event.

Investment comprises of shares traded on a daily basis where the valuation is based on the market value at the date of the Statement of Financial Position and also cash held with the investment managers for future investment in equity.

All gains and losses on investment are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or date of purchase if later).

1.2 Associate entities

Associate entities are those over which the NHS Foundation Trust has the power to exercise a significant influence. Associate entities are recognised in the NHS Foundation Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the NHS Foundation Trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution e.g. share dividends are received by the NHS Foundation Trust from the associate. However, where the NHS Foundation Trust's proportion of an associate's cumulative profits or losses at year end are less than £50,000; no adjustment is made to the cost of the investment on the basis of immateriality. The NHS Foundation Trust does not have any material associates.

1.3 Revenue recognition

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC 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). As directed by the DHSC GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the standards: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of services provided is recognised when performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end the NHS Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the NHS Foundation Trust's entitlement to consideration for those services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than a 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.

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

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

Where research contracts fall under IFRS15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that

are substantially the same and that have the same pattern of transfer. The NHS Foundation Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

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

- the entity has transferred to the buyer the significant risks and rewards of ownership of the asset;
- the entity retains neither continuing managerial involvement to the degree usually associated with ownership nor effective control over the assets sold;
- the amount of revenue can be measured reliably;
- it is probable that the economic benefits associated with the transaction will flow to the entity;
- the costs incurred or to be incurred in respect of the transaction can be measured reliably.

1.4 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.

1.5 Pension costs

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

Employer's pension cost contributions are charged to the 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 NHS Foundation Trust commits itself to the retirement, regardless of the method of payment.

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.

1.7 Property, Plant and Equipment

Capitalisation Recognition

Property, plant and equipment assets are capitalised if they are capable of being used for a period which exceeds one year and:

- are 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 NHS Foundation Trust;
- the cost of the item can be measured reliably;
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Measurement

Valuation

All property, plant and equipment assets are initially measured at cost (for leased assets, fair value) including any costs directly attributable to acquiring or constructing the asset and bringing them to a location and condition necessary for them to be capable of operating in the manner intended by the NHS Foundation Trust.

All assets are measured subsequently at fair value.

Property

All land and buildings used for the NHS Foundation Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Valuations are carried out by professionally qualified valuers in accordance with the Valuation Standards published by the Royal Institute of Chartered Surveyors (previously the RICS Appraisal and Valuations Standards). Revaluations are performed on at least a 5 yearly basis, with an interim valuation every 3 years; to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The timing of these valuations will be adjusted, to become more frequent or less frequent, depending on the situation in the market. Fair values are determined as follows:

- Land - existing use value
- Non-specialised buildings - existing use value (see below)
- Specialised buildings - depreciated replacement cost based on a modern equivalent basis

For non-operational properties including surplus land, the valuations are carried out at fair value based on alternative use.

The latest asset valuation for the existing Royal Papworth Hospital and off-site dwellings in Papworth Everard was undertaken in 2014/15 at the prospective valuation date of 1 April 2015. The valuation at that date was accounted for on 31 March 2015. See Note 10.

A valuation of the New Royal Papworth Hospital PFI site was carried out in 2017/18 by the NHS Foundation Trust's externally appointed independent valuer, Boshiers and Company, Chartered Surveyors. The effective date of valuation was the 31st March 2018 and was accounted for in the 2017/18 accounts. See Note 10.

Non-specialist assets on the existing Royal Papworth Hospital site have been valued at Existing Use Value (EUV), with the economic life of these buildings beyond the date of the move to the new site. This is due to unconfirmed status of the existing site disposal at this time. The NHS Foundation Trust's intention is to dispose of the site at a future date; however, this is not certain at this stage and not resolved at the balance sheet date, therefore, the NHS Foundation Trust considers EUV to be the appropriate valuation method.

Assets in the Course of Construction

Assets in the course of construction for service or administration purposes are valued at cost and are valued by professional valuers as part of the 5 or 3 yearly valuations or when they are brought into use. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for assets held at fair value. Depreciation on these assets commences when the asset is brought into use.

Equipment

For non-IT operational equipment depreciated historical cost is considered to be a satisfactory proxy for current value but this will be kept under review and advice on fair value sought from external sources if considered appropriate. For operational IT equipment, in view of its generally short life nature, depreciated historical cost is considered to be a satisfactory proxy for current value. Equipment surplus to requirements is valued at net recoverable amount.

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 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 assets are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have infinite life and is not depreciated.

The estimated useful life of an asset is the period over which the NHS Foundation Trust expects to obtain economic benefits or service potential from it.

Property, plant and equipment assets which have been reclassified as 'Held for sale' cease to be depreciated upon 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 NHS Foundation Trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

The carrying values of property, plant and equipment assets are reviewed for impairments in periods if events or changes in circumstances indicate carrying values may not be recoverable.

De-recognition

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

- i. The asset is available for immediate sale in its present condition subject only to the terms which are usual and customary for such sales;
- ii. 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 dropped 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amounts. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount less cost of sale and is recognised in operating income or operating expenses respectively. On disposal, the balance for the asset in the revaluation reserve is transferred to the income and expenditure reserve.

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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets

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

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

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC12 definition of service concession, as interpreted in HM Treasury's FREM, are accounted for as 'on Statement Financial Position' by the NHS Foundation Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment when it is brought into use, 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 annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

Useful economic life

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the NHS Foundation Trust's professional valuers.

The current ranges of estimated lives being used are:

	Min Life	Max Life
	Years	Years
Buildings	0	80
Dwellings	0	0

Leaseholds are depreciated over primary lease term.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the NHS Foundation 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.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	Min Life	Max Life
	Months	Months
Medical Equipment and Engineering Plan and Equipment	2	180
Furniture	2	180
Soft Furnishings	2	84
Office and Information Technology Equipment	2	60
Set-up Costs in New Buildings	2	60
Vehicles	60	60

At the end of each reporting period a transfer is made from the revaluation reserve to the income and expenditure reserve in respect of the difference between the depreciation expense on the revalued asset and the depreciation expense based on the asset's historic cost carrying value.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without a physical substance which are capable of being sold separately from the rest of the NHS Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential is provided to the NHS Foundation Trust for more than one year; their cost can be reliably measured; and they have a cost of at least £5,000. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the NHS Foundation Trust intends to complete the asset and sell or use it
- the NHS Foundation Trust has the ability to sell or use the asset

- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the NHS Foundation Trust to complete the development and sell or use the asset and
- the NHS Foundation Trust can measure reliably the expenses attributable to the asset during development.

Software

Purchased computer software, where expenditure of at least £5,000 is incurred, which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use valued at fair value under IFRS 13, if it does not meet the requirement of IAS 40 or IFRS 5.

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

Amortisation

Intangible assets are amortised over their expected useful economic lives on a straight line basis or in the case of software the shorter of the term of the licence or the expected useful economic life using the following lives:

	Min Life	Max Life
	Months	Months
Software	2	60

1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Grants from the Department of Health and Social Care are accounted for as government grants, as are grants from the Big Lottery Fund.

Government grants for capital purposes are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Where the government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the *first-in-first-out* cost (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.11 Financial Instruments and financial liabilities

Recognition

Financial assets and financial liabilities arise where the NHS Foundation 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 DHSC GAM expand the definition of a contract to include legislation and regulations which give rise to arrangements that in all other aspects 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 NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or service is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with accounting policy for leases described below at note 1.13.

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

De-recognition

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

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

Classification and Measurement

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

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

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets).

The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

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

Impairment of financial assets

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

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

Expected credit losses for private patient activity are determined through a review of existing outstanding debt. For all other categories of debt the expected credit losses are determined using historic debt write off data.

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.

A receivable will be written off when either all avenues of collection have been exhausted or it is no longer economically viable to pursue the outstanding amount.

1.12 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.

These balances exclude monies held in the NHS Foundation Trust's bank account belonging to patients (see note 28). Account balances are only off set where a formal agreement has been made with the bank to do so.

1.13 Leases

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

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation 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 as an item of property, plant and equipment.

The annual rental 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. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating Leases

Other leases are regarded as operating leases and the rentals charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the term of the lease.

Income received by the NHS Foundation Trust from operating leases is recognised in other operating income on a straight line basis over the term of the lease.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of Land and Buildings

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

1.14 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligations that is of uncertain timing or amount for which it is probable that there will be a future outflow of cash or other resource and that a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resource 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 by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 18, but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS Foundation Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The NHS Foundation Trust does not include any amounts in its financial statements relating to these cases. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingent assets and liabilities

Contingent assets (that is, assets arising from past events and whose existence will only be confirmed by one or more future events not wholly within NHS Foundation Trust's control) are not recognised as assets but disclosed in a note to the financial statements where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 19 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 sufficiently reliability.

1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. 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 NHS Foundation Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS Foundation 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 NHS Foundation 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, and (iii) any PDC dividend balance receivable or payable.

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

The actual dividend figure is included in the Statement of Comprehensive Income and the receivable/payable arising is included in the Statement of Financial Position.

1.17 Value added tax (VAT)

Most of the activities of the NHS Foundation 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 non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation tax

An NHS Foundation Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, a 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 from these activities exceed £50k per annum. There are no such profits and therefore no liability for corporation tax in relation to the year ended 31 March 2019 or prior periods.

1.19 Foreign exchange

The functional and presentational currency of the NHS Foundation Trust is sterling.

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

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

- monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate at 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirement of the HM Treasury Financial reporting Manual (FRoM). See note 28.

1.21 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 NHS foundation trusts not been bearing their own risks (with insurance premiums then being incurred as normal revenue expenditure). See note 29.

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

1.22 Gifts

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

1.23 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors, who are responsible for making strategic decisions.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.25 Accounting standards that have been issued but have not yet been adopted

The following accounting standards or interpretations have been issued by the International Accounting Standards Board, but have not yet been implemented. The NHS Foundation Trust cannot adopt new standards unless they have been adopted in the DHSC GAM issued by Department of Health and Social Care, which in turn only adopts them once adopted in HM Treasury FReM. The HMT FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies. In some cases, the standards may be interpreted in the HMT FReM and therefore may not be adopted in their original form. The standards listed below are not expected to have an impact on the NHS Foundation Trust's accounts except where indicated.

Standards issued or amended but not yet adopted in HMT FReM

- IFRS 14 Regulatory deferral accounts – Not yet EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.
- IFRS 16 Leases – Expected to be effective from 2019/20.

1.26 Critical judgements and key sources of estimation uncertainty

In the application of the NHS Foundation 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 the revision and future periods if the revision affects both current and future periods.

Property valuation

The NHS Foundation Trust's estate has been valued as explained at note 1.7.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reported period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 10.1.

Intangible assets

The intangible assets balance is composed entirely of software under development and software licences. These are stated at historic depreciated cost on the basis that this is not materially different from their fair value.

Allowances for impaired receivables

Allowances are made for impaired receivables for estimated losses arising from the subsequent inability or refusal of patients or commissioners to make the required payment. Further detail is given at notes 13.2 and 13.3.

Private Finance Initiative

An assessment of the NHS Foundation Trust's Private Finance Initiative (PFI) scheme has been made, and it has been determined that the PFI scheme in respect of the new hospital building should be accounted for as an on-Statement of Financial Position asset under IFRIC 12. This requires a judgement to be made around how to model the scheme in order to determine the required accounting entries. The key judgements were to initially value the hospital at the cost of construction, to attribute asset lives up to 80 years on certain components and to identify the components of the hospital subject to lifecycle maintenance, which should be accounted for separately.

An estimate has also been used to determine total future obligations under PFI contracts as disclosed in note 21, in relation to future rates of inflation. The estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2018, or the amounts charged through the Statement of Comprehensive Income.

2. OPERATING INCOME FROM PATIENT CARE ACTIVITIES**2.1 Income from patient care activities (by nature)**

	2018/19	2017/18
	£000	£000
Elective income	62,370	59,053
Non-elective income	34,329	31,795
First outpatient income	7,254	7,111
Follow up outpatient income	8,762	8,104
High cost drugs income from commissioners	5,203	5,445
Other NHS clinical income	14,919	14,463
Private patient income	8,115	8,151
AfC pay award central funding	1,153	-
Other clinical income	12	69
	142,117	134,191

2.2 Patient income by source

	2018/19	2017/18
	£000	£000
NHS Foundation Trusts	-	9
NHS Trusts	-	11
NHS England	98,473	93,590
Clinical Commissioning Groups	32,032	30,298
Department of Health and Social Care*	1,154	25
NHS Other	2,331	2,058
Non NHS:		
- Private patients	8,115	8,151
- Overseas chargeable patients	12	49
Total revenue from patient care activities	142,117	134,191

* Includes £1,153k of centrally funded Agenda for Change (AfC) pay award for 2018/19 paid directly to the NHS Foundation Trust. This was not included in the 2018/19 tariff prices due to the late agreement of AfC pay awards payable in 2018/19.

Income of £571k relating to patient treatment spells which were partially complete at 31 March 2019 (£561k – 31 March 2018) has been recognised in the 2018/19 accounts under the accounting policy described in note 1.3.

2.3 Operating segments

IFRS8 requires income and expenditure to be broken down into the operating segments reported to the chief operating decision maker. The NHS Foundation Trust considers the Board to be the chief operating decision maker because it is responsible for approving its budgets and hence responsible for allocating resources to operating segments and assessing their performance. The Foundation Trust has seven clinical directorates: cardiology; cardiac surgery, thoracic surgery; thoracic medicine; respiratory support and sleep centre; transplant; and clinical diagnostics (which includes theatres, critical care, anaesthetics, radiology, ambulatory and pathology). The clinical and diagnostics directorate largely supports the services provided by the first six. The Foundation Trust's operating segments reflect the service that it provides. Income is reported to the Board on a regular basis by service:

Patient income by service

	2018/19			2017/18		
	Inpatients £000	Outpatients £000	Total £000	Inpatients £000	Outpatients £000	Total £000
Cardiology	31,594	5,362	36,956	31,364	5,090	36,454
Cardiac surgery	24,488	635	25,123	24,758	706	25,464
Thoracic surgery	11,399	212	11,611	10,474	220	10,694
Respiratory support and sleep centre	7,070	3,898	10,968	6,797	3,987	10,784
Thoracic medicine	11,749	2,876	14,625	11,843	2,588	14,431
Transplant/Ventricular assist devices	18,387	-	18,387	16,322	-	16,322
Clinical and diagnostics	15,171	2,404	17,575	14,627	-	14,627
Total of income from reporting segments	119,858	15,387	135,245	116,185	12,591	128,776
Other patient related activity			-			20
2018/19 Agenda for Change pay award funding			1,153			-
Market Forces Factor (inpatients and outpatients)			5,719			5,395
Total revenue from patient care activities per note 2.1			<u>142,117</u>			<u>134,191</u>

Cardiology (heart) deals with all aspects of the diagnosis, management and treatment of heart condition in adults. Cardiac surgery includes coronary artery bypass grafting and valve repair and replacement. Thoracic surgery (lungs) provides a 24 hour thoracic surgery service, including surgery for lung cancer. The respiratory support and sleep centre provides ventilator support and sleep medicine. Transplant/Ventricular Assist Devices relates to the transplantation of cardiothoracic organs, and bridging therapy before transplantation. Thoracic medicine includes the treatment of pulmonary vascular diseases and cystic fibrosis. Further explanation of the activity of each segment can be found in the Directors' report.

Expenditure is not analysed into these segments as part of reporting to the Board because the cost of developing such analysis would be excessive and the NHS Foundation Trust is not presenting an analysis of the surplus for the year on a segmental basis. An analysis of assets and liabilities by operating segment is also not reported to the Board or otherwise available.

All income for each patient service above is received from external commissioners as follows:

	2018/19	2017/18
	£000	£000
NHS England	98,473	93,590
Cambridgeshire and Peterborough CCG*	13,070	12,234
West Suffolk CCG	4,149	4,124
West Norfolk CCG	2,841	2,856
Bedfordshire CCG	2,194	1,937
Ipswich & East Suffolk CCG	1,606	1,754
South Lincolnshire CCG	1,348	1,153
West Essex CCG	1,223	1,035
East and North Hertfordshire CCG	1,165	1,171
Department of Health and Social Care	1,154	-
South Norfolk CCG	597	498
North East Essex CCG	419	338
Great Yarmouth and Waveney CCG	268	358
North Norfolk CCG	247	216
Other CCGs	2,906	2,623
Other NHS	1,165	1,208
Subtotal	132,825	125,095
Welsh Health Boards	881	714
Scottish Health Board	94	75
Northern Ireland Health Boards	190	87
Private patients	8,115	8,151
Other non-NHS	12	49
Total patient service income	142,117	134,171
Other patient related activity	-	20
Total revenue from patient care activities per note 2.1	142,117	134,191

* Includes funding for treatment of overseas patient where a reciprocal agreement is in place.

Under the terms of its license, the NHS Foundation 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 trust license and are services that commissioners believe would need to be protected in the event of trust failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	142,117	134,191

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

	2018/19 £000	2017/18 £000
Income recognised this year	12	49
Cash payments received in-year	18	3
Amounts added to provision for impairment of receivables	6	35
Amounts written off in-year	44	13

2.5 Private patient income

As a result of the Health and Social Care Act 2012 changes to the way the cap on private patient income of NHS Foundation Trusts is enforced came into effect during 2012/13.

As from 1 October 2012 Foundation Trusts are obliged to make sure that the income they receive from providing goods and services for the NHS (their principle purpose) is greater than their income from other sources (e.g. private patient work).

This effectively means that the former private patient cap has been removed.

3. OTHER OPERATING INCOME

	Group		Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Research and development NHS Levy	1,757	680	1,757	680
Education and training	3,515	2,988	3,515	2,988
Charitable and other contributions to expenditure	-	-	2,613	1,416
Merit award funding	1,297	1,204	1,297	1,204
Staff lodging	667	565	667	565
Staff recharges*	2,659	2,562	2,659	2,882
Research and development gross up**	2,167	2,897	2,167	2,897
NHS Charitable income:				
Incoming resource excluding investment income	2,262	1,786	-	-
Transitional funding ***	6,900	-	6,900	-
Other income	4,201	1,946	4,201	1,946
	25,425	14,628	25,776	14,578

* Staff recharges have been shown gross in income and expenditure.

** Funding received to cover costs of research and development incurred in the year.

*** As part of the business case for the new hospital the NHS Foundation Trust will receive £15m of transitional funding over the next 3 years. The NHS Foundation Trust received £6.9m of this funding in 2018/19 and will receive a further £4.05m in each of the next two years.

4. OPERATING EXPENSES

4.1 Operating expenses comprise:

	Group		Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Executive Directors' costs*	1,071	1,272	1,071	1,272
Non-Executive Directors' costs	121	141	121	141
Staff costs	93,941	86,382	93,941	86,382
Drug costs	5,875	5,700	5,875	5,700
Supplies and services - clinical	36,552	36,066	36,552	36,066
Supplies and services - general	3,879	4,786	3,879	4,786
Establishment	1,613	1,301	1,613	1,301
Research & Development	1,291	1,193	1,291	1,193
Transport	810	726	810	726
Premises	7,575	5,367	7,575	5,367
Increase/(decrease) in provision for impairments of receivables	(32)	464	(32)	464
Depreciation of property, plant and equipment	2,242	3,412	2,238	3,408
Amortisation of intangible assets	175	250	175	250
Impairments of property, plant and equipment	1,556	44,698	1,556	44,698
Impairments of intangibles	1	-	1	-
Audit services - statutory audit	47	52	47	52
Other auditors remuneration - other assurance services	7	7	7	7
NHS Charitable Funds - statutory audit services	4	4	-	-
Consultancy	1,750	1,225	1,750	1,225
Internal audit and counter fraud services	54	58	54	58
Clinical negligence	845	680	845	680
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes on IFRS basis	6,088	702	6,088	702
Other	5,874	4,145	5,886	4,157
NHS Charitable Funds - other resources expended	1,316	1,227	-	-
	172,655	199,858	171,343	198,635

4.2 Audit services

The Council of Governors has appointed KPMG LLP (KPMG) as external auditors of the NHS Foundation Trust from 1 April 2015. The audit fee for the statutory audit is £47,500 (2017/18: £52,100), excluding VAT. This is the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. A further £7,400 has been paid for other services in relation to the Quality Report opinion (2017/18: £7,400 for the Quality Report opinion).

The engagement letter signed on 27 November 2015 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £1 million in the aggregate in respect of all such services.

External auditors will also receive remuneration of £4,450 (2017/18: £4,450), excluding VAT, for the statutory audit of the NHS Charity.

4.3 Operating leases

4.3.1 As lessee

Payments recognised as an expense

	2018/19	2017/18
	£000	£000
Minimum lease payments	1,403	1,106

Total future minimum lease payments

	2018/19	2017/18
	£000	£000
Payable:		
Not later than one year	1,479	1,028
Between one and five years	3,964	1,014
After five years	16,432	-
	21,875	2,042

The NHS Foundation Trust has entered into a number of leases for medical equipment, land and property.

There are 2 (2017/18: 2) leases where the capital value of the equipment (including VAT) exceeded £250k. All other leases are for equipment with a capital value (including VAT) under this amount. The lease rental is fixed at the outset of the leases.

The NHS Foundation Trust has 4 (2017/18: 6) leases relating to land used for the purpose of car parking. The leases are all for a period of 10 years or less. Two leases include an early termination clause; two of 6 months' notice if the NHS Foundation Trust ceases to operate on its current site, and one of 12 months' notice if the NHS Foundation Trust ceases occupation of its current site.

The NHS Foundation Trust leases two buildings used as office space. One lease had an original lease period of 15 years. A variation to the lease was entered into in April 2013 extending the terms of the lease to April 2019 and agreeing a fixed annual rental charge. The lease will come to an end in April 2019. The second lease (offices in Huntingdon) has a lease period of 5 years and will expire in December 2022.

The NHS Foundation Trust has a lease for residential accommodation in Waterbeach. The lease period is for 25 years and will expire in July 2043. There is annual indexation of a minimum of 1.25% on this lease.

The Trust has given notice on the leases where the lease end date is later than the move date to the new hospital. A provision has been made in these accounts for the costs of the leases the Trust will no longer require following the move to the new hospital in May 2019.

4.3.2 As lessor

Rental revenue

	2018/19	2017/18
	£000	£000
Other	-	19
Total rental revenue	-	19

Total future minimum lease payments

	2018/19	2017/18
	£000	£000
Receivable:		
Not later than one year	-	6

The NHS Foundation Trust had an agreement to rent out office and laboratory space to an organisation involved in medical research. This agreement which was a short term lease agreement was terminated in June 2018.

5 IMPAIRMENT OF ASSETS

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus/(deficit) resulting from:		
Impairment of New Papworth Hospital	-	44,698
Impairment of existing Papworth site buildings, plant and equipment	1,556	-
Impairment of intangibles	1	-
	1,557	44,698

During the year the NHS Foundation Trust has considered the carrying value of capital assets not previously impaired in use on its Papworth Everard site. This has resulted in an impairment of £2,635k, being the difference between the previous carrying value of £6,013k and its depreciated replacement cost of £3,378k when considering the move to the New Hospital in May 2019. The net impairment charged to the revaluation reserve is £1,033k with the balance (£1,603k) being charged to income and expenditure. There was a part reversal (£46k) of the 2017/18 impairment of New Papworth Hospital charged to income and expenditure due to actual costs relating to fees being lower than anticipated.

6 EMPLOYEE COSTS AND NUMBERS

6.1 Employee costs

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Salaries and wages	72,634	69,586	72,634	69,586
Social security costs	7,159	6,753	7,159	6,753
Apprenticeship levy	347	325	347	325
Employer contributions to NHS Pensions Agency	8,274	7,902	8,274	7,902
Temporary staff (including agency)	6,598	3,088	6,598	3,088
Employee benefit expenses	95,012	87,654	95,012	87,654

All employee benefit expenses have been charged to revenue. The total employer pension contributions paid for the year is £8,288k (2017/18: £7,978k).

* Excludes Non-Executive Directors' salary costs. These salary costs are included in note 4.1.

Pension Costs

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 2019 is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years' pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as

defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in Retail Prices in the 12 months ending 30th September in the previous calendar year. From 2011/12, the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Ill-health Retirement

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Death Benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Early Retirement

For early retirements other than those due to ill-health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Additional Voluntary Contributions (AVC's)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

NEST is a Workplace Pension Scheme operated by the Government; it is an alternative pension scheme (to the Superannuation Scheme) which is not NHS specific. It is a defined contribution, off statement of financial position scheme (as it is not exclusively NHS). The number of employees opting in and the value of contributions have been negligible. The cost in 2018/19 was £7k (2017/18 £3k).

6.2 Staff Exit Packages

	2018/19		2017/18	
	Number of other departures agreed	Total number of exit packages by cost band	Number of other departures agreed	Total number of exit packages by cost band
£25,001-£50,000	-	-	1	1
£50,001-£100,000	-	-	1	1
Total number of exit packages by type	-	-	2	2
		£000		£000
Total resource cost		<u><u>-</u></u>		<u><u>97</u></u>

Exit packages are agreed with due regards to national terms and conditions, adherence to local policies and procedures and a risk assessment.

6.3 Average number of persons employed

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	Total	Total	Total	Total
	Number	Number	Number	Number
Permanently Employed				
Medical and dental	211	206	211	206
Administration and estates	371	374	371	375
Healthcare assistants and other support staff	350	340	350	340
Nursing, midwifery and health visiting staff	576	561	576	561
Scientific, therapeutic and technical staff	147	141	147	141
Health care science staff	75	74	75	73
Other				
Bank staff	55	53	55	53
Agency/contract staff	59	59	59	59
Other	10	2	10	2
Total	1,854	1,810	1,854	1,810

6.4 Retirements due to ill-health

In the year to 31 March 2019, there was 1 early retirement agreed on the grounds of ill-health (31 March 2018: nil). The estimated additional pension liability in respect of early retirements agreed on the grounds of ill-health is £57k (31 March 2018: £nil); the cost of which is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

6.5 Directors' remuneration

The aggregate amounts payable to directors were:

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	Total	Total	Total	Total
	£000	£000	£000	£000
Salary	992	1,151	992	1,153
Taxable benefits	20	9	20	9
Employer's pension contributions	79	119	79	119
Total	1,091	1,279	1,091	1,281

Further details of directors' remuneration can be found in the remuneration report.

7 FINANCE INCOME

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest revenue:				
Investments in listed equities	191	188	-	-
Short term investments and deposits	4	17	-	17
Bank accounts	207	41	207	41
	402	246	207	58

8 FINANCE EXPENSES

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Loans from the Department of Health and Social Care	57	92	57	92
Main finance costs on PFI scheme obligations	4,919	711	4,919	711
Contingent finance costs on PFI scheme obligations	386	101	386	101
	5,362	904	5,362	904

9 INTANGIBLE ASSETS

2018/19	Computer Software Purchased £000	Intangible Assets Under Construction £000	Total Intangible Assets £000
Gross cost at 1 April 2018	3,396	292	3,688
Additions purchased - Trust	-	1,265	1,265
Gross cost at 31 March 2019	3,396	1,557	4,953
Accumulated amortisation at 1 April 2018	3,077	-	3,077
Provided during the year	175	-	175
Impairments charged to operating expenses	1	-	1
Accumulated amortisation at 31 March 2019	3,253	-	3,253
Net book value			
- Purchased at 31 March 2019	120	1,557	1,677
- Donated at 31 March 2019	23	-	23
Total at 31 March 2019	143	1,557	1,700

2017/18	Computer Software Purchased £000	Intangible Assets Under Construction £000	Total Intangible Assets £000
Gross cost at 1 April 2017	3,502	-	3,502
Additions purchased - Trust	(5)	292	287
Impairment charged to operating expenses	(101)	-	(101)
Gross cost at 31 March 2018	3,396	292	3,688
Accumulated amortisation at 1 April 2017	2,881	-	2,881
Provided during the year	250	-	250
Disposals	(54)	-	(54)
Accumulated amortisation at 31 March 2018	3,077	-	3,077
Net book value			
- Purchased at 31 March 2018	281	292	573
- Donated at 31 March 2018	38	-	38
Total at 31 March 2018	319	292	611

10 PROPERTY, PLANT AND EQUIPMENT
10.1 Property, plant and equipment at the financial year end comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
2018/19									
Cost/valuation at 1 April 2018	24,421	9,738	928	131,036	29,488	135	4,534	261	200,541
Additions purchased - Trust	-	17	-	16,252	1,004	-	-	314	17,587
Additions purchased - cash donations	-	-	-	1,750	141	-	-	-	1,891
Impairments charged to operating expenses	-	-	-	46	-	-	-	-	46
Reversal of impairments credited to operating income	-	-	-	-	-	-	-	-	0
Revaluations	-	-	-	-	-	-	-	-	0
Reclassifications	-	10	-	(261)	32	-	-	219	-
Transfer to assets held for sale	-	-	-	-	-	-	-	-	0
Disposals	-	-	-	-	(333)	-	-	-	(333)
At 31 March 2019	24,421	9,765	928	148,823	30,332	135	4,534	794	219,732
Accumulated depreciation at 1 April 2018	-	6,916	213	-	27,305	119	3,796	226	38,575
Provided during the year	-	872	42	-	1,017	6	239	66	2,242
Revaluations	-	-	-	-	-	-	-	-	0
Impairments charged to operating expenses	-	1,148	183	-	147	-	109	15	1,602
Impairments charged to the revaluation reserve	-	684	349	-	-	-	-	-	1,033
Disposals	-	-	-	-	(333)	-	-	-	(333)
Accumulated depreciation at 31 March 2019	-	9,620	787	-	28,136	125	4,144	307	43,119
Net book value									
- Purchased at 31 March 2019 - Trust	23,537	125	4	27,232	1,912	4	387	483	53,684
- Purchased at 31 March 2019 - NHS Charity	85	-	135	-	-	-	-	-	220
- On-SoFP PFI contract at 31 March 2019	-	-	-	118,900	-	-	-	-	118,900
- Government granted at 31 March 2019	-	11	-	-	-	-	-	-	11
- Donated at 31 March 2019	799	9	2	2,691	284	6	3	4	3,798
Total at 31 March 2019	24,421	145	141	148,823	2,196	10	390	487	176,613

10.2 Property, plant and equipment at the financial year end comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
2017/18									
Cost/valuation at 1 April 2017	24,421	9,756	928	3,592	29,245	126	4,175	257	72,500
Additions purchased - Trust	-	(18)	-	24,301	194	-	359	4	24,840
Additions leased - Trust	-	-	-	146,901	-	-	-	-	146,901
Additions purchased - cash donations	-	-	-	940	-	9	-	-	949
Impairments charged to operating expenses	-	-	-	(44,698)	-	-	-	-	(44,698)
Revaluations	-	-	-	-	75	-	-	-	75
Disposals	-	-	-	-	(26)	-	-	-	(26)
At 31 March 2018	24,421	9,738	928	131,036	29,488	135	4,534	261	200,541
Accumulated depreciation at 1 April 2017	-	5,063	152	-	26,345	111	3,478	215	35,364
Provided during the year	-	1,853	61	-	1,161	8	318	11	3,412
Impairments charged to operating expenses	-	-	-	-	(194)	-	-	-	(194)
Disposals	-	-	-	-	(7)	-	-	-	(7)
Accumulated depreciation at 31 March 2018	-	6,916	213	-	27,305	119	3,796	226	38,575
Net book value									
- Purchased at 31 March 2018 - Trust	23,537	1,704	506	11,196	1,930	9	701	29	39,612
- Purchased at 31 March 2018 - NHS Charity	85	-	139	-	-	-	-	-	224
- On-SoFP PFI contract at 31 March TRUE	-	-	-	118,900	-	-	-	-	118,900
- Government granted at 31 March 2018	-	883	-	-	-	-	-	-	883
- Donated at 31 March 2018	799	235	70	940	253	7	37	6	2,347
Total at 31 March 2018	24,421	2,822	715	131,036	2,183	16	738	35	161,966

In March 2015 the NHS Foundation Trust achieved financial closure on the plans to go ahead with the construction of the New Royal Papworth Hospital on the Cambridge Biomedical Campus.

The finalisation of the contract has led to the NHS Foundation Trust considering the fair value of the existing site, the remaining economic use to be derived from the site assets and the appropriate value of the existing site at 31 March 2019.

During the year the NHS Foundation Trust secured an agreement to sell the site and contracts were exchanged on 27th March 2019. Completion of the sale is anticipated to take place by September 2019.

A valuation of the existing site at 31 March 2015 was carried out by external organisation, Boshiers and Company, Chartered Surveyors, in accordance with the requirements of the HM Treasury Financial Reporting Manual, Department of Health and Social Care Foundation Trust Annual Reporting Manual and International Financial Reporting Standards (IFRS).

The buildings and dwellings not expected to be of value to the NHS Foundation Trust following its relocation to the new site, or any expected existing use value, were valued to reflect their remaining economic life. Land, buildings and dwellings expected to have continued existing use value after the relocation were valued on that basis.

The existing site and off-site dwellings are still operational property and will be until 9 May 2019 when the Hospital has fully relocated.

The NHS Foundation Trust is of the opinion that the fair value of its land, buildings and dwellings has not changed from the 31 March 2015 valuation. The NHS Foundation Trust's land, buildings and dwellings have therefore not been revalued in year.

Valuations are carried out by professionally qualified individuals in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A valuation of the New Royal Papworth Hospital PFI site was carried out in the 2017/18 financial year, by the NHS Foundation Trust's externally appointed independent organisation, Boshiers and Company, Chartered Surveyors. The effective date of valuation was the 31 March 2018. More detail about the valuation process is contained in the accounting policies, note 1.7 and impairment of assets, note 5.

11 INVESTMENTS

The investments relate to the NHS Charity and comprise of shares, and also cash held with the investment managers for future investment in equity.

	31 March 2019 £000	31 March 2018 £000
Investment Managers		
Market value at 1 April	6,627	6,362
Add: Additions of shares	880	552
Less: Disposals at carrying value	(1,150)	(498)
Net gain on revaluation	257	210
Market value at 31 March (shares only)	6,614	6,626
Cash held with Investment Managers at 31 March	1,096	2,637
Total value of investments	7,710	9,263
Historic cost at 31 March (shares only)	4,615	4,832

The valuation of the investments is at 31 March 2019 and may not be realised at the date the investments are disposed of.

At 31 March 2019 5,000 (31 March 2018: 5,000) shares were held with a market value of £462,052 (31 March 2018: £382,806) in Findlay Park Funds American USD Dis., which represents 7.8% of the total market value of shares held.

Shares were purchased and sold during the year by the NHS Foundation Trust's Investment Managers. The historic cost represents the value of shares after purchases and sales at 31 March 2019 before the shares were revalued.

Cash held with the NHS Foundation Trust's Investment Managers is for future investment. The majority of cash held is the balance of the sale proceeds from the sale of shares, less the purchase of shares, with some additional cash as a result of dividend income received. Cash held by the NHS Foundation Trust's Investment managers for re-investment is all held within the UK.

12 INVENTORIES

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Drugs	534	453	534	453
Consumables	3,971	3,409	3,971	3,409
NHS Charity - gift shop	26	18	-	-
TOTAL	4,531	3,880	4,505	3,862

The cost of inventories recognised as an expense and included in 'operating expenses' amounted to £25,603k (2017/18: £25,749k).

An additional £5k (2017/18: £20k) was recognised as a write-down expense.

13 TRADE AND OTHER RECEIVABLES

Current	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Contract receivables: invoiced NHS	1,538	2,169	1,538	2,169
Contract receivables: invoiced other	2,881	3,101	3,084	4,226
VAT receivables	1,349	1,485	1,349	1,485
Contract receivables: not yet invoiced	1,278	2,450	816	2,280
Allowance for the impaired contract receivables	(680)	(1,175)	(680)	(1,175)
PDC dividend receivable	540	-	540	-
Prepayments other	2,512	1,726	2,512	1,726
Other receivables	55	3	55	3
TOTAL	9,473	9,759	9,214	10,714
Non-current				
PFI lifecycle prepayments	114	38	114	38
TOTAL	114	38	114	38

13.1 Provision for impairment of receivables

	Total trade receivables £000	Other trade receivables £000
At 1 April 2018	1,175	1,175
Impact of IFRS 9 implementation on 1 April 2018 balance	(447)	(447)
New allowance arising	54	54
Changes in the calculation of existing allowances	(1)	(1)
Receivables written off during the year as uncollectable	(16)	(16)
Reversals of allowances	(85)	(85)
At 31 March 2019	680	680

	Total trade receivables £000	Other trade receivables £000
At 1 April 2017	746	746
New allowance arising	714	714
Receivables written off during the year as uncollectable	(35)	(35)
Reversals of allowances	(250)	(250)
At 31 March 2018	1,175	1,175

13.2 Analysis of impaired receivables

	31 March 2019 £000	31 March 2018 £000
Ageing of impaired receivables		
Current	8	183
0 - 30 days	7	-
30 - 60 days	2	-
60 - 90 days	3	-
90 - 180 days	137	124
Over 180 days	523	868
TOTAL	680	1,175

13.3 Analysis of non-impaired receivables

	31 March	31 March
	2019	2018
	£000	£000
Ageing of non-impaired receivables		
Current	2,931	4,215
0 - 30 days	210	535
30 - 60 days	(22)	351
60 - 90 days	411	180
90 - 180 days	173	69
Over 180 days	239	(127)
TOTAL	3,942	5,223

14 CASH AND CASH EQUIVALENTS

	Group		Trust	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
At 1 April	51,627	36,716	50,224	34,721
Net change in year	(28,306)	14,911	(27,505)	15,503
Balance at 31 March	23,321	51,627	22,719	50,224
Made up of:				
Government Banking Services	21,754	49,697	21,754	49,697
Cash at commercial banks and in hand	1,567	1,930	965	527
Cash and cash equivalents as in statement of cash flows	23,321	51,627	22,719	50,224

The change to the calculation of net cash balances used when calculating the PDC dividend restricts the NHS Foundation Trust's investment options. The NHS Foundation Trust's surplus cash is invested in short term deposits with the National Loans Fund where applicable. The reduction in interest earned by keeping cash surplus in government banking is less than the impact of not including them in the PDC dividend calculation.

Interest earned on these deposits is accrued in the financial statements and is disclosed on the face of the Statement of Comprehensive Income.

Surplus cash balances held by the NHS Charity are either invested in a notice account or invested in short term deposits with a small range of approved commercial banks.

As at 31 March 2019 £nil was held on short term deposit (31 March 2018: £nil) by the NHS Foundation Trust and £0.2m (31 March 2018: £0.2m) was held on short term deposit by the NHS Charity.

15 TRADE AND OTHER PAYABLES

Current	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
NHS Payables - revenue	5,032	7,211	5,032	7,211
Other trade payables - revenue	6,453	3,892	6,453	3,892
Other trade payables - capital	5,952	9,059	5,952	9,059
Receipts in advance	2,972	3,385	2,972	3,385
Other taxes payable	2,058	1,860	2,058	1,860
Accruals	11,489	8,744	11,396	8,730
PDC dividend payable	-	973	-	973
Other payables	1,300	1,148	1,300	1,148
TOTAL	35,256	36,272	35,163	36,258

Non-current

The Group has no non-current trade and other payables.

Outstanding pension contributions of £1,242k falling within one year are included within 'Other payables' for the year to 31 March 2019 (31 March 2018: £1,114k).

16 OTHER LIABILITIES

	Current	
	31 March 2019 £000	31 March 2018 £000
Deferred Income	248	47

17 BORROWINGS

	Current		Non-current	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Loans from Department of Health	2	-	10,000	10,000
Obligations under PFI contract	2,110	2,006	84,334	86,444
	2,112	2,006	94,334	96,444

17.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	10,000	88,450	98,450
Cash movements:			
Financing cash flows - payments and receipts of principal	-	(2,006)	(2,006)
Financing cash flows - payments of interest	(57)	(4,919)	(4,976)
Non-cash movements:			-
Impact of implementing IFRS 9 on 1 April 2018	2	-	2
Application of effective interest rate	57	4,919	4,976
Carrying value at 31 March 2019	10,002	86,444	96,446

The loan from Department of Health and Social Care represents a bridging loan from the Secretary of State for Health against the sale of land at the existing Royal Papworth hospital site at Papworth Everard to support working capital. The repayment date of the loan is 18 March 2022. Interest on the loan is charged at 0.59%.

18 PROVISIONS

	31 March 2019		
	Pensions relating to other staff £000	Other £000	Total £000
At 1 April 2018	506	867	1,373
Change in the discount rate	56	-	56
Arising during the year	-	1,184	1,184
Utilised during the year	(31)	(179)	(210)
At 31 March 2019	531	1,872	2,403
Expected timing of cash flows:			
- not later than one year;	48	1,520	1,568
- later than one year and not later than five years;	139	352	491
- later than five years.	344	-	344
Total	531	1,872	2,403

	31 March 2018		
	Pensions relating to other		
	staff £000	Other £000	Total £000
At 1 April 2017	454	-	454
Change in the discount rate	86	-	86
Arising during the year	-	867	867
Utilised during the year	(34)	-	(34)
At 31 March 2018	<u>506</u>	<u>867</u>	<u>1,373</u>
Expected timing of cash flows:			
- not later than one year;	43	588	631
- later than one year and not later than five years;	145	279	424
- later than five years.	318	-	318
Total	<u>506</u>	<u>867</u>	<u>1,373</u>

The lease dilapidations provision relates to costs the NHS Foundation Trust is likely to incur carrying out remedial and/or dilapidation works at the end of some of its land and building leases. The majority of the costs are likely to be incurred during 2019/20 once services have been transferred to the new Royal Papworth Hospital in May 2019.

Other provisions relate to payments due on 1 July 2019 or if earlier, the date upon which the NHS Foundation Trust is planning to dispose of the existing Papworth Everard hospital site, to release pre-emption rights and restrictive covenant on the site. It also relates to payments due to be made by the NHS Foundation Trust under two land and two equipment operating leases from 9 May 2019 until their termination dates, as the NHS Foundation Trust will no longer require the associated assets once it relocates to the new Royal Papworth Hospital in May 2019. In addition other provisions include a provision for four employment tribunal claims that are currently ongoing.

The balance on provisions relates to staff pension costs for staff who took early retirement, before 6 March 1995 and staff entitled to injury benefit. This is settled by a quarterly charge from the NHS Pensions Agency.

The amount included in the provision of NHS Resolution at 31 March 2019 in respect of clinical negligence liabilities of the NHS Foundation Trust is £13,444k (31 March 2018: £10,298k).

19 CONTINGENT ASSETS AND LIABILITIES

The value of contingent liabilities in respect of NHS Resolution legal claims at 31 March 2019 is £17k (31 March 2018: £5k).

There are no contingent assets.

20 CAPITAL AND CONTRACTUAL COMMITMENTS

The value of commitments under capital expenditure contracts at the end of the financial year was £1.3m (31 March 2018: £8.9m). There were no commitments under finance leases at the end of the financial year (31 March 2018: £nil).

These commitments relate to orders that had been raised for equipment and intangibles relating to the new hospital which were not delivered to site at the year end. These will be funded from Trust resources in 2018/19 as part of the new hospital equipping programme.

Details of commitments in respect of operating leases can be found at note 4.3.1.

21 ON SOFP PFI ARRANGEMENTS

On 12 March 2015 the NHS Foundation Trust concluded contracts under the Private Finance Initiative (PFI) with NPH Healthcare Ltd for the construction of a new 310 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 NHS Foundation Trust, being acquired through a finance lease. The payments to NPH Healthcare Ltd in respect of the facility (New Royal Papworth Hospital) 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 £6.09m (2017/18 £0.70m). The hospital was handed over to the NHS Foundation Trust in February 2018 and will be fully operational in May 2019. Payments under the scheme commenced in February 2018. The agreement is due to end in March 2048.

The value of the scheme at inception was £163.60m, but was subsequently re-valued to £118.90m on 19 February 2018 to depreciated replacement cost on a modern equivalent asset basis.

Finance charges include both interest payable and contingent rent payable. Contingent rent is variable dependent of the future rate of inflation using the Retail Price Index (RPI).

21.1 PFI finance lease obligations

	Group		Trust	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
Gross PFI finance lease liabilities	86,444	88,450	86,444	88,450
Of which liabilities are due				
- not later than one year;	2,110	2,006	2,110	2,006
- later than one year and not later than five years;	8,578	8,403	8,578	8,403
- later than five years.	75,756	78,041	75,756	78,041
Finance charges allocated to future periods	-	-	-	-
Net PFI liabilities	86,444	88,450	86,444	88,450
- not later than one year;	2,110	2,006	2,110	2,006
- later than one year and not later than five years;	8,578	8,403	8,578	8,403
- later than five years.	75,756	78,041	75,756	78,041

21.2 PFI total unitary payments obligations

	Group		Trust	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
Total future payments committed in respect of the PFI arrangement	531,488	541,827	531,488	541,827
Of which liabilities are due				
- not later than one year;	14,184	14,127	14,184	14,127
- later than one year and not later than five years;	60,093	58,748	60,093	58,748
- later than five years.	457,211	468,952	457,211	468,952

21.3 Analysis of amounts payable to service concession operator

	Group		Trust	
	31 March	31 March	31 March	31 March
	2019	2018	2019	2018
	£000	£000	£000	£000
Unitary payment payable to service concession operator	13,475	2,002	13,475	2,002
Consisting of:				
- Interest charge	4,919	711	4,919	711
- Repayment of finance lease liability	2,006	450	2,006	450
- Service element and other charges to operating expenditure	6,088	702	6,088	702
- Contingent rent	386	101	386	101
- Addition to lifecycle prepayment	76	38	76	38
	13,475	2,002	13,475	2,002

22 EVENTS AFTER THE REPORTING YEAR

There have been no events after the reporting year end that requires disclosure in these accounts.

23 PUBLIC DIVIDEND CAPITAL

The dividend payable on public dividend capital (PDC) is based on the pre-audit actual (rather than forecast) average relevant net assets at an annual rate of 3.5% (see note 1.16).

The NHS Foundation Trust received £0.14m of PDC funding in 2018/19 to fund the implementation of 2020 secondary care WiFi and a pharmacy system upgrade. In 2017/18, the NHS Foundation Trust received £45.5m structural debt re-financing in the form of PDC funding.

24 RELATED PARTY TRANSACTIONS

Royal Papworth Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The key management personnel of the NHS Foundation Trust are the Executive and Non-Executive Directors of the NHS Foundation Trust. The total number of Directors to whom benefits are accruing under a defined benefit scheme is 6 (2017/18: 7).

	2018/19	2017/18
	£000	£000
Remuneration payment	975	1,151
Employer contribution to the NHS Pension Scheme	79	119
	<u>1,054</u>	<u>1,270</u>

* Includes third party agency fees for interim services of Director of HR 2017/18 (value is gross of VAT)

The remuneration payment relating to the highest paid director is £169k (2017/18: £168k). The highest paid director opted out of the pension scheme in March 2018. Further information is available in the Remuneration Report, which is included within the NHS Foundation Trust's Annual Report.

During the year none of the senior managers of the NHS Foundation Trust or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

Dr S Lintott, a Non-Executive Director of the NHS Foundation Trust, held various positions within the University of Cambridge, particularly in relation to fundraising. During the year the NHS Foundation Trust made payments to the University of Cambridge of £385k (2017/18: £407k) for staff recharges relating to medical staff. At the 31 March 2019 the NHS Foundation Trust has £202k (31 March 2018: £nil) owing to the University of Cambridge relating to staff recharges.

Mr M Millar, a Non-Executive Director of the NHS Foundation Trust, held the position as Independent Chair of the Finance, Planning and Performance Group for the Cambridge and Peterborough Sustainability and Transformation Programme, which is hosted by Cambridge and Peterborough NHS Foundation Trust until 31 March 2018. Mr M Millar left the Trust on 31 October 2018. During the year the NHS Foundation Trust made payments to the Cambridge and Peterborough NHS Foundation Trust of £137k (2017/18: £329k). At the 31 March 2019 the NHS Foundation Trust has £26k (31 March 2018: £58k) owing to Cambridge and Peterborough NHS Foundation Trust.

In partnership with the University of Cambridge, Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust, the NHS Foundation Trust set up an Academic Health Science Centre. The partnership vehicle, called Cambridge University Health Partners (CUHP) is a company limited by guarantee. The objects of CUHP are to improve patient care, patient outcomes and population health through innovation and the integration of service delivery, health research and clinical education.

The CUHP is regarded as a related party of the NHS Foundation Trust. During the year the NHS Foundation Trust made a payment of £103k (2017/18: £103k) to the CUHP for its share of the CUHP running costs. At 31 March 2019 there was £26k owing by the NHS Foundation Trust to CUHP (31 March 2018: £26k). There were no amounts written off during the year and there are no provisions for doubtful debts at 31 March 2019 in respect of CUHP (31 March 2018: £nil). The Chief Executive, Chairman and the Non-Executive Director University nominee, nominated by the University of Cambridge, are 3 out of 12 Directors of the CUHP.

The NHS Foundation Trust is also a member of the Eastern Academic Health Science Network (EAHSN) which is involved with the local Health Education and Innovation Cluster (HIEC) and hosts the national Small Business Research Initiative (SBRI) Healthcare.

The Department of Health and Social Care is regarded as a related party. During the year Royal Papworth Hospital NHS Foundation Trust has had a significant number of material transactions

with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income		Current Receivables	
			At 31 March	At 31 March
	2018/19	2017/18	2019	2018
	£000	£000	£000	£000
NHS England	106,686	94,805	817	643
NHS Cambridgeshire and Peterborough CCG	13,070	12,233	-	-
NHS West Suffolk CCG	4,126	4,160	-	251
Health Education England	3,288	2,989	-	838
NHS West Norfolk CCG	2,841	2,861	-	-
NHS Bedfordshire CCG	2,194	1,941	-	-
Department of Health and Social Care	1,825	2,252	1	17
NHS Ipswich and East Suffolk CCG	1,606	1,760	-	111
NHS South Lincolnshire CCG	1,348	1,156	26	108
NHS Blood and Transplant	1,298	1,183	147	71
NHS West Essex CCG	1,223	1,035	-	-
NHS East and North Hertfordshire CCG	1,165	1,172	-	-

The figures above differ from those in note 2.2 due to the inclusion of sundry income.

The related party organisations listed above are those where income for the year to 31 March 2019 is greater than £1,000k.

Under the new reforms, the NHS Foundation Trust's lead commissioner from 2013/14 is NHS England – Specialised Commissioning Midlands and East (East of England). The NHS Foundation Trust has reached an agreement on a contract to provide healthcare services of £122.4m for 2019/20.

	Expenditure		Current Payables	
			At 31 March	At 31 March
	2018/19	2017/18	2019	2018
	£000	£000	£000	£000
NHS Pension Scheme	8,274	7,902	1,242	1,114
HM Revenue & Customs - NI Contributions	7,506	7,078	2,058	1,860
Cambridge University Hospitals NHS Foundation Trust - medical, staffing, pathology and other services	4,617	3,757	1,319	1,315
NHS Resolution (formerly NHS Litigation Authority)	843	663	-	3
Public Health England (was Health Protection Agency)	579	524	176	3
NHS England	411	1,303	4,952	5,787
Cambridgeshire and Peterborough NHS Foundation Trust	307	533	268	86

The related party organisations listed above are those where expenditure for the year to 31 March 2019 is greater than £500k.

The NHS Foundation Trust is the Corporate Trustee of the Royal Papworth Hospital Charitable Fund, a registered Charity. The NHS Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a key related party of the NHS Foundation Trust. The

NHS Foundation Trust has consolidated the NHS Charity into the NHS Foundation Trust's accounts (see note 1.1).

25 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with NHS commissioning bodies and the way those NHS commissioning bodies are financed, the NHS Foundation 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 NHS Foundation 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 NHS Foundation 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 interest and the NHS Foundation Trust's income and operating cash flows are subsequently independent of changes in market interest rates.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the NHS Foundation Trust. Credit risk arises from deposits with banks and financial institutions as well as credit exposures to the NHS Foundation Trust's commissioners and other receivables. Surplus operating cash is only invested with banks and financial institutions that are rated independently with a minimum score of A1 (Standard and Poor's), P-1 (Moody's) or F1 (Fitch). The NHS Foundation Trust's net operating costs are incurred largely under annual service agreements with NHS commissioning bodies, which are financed from resources voted annually by Parliament. As NHS commissioning bodies are funded by government to buy NHS patient care services, no credit scoring of these is considered necessary. An analysis of the ageing of receivables and provision for impairments can be found at note 13 'Trade and other receivables'.

Liquidity risk

Liquidity risk is the possibility that the NHS Foundation Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities. NHS Foundation Trusts are required to assess liquidity as one of the two measures in the Continuity of Services Risk rating set out in Monitor's Risk Assessment Framework.

26 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY
Financial assets

	Group		Trust	
	Total	Financial assets at amortised cost	Total	Financial assets at amortised cost
	£000	£000	£000	£000
Receivables with DHSC group bodies	1,263	1,263	1,263	1,263
Receivables not yet invoiced	1,300	1,300	838	838
Other receivables (net provision for impaired debts)	2,509	2,509	2,509	2,509
Other investments	7,710	7,710	-	-
Cash at bank and in hand	23,321	23,321	22,719	22,719
Total at 31 March 2019	36,103	36,103	27,329	27,329
Receivables with DHSC group bodies	2,032	2,032	2,032	3,493
Receivables not yet invoiced	2,440	2,440	2,270	1,836
Other receivables (net provision for impaired debts)	2,076	2,076	3,201	3,612
Other investments	9,263	9,263	-	-
Cash at bank and in hand	51,627	51,627	50,224	34,721
Total at 31 March 2018	67,438	67,438	57,727	43,662

Financial liabilities

	Group		Trust	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Payables with DHSC group bodies	5,028	5,028	5,028	5,028
Other payables	13,709	13,709	13,709	13,709
Accruals	11,489	11,489	11,396	11,396
Provisions under contract	2,403	2,403	2,403	2,403
DHSC loans	10,002	10,002	10,002	10,002
Finance leases and PFI liabilities	86,444	86,444	86,444	86,444
Total at 31 March 2019	129,075	129,075	128,982	128,982
NHS payables	7,211	7,211	7,211	7,211
Other payables	16,932	16,932	16,932	16,932
Accruals	8,744	8,744	8,730	8,730
Provisions under contract	867	867	867	867
DHSC Loans	10,000	10,000	10,000	10,000
Finance leases and PFI liabilities	88,450	88,450	88,450	88,450
Total at 31 March 2018	132,204	132,204	132,190	132,190

Notes:

In accordance with IFRS 9, the fair value of the financial assets and liabilities (held at amortised cost) are not considered significantly different to book value.

27 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	At 31 March 2019 £000	At 31 March 2018 £000	At 31 March 2019 £000	At 31 March 2018 £000
Less than one year	33,906	35,482	33,813	35,468
In more than one year but not more than two years	2,497	2,388	2,497	2,388
In more than two years but not more than five years	16,572	16,293	16,572	16,293
Greater than five years	76,100	78,041	76,100	78,041
	129,075	132,204	128,982	132,190

28 THIRD PARTY ASSETS

The NHS Foundation Trust held £786k cash at bank at 31 March 2019 (31 March 2018: £2,329k) relating to Health Enterprise East, a research and development company limited by guarantee for which the NHS Foundation Trust is the host organisation. This amount is held to offset any possible liabilities that might fall to be settled on behalf of Health Enterprise East. These balances are excluded from the cash and cash equivalents figure reported in the NHS Foundation Trust's Statement of Financial Position. £nil cash at bank and in hand at 31 March 2019 (31 March 2018: £nil) was held by the NHS Foundation Trust on behalf of patients.

29 LOSSES AND SPECIAL PAYMENTS

	2018/19		2017/18	
	No. of cases	Value of cases £000	No. of cases	Value of cases £000
Losses:				
Overpayment of salaries	1	-	9	9
Fruitless payments	-	-	1	-
Private patients	4	58	1	12
Overseas visitors	3	44	1	13
Other	4	1	272	21
Total losses	12	103	284	55
Special payments:				
Loss of personal effects	4	1	8	2
Other	-	-	1	-
Total special payments	4	1	9	2
Total	16	104	293	57

These payments are calculated on an accruals basis but exclude provisions for future losses. There were no individual cases in 2018/19 (2017/18: nil) where a debt write off exceeded £100k.

30 INITIAL APPLICATION OF NEW STANDARDS

30.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the DHSC GAM has been applied by the NHS Foundation Trust from 1 April 2018. The standard is applied retrospectively with any cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and liabilities, a forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently on 1 April 2018 borrowings increased by £2k and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £477k increase in the carrying value of receivables.

30.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the DHSC GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with any cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the DHSC GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 has had no impact on the accounts of the NHS Foundation Trust.

31 FOREIGN CURRENCY

During the year income with a value of £nil was received in foreign currency (2017/18: £nil) and expenditure with a value of £564k was paid to suppliers in foreign currency (2017/18: £751k).

32 CHARITABLE FUND RESERVE

	Balance 1 April 2018 £000	Incoming Resources £000	Resources Expenses £000	Balance 31 March 2019 £000
Restricted Fund Balance	4,424	2,647	(3,544)	3,527
Unrestricted Fund Balance	5,515	4,328	(4,646)	5,197
Total	9,939	6,976	(8,190)	8,724

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the Royal Papworth Hospital NHS Foundation Trust.

Where there is a legal restriction on the purpose to which a fund may be used the fund is classified as a restricted fund. The major funds in this category are for the purpose of research, the transplant service and the treatment of heart patients.

Other funds are classified as unrestricted, which are not legally restricted but which the Trustees of the Charity have chosen to earmark for set purposes. These funds are classified as 'designated' within unrestricted funds and are earmarked for the payment of medical equipment leases contracted for by the NHS Foundation Trust and future payments for the direct benefit of the staff and patients within the NHS Foundation Trust.

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