NHS

Royal Papworth Hospital

NHS Foundation Trust

Annual Report and Accounts

April 2019 to March 2020

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Contents

The Quality Report for 2019/20 is to be published by 15 December 2020 and will be made available for review on the Trust's website.

Annual Accounts

This report is based on guidelines issued by NHS Improvement and was approved by the Board of Directors on the 17 June 2020.

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1. Performance Report

1.1 Overview of Performance

Statement from Chief Executive Officer

Even before we were confronted with the challenges of a global pandemic, the last 12 month period had been an extremely busy and challenging time for all of us at Royal Papworth Hospital. It was a year in which a series of remarkable milestones were achieved by all that work here and one in which our staff and volunteers, yet again, worked incredibly hard to deliver the best care possible for our patients.

In May 2020, we marked the first anniversary of the move to our new hospital on the Cambridge Biomedical Campus. While we could have never predicted the challenges we would face this year, there is no doubt that our experience of moving a hospital and managing an ongoing incident control centre has been extremely valuable in responding to the pandemic. Our purpose-built hospital, with its single patient rooms, enhanced air ventilation system and flexible layout, has proved highly effective in supporting our response to a highly infectious, airborne disease such as COVID19.

Following the move to the new site in May 2020 we have focussed significantly on the optimisation of our new facilities to ensure that as many patients as possible can benefit from the excellent care provided at Royal Papworth Hospital. We have so much to be proud of, however, as with all major strategic change programmes, we recognise that there have also been inevitable challenges and so despite our achievements we fully recognise that we have more to do.

We have successfully managed a range of issues relating to our Facilities Management mobilisation and our staff helped considerably with this by ensuring that there was timely reporting so that problems could be addressed swiftly through the framework of contracts that support our new building and services.

We have received feedback from our staff that has told us that they have felt under significant pressure in this year following the move to our new Hospital and the process of optimisation of our new facilities. In particular we saw pressures in our critical care and put in place remedial actions to support the staff in that area alongside developing plans to deliver a sustainable service model. This work has been overtaken by the steps put in place to respond to the national pandemic. Critical Care remains an area we will continue to support through 2020/21, following the team's incredible response to Covid-19 and the support and positive outcomes they and their colleagues across the Hospital provided to our patients from across the East of England and nationally.

In October 2019 we received our 'Outstanding' inspection report and rating from the Care Quality Commission, becoming the first NHS Hospital to achieve an 'Outstanding' rating in all 5 CQC domains, Safe, Caring, Effective, Responsive and Well-Led, and the first NHS Hospital to achieve 'Outstanding' for the Safe domain. As a Trust we will continue to set high standards and strive to meet all of our performance standards, and this means that we still have work to do to achieve this ambition and to identify opportunities to continuously improve.

Through feedback from national and local staff surveys we recognise that we have more work to do to support our staff and create the best possible environment for them to work and develop their careers in. We will be working through our Compassionate and Collective

leadership programme to ensure that we are enabling our staff to deliver the very best care for their patients. We have included commentary on these matters through our report.

The global impact of COVID19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. The response to this threat has been managed at national, regional and local tiers of the public sector (including but not limited to the NHS, Local Government, the Police Force and the Army). The response has included unprecedented steps which have impacted on all economic sectors and have restricted civil liberties.

Royal Papworth Hospital (RPH), as a nationally recognised centre of excellence for specialist cardiothoracic health care, will continue to play a leading role in the national, regional and local response to this crisis. The Trust has undertaken roles in both an advisory capacity and in our capacity as a direct provider of health care to the population.

As we now move in to a new phase of the pandemic response, we are working to restore other clinical services whilst continuing to care for patients with COVID19.

At the time of writing, we continue to play an important role in caring for some of the most seriously ill patients across the East of England, including those needing our ECMO service for acute respiratory failure. We have now cared for 119 patients with COVID19 since the start of the pandemic, and thanks to the hard work and dedication of our staff 85 have already been discharged home. Sadly, 22 patients with COVID-19 have died in our hospital and our thoughts remain with their loved ones and our staff who were involved in their care.

There is no doubt that responding to a global pandemic has placed huge pressure on our staff. Many have had to work in completely different ways, quickly learning new skills and joining new teams. Some have even moved into our staff accommodation to protect family members in high-risk groups. Many have also been dealing with caring responsibilities, school and nursery closures, financial worries and concerns for loved ones at the same time. We owe them a great deal and must focus on supporting them and giving them a chance to rest in the weeks and months ahead.

While it is too early to predict how the easing of ‘lockdown’ measures in the UK will impact on hospital admissions, we can be certain that we will be dealing with COVID19 for the foreseeable future.

In May we gradually increased our elective activity across our cardiology, surgery and respiratory services, prioritising patients in most urgent need of treatment. We established our ‘Living with COVID’ Steering Group with representatives from all hospital divisions to develop plans for adapting the hospital environment to reflect new patient pathways and ensure that patients, staff and visitors can observe social distancing and remain safe. We are regularly reviewing new guidance and carrying out risk assessments to ensure that we protect all of our staff who are at higher risk from COVID19 – including those from Black, Asian and Minority Ethnic (BAME) backgrounds, pregnant staff and those with underlying health conditions.

We are continuing to work with our system, regional and national partners to ensure that we are in a position to support our patients, our community and the wider population that we serve using our resources effectively and delivering high quality and effective services.

I am confident, given the remarkable people that work and volunteer at Royal Papworth Hospital and them having delivered so much in 2019/20 and responding so well to the Global Pandemic, that our services will continue to improve as we work together to deliver the best possible care and outcomes to our patients in 2020/21 and beyond.

Stephen Posey
Chief Executive
17 June 2020

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 heart and lung transplantation, 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 22,546 inpatient/day cases and delivered 93,203 outpatient contacts in 2019/20 from across the UK. Royal Papworth Hospital's services are internationally recognised and include cardiology, respiratory medicine, cardiothoracic surgery and transplantation.

Royal Papworth Hospital

In May 2019, we moved 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 hospital can be found on the Trust's website:
https://royalpapworth.nhs.uk/

Heart and Lung Research Institute

The Trust and the University of Cambridge (UoC) saw their plans to create a world-class Heart and Lung Research Institute (HLRI) alongside the new Royal Papworth Hospital come to fruition, and construction of the Heart and Lung Research Institute started on site in January 2020. The HLRI will establish one of the largest concentrations of biomedical and scientific research into heart and lung disease in the UK and will mean new treatments will be created, tested and delivered all on one site. 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.

The Institute has been supported with contributions totalling c.£12m from the UoC and the Trust; the British Heart Foundation (BHF) have committed a £10m Strategic Initiative Award to the HLRI. The UoC secured £30m from the UK Research Partnership Investment Fund (RPIF) to bring the total available funds to c.£52m. 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 2019/20 we enrolled 3397 patients across a balanced portfolio of 68 studies that were open to recruitment with 45% of these studies being interventional (testing of new therapies and treatments). Further information will be published with our Quality Accounts by December 2020. 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 35% of the interventional studies and in the top 3 highest recruiters for 70% of the interventional multicentre NIHR portfolio studies we supported. The fantastic recruitment figures are in spite of the hospital move.

R&D Highlights

- Dr Andrew Klein was awarded at £1.3m National Institute for Health Research (NIHR) Health Technology Assessment grant to evaluate the use of high flow nasal oxygen following cardiac surgery in over 10 sites across the UK.

- Dr Tim Quinnell was awarded a £250K NIHR Research for Patient Benefit (RfPB) grant to evaluate combining the use of mandibular advancement devices with CPAP for the treatment of sleep apnoea.
- The Heart Lung Research Institute is now under construction, and occupation should be in April 2022. This is a £65m project in conjunction with the University of Cambridge to create a hub for world class heart and lung research.
- Radiology have made their first academic appointment with Dr Jonathan Weir-McCall joining the Trust.
- The Trust held its second Research Symposium in September 2019, this time on the Cambridge Biomedical Campus. Over 150 delegates attended to hear from a wide range of speakers from the University of Cambridge, industry partners, RPH Investigators and PPI representatives.

Research Impact and Publications

Over 320 papers with Royal Papworth Hospital authors were published during 2019 across a breadth of clinical disciplines and published in a range of journals. This is an increase of more than 10% from 2018.

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 our popular events was the annual 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.

In response to the national pandemic the Royal Papworth Hospital COVID19 Appeal was established to raise vital funds for three core areas in the fight against Corona Virus (COVID19): staff support, research and patient welfare.

The charity team has established a pipeline of over 20 projects to fund from the COVID19 appeal, supporting initiatives in staff psychological wellbeing services, employee rest and recharge stations, patient welfare services and research.

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 2021 deadline.

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

Cambridge University Health Partners (CUHP)

Cambridge University Health Partners (CUHP) was established as a Limited Company in 2009. It is one of six Academic Health Science Centres in England whose mission is to improve patient healthcare by bringing together the NHS, industry and academia.

The 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 Registrary and the Regius Professor of Physic. There are also three further Directors with both clinical and academic responsibilities, one linked with each of the member NHS Trusts.

In April 2020 CUHP was re-designated as a National Institute for Health Research – NHS England/Improvement (NIHR-NHSE/I) Academic Health Sciences Centre (AHSC) for a further five years.

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.

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

Highlights 2019/20

Hospital Move

At the end of April 2019 we began our much anticipated move to our new hospital on the Cambridge Biomedical Campus, 101 years after the hospital was founded in the village of Papworth Everard in Cambridgeshire.

At midday on 1 May 2019 we switched over the ambulance pathways to take patients to the new hospital instead of the old hospital, and the first heart attack patient underwent a life-saving procedure in the new hospital that afternoon. On the same day, our surgical teams performed their first operations in the new building as if it had just been a normal day at work.

For a period of time, we were running one hospital across two locations, gradually closing services down at the old site and opening them in the new building, but by 7 May 2019 the new hospital was fully up and running. This complex logistical task was run as a major incident, supported by a “command and control” centre which was open 24/7. It is a real testament to the commitment and expertise of our staff that we were able to move patients safely and open all of our services in the new hospital while maintaining an excellent patient experience.

CQC inspection

Within weeks of the hospital move we received a visit from the Care Quality Commission (CQC) to carry out an inspection. It was incredibly rewarding for all our staff when the report was published in October 2019, making us the first hospital trust in the country to receive an ‘outstanding’ rating in all five of the regulatory body’s domains.

Royal Opening

In July 2020, we were honoured to receive a visit from HM The Queen to officially open our new hospital. This was a huge privilege and a fitting reward for our staff who had worked so hard to deliver a safe and successful move.

Our Services

Between 1 April 2019 and 31 March 2020, we cared for around 50,000 patients. We had over 93,200 outpatient contacts; we performed 16,300 procedures (including 80 heart, lung and heart-lung transplants) and treated over 22,500 inpatients and day cases.

Our clinicians continued to develop innovative treatments for the benefit of patients. In summer 2019, Royal Papworth surgeons Mr Pedro Catarino, Mr Yasir Abu-Omar and their team carried out the world's first Donation after Circulatory Death (DCD) heart-lung transplant. This was an important step forward for the hospital after we became the first hospital in Europe to perform a DCD heart transplant in 2015.

We also became the UK's first hospital to perform opioid-free thoracic anaesthesia, which gives patients a reduced risk of developing long-term addiction to painkillers as well as fewer side effects compared to opioid anaesthetics. This method of anaesthetic was used when we performed a world-first procedure to remove a lung using the 'sub-xiphoid' technique (through a small incision between the abdominal muscles rather than having to open the chest).

Our Cystic Fibrosis team has also been conducting an innovative study to investigate whether equipment and monitoring software can be used to change the way that care for CF patients is delivered and save them many time-consuming and costly visits to hospital.

Heart & Lung Research Institute

In February 2020, we marked another historic occasion by holding a ground-breaking ceremony for the new Heart and Lung Institute next to the hospital on the Cambridge Biomedical Campus – a joint project with the University of Cambridge.

COVID19

At the beginning of 2020 we could not have predicted that a global crisis was coming that would completely change the way the hospital functions. When we first heard about the 'Wuhan Novel Coronavirus' in the new year, we had no idea just how much of a risk it would pose to our patients and how much we would be called upon to change our practices, increase our capacity, develop new skills and summon every ounce of our collective knowledge, compassion and resilience.

Our purpose-built hospital - with its single patient rooms, air ventilation system and flexible layout - proved incredibly useful in dealing with a highly infectious, airborne disease. We would simply not have been able to respond to COVID19 as effectively had we still been at our old site. In addition our experience of having recently moved a hospital and managed an ongoing command and control centre was been invaluable. However it is the way our staff worked together, and the extraordinary commitment, compassion and resilience they have demonstrated throughout the outbreak that has made the biggest difference in getting us through these most challenging times.

The COVID19 pandemic has placed great pressure on all of our staff. They have all been working hard, often taking on new roles at short notice and having to quickly learn new skills. Those working on the frontline may have witnessed incredibly difficult things and many have also been dealing with caring responsibilities, school and nursery closures, financial worries and concerns for loved ones at the same time.

Looking ahead to 2020/21 much is uncertain. We expect to be caring for patients with COVID19 for the foreseeable future, but we will also need to restore services for other

patients who need our specialist care. The last 12 months have brought huge change for Royal Papworth Hospital as an organisation and we can expect the next year to do the same.

Rapid NSTEMI pathway

In September 2019 we saw the first anniversary of our Rapid NSTEMI 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. The new pathway saves the NHS ambulance transfers, occupied bed days and improves outcomes for patients. This service has been recognised as good practice in the Sustainability and Transformation Partnership (STP) programmes and by the national GIRFT team and the service model has been extended and replicated in centres across the region.

Cardiovascular Outcomes – NICOR report 2015-2018

Royal Papworth Hospital is one of the best-performing NHS hospitals in the UK for cardiac surgery survival, according to the latest NICOR annual report. Over a three-year period, the hospital had a risk adjusted survival rate of >98%, and was above the national average. During that time, Royal Papworth performed the 5422 procedures, one of the largest case volumes in the UK. The data comes from the National Institute for Cardiovascular Outcomes Research (NICOR) report, which looked at hospital performance between 2015 and 2018.

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 August 2019.

The report identified that the national 30 day rate of survival following adult heart transplantation was 90.3%, which ranged from 78.5% to 94.2% across centres (risk-adjusted), with some evidence of a significantly higher rate of survival at Papworth (94.2%). The national 1 year survival rate was 86.6%, ranging from 78.4% to 91.3% across centres (risk-adjusted), again with some evidence of a significantly higher rate at Papworth (91.3%). The national 5 year survival rate was 69.7%, ranging from 60.5% to 79.3% across centres with a rate of 79.3% at Papworth (risk-adjusted) indicating a rate significantly higher than the national rate. The report noted that at all time points analysed, there was some evidence of a significantly higher survival rate at Royal Papworth in comparison to the national rate.

For lung transplant the 90-day post-transplant Papworth had a rate of 90.6% (90.2% risk adjusted). This was statistically consistent with the national rate of survival which was 88.8%. The national 5 year survival rate was 56.2%, ranging from 45.7% to 60.7% across centres (risk-adjusted), with no significant outliers. The 5 year survival rate at Papworth was 53.9% (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 a higher proportion of organs offered for donation than any other UK centre.

Strategy and operational plans

2019 was a historic year for Royal Papworth Hospital. After years of planning we achieved our long-term vision of moving to our new hospital on the Cambridge Biomedical Campus.

Now looking to the future and the Trust has drawn up a new strategy for 2020-2025 which will guide our work for the next five years. Our strategy was developed with involvement from our staff, patients and partners and it will help us build on our strengths, address our challenges, and realise the potential of our new hospital and our exceptional staff.

Clinical excellence and innovation have helped us to get where we are today, and remain at the heart of everything we do but how we do things is just as important as what we do, and our strategy is clear about improving our staff experience, creating a compassionate and collective leadership culture and building meaningful partnerships with organisations who share common goals. We recognise that there is much work to do, and acknowledge that the future response to COVID19 will require us to reconsider how we bring our strategy into being, but we have the energy and optimism for the journey ahead of us. Together, we will continue to bring tomorrow's treatments to today's patients.

Our new strategy sets out a clear direction of travel for the future. It will guide our decisions on priorities and investments, and steer the ongoing development of both services and partnerships. In light of the strategic context, the key questions facing us, and the direction in which we want to travel, we have defined six strategic goals that will underpin our work over the period from 2020 to 2025.

Figure 5: Strategic Goals 2020 – 2025

The implementation of our 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 2020/21 as set out in the table below together with the method of measurement:

Strategic Objectives

2020/21 Strategic Objectives	Measure:
1. Deliver clinical excellence	To deliver excellent care, experience and outcomes for our patients we will: • Implement our Quality Strategy (2019-22) and respond to our CQC feedback • Deliver our activity plan and meet our patient access targets • Use our Digital programme as a key enabler to support our staff, improve care to our patients and protect our services from the threat of Cyber-attack.
2. Grow pathways with partners	In order to develop services with partners and patients we will: • Continue to work in partnership with our Sustainability and Transformation Partnership (STP) partners to support the delivery of our system plan and an Integrated Care System for Cambridgeshire and Peterborough
3. Offer a positive staff experience	To provide a better working environment where staff members feel valued and able to fulfil their potential, we will: • Invest in our 'Compassionate and Collective' leadership programme to ensure that we take steps to improve our culture and create the best possible staff experience • Further enhance our reputation as an employer, attracting new staff and retaining our existing colleagues
4. Share and educate	To grow and develop not only our own staff but also share our expertise with others, we will: • Establish a Royal Papworth School, which would offer multidisciplinary education provision to our own staff and other healthcare professionals.
5. Research and innovate	To develop the Trust as a centre for research and development, we will: • Ensure that the new Heart and Lung Research Institute (HLRI) development progresses to plan. • Develop plans to make the most of the opportunities the HLRI will offer to enhance our reputation and develop the treatments of tomorrow.
6. Achieve sustainability	To establish a sustainable operational and financial position, we will: • Deliver our financial plan and recovery programme, continuing the Trust's return to financial sustainability

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/

Key issues and risks for 2020/21 are:

Risk Description	Mitigation
COVID19 The global impact of COVID19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. In the UK the response to this threat is being managed at national, regional and local tiers of the public sector (including but not limited to the NHS, Local Government, the Police Force and the Army). For the Trust the key risk factors include managing the impact across: • Keeping our patients and our staff safe • Balancing risks in the delivery of services for patients with COVID and non-COVID disease. • Manging the immediate and longer term impact of COVID19 on our workforce. • Managing the impact of COVID19 on the flow of work and the associated financial consequences. • Anticipating and planning for the longer term economic and financial forecasts for the local and wider NHS system. • The operational impact of managing any subsequent waves of COVID19.	Royal Papworth Hospital (RPH), as a nationally recognised centre of excellence for specialist cardiothoracic health care, has and continues to play a leading role in the national, regional and local response to this crisis. The Trust has taken roles in both an advisory capacity and in the direct provision services to the population. The Trust agreed and initiated its Critical Care Surge Plan in early April and moved into ECMO super surge. This was delivered by accelerated training and deployment of ward staff into critical care. The Trust trained over 300 staff to support critical care and redeployed 178 staff to critical care during the surge phase. Restarting postponed activity will require staff to move back to their speciality areas, with a consequential reduction in critical care capacity, but which could be reinstated in the event of a subsequent wave of pandemic. In line with other providers the Trust experienced a reduction in demand through emergency pathways during the initial COVID19 response. The Trust has subsequently experienced a re-bound effect as patients are presenting in a more acutely unwell state. This has been seen first in Cardiology but is anticipated across other specialities over time and plans are being developed to manage this demand. It is assumed that the levels of COVID related conditions post incident will reduce but there will be residual demand for at least 18 months or until an effective testing regime and vaccine is developed. As a “centre of excellence” for treatment of respiratory diseases it is anticipated that critical care capacity required to service this demand will be greater than planned provision pre-COVID19. Re-starting elective activity will only be safely done and, importantly, acceptable to patients when it is possible to clearly delineate between COVID and non-COVID areas across all functions that support care, wards, diagnostic and treatment functions. Ensuring that adequate PPE, medicines and consumables are available to undertake all necessary activities identified in the plan.

Workforce Recruitment and Retention Workforce, and the need to focus on recruitment and retention to support flow and our ability to deliver activity	The Trust has a Recruitment and Retention Strategy and has a very strong recruitment pipeline. Over the year significant work has been undertaken to improve the recruitment and retention of staff to support key areas across the Trust. As part of the COVID19 response we are using a rapidly developed streamlined recruitment and induction process we have recruited a total of 110 new staff since March 2020. We have established a steering group to oversee the medium term the challenges arising from COVID19 for our workforce, environment and organisational development plans. We have a process of risk assessment for our staff in relation to managing those staff with increased risk factors which has been refined and will support how we manage the impact of COVID19 on our staff going forward. We continue to focus on the themes that came out of our Compassionate and Collective Leadership Programme as we move into Phase II of the programme. All areas of the Trust are planning around the issues and opportunities arising from the COVID19 pandemic on matters such as: the impact of travel & transport; staff facilities & environment; digital support; office environment and IPC/social distancing; the organisation of clinical areas as well as the impact on individual staff through new working arrangements in terms of shifts & hours and how that impacts on teams.
Hospital Optimisation: Failure to optimise the new facility to deliver activity plans and meet patient demand.	Our Hospital optimisation programme had identified a number of opportunities to improve the flow of patients through the hospital and saw us implement improvement plans in outpatients, critical care and across the Trust. Whilst our Hospital Optimisation programme has been largely subsumed into the plans for the reshaping services to respond to COVID19. We recognise that the issues that we had identified will need to be addressed in the work that is now underway. We have established a living with COVID Steering group and are putting in place phased plans to reintroduce pathways across all services that had been reduced or suspended in the initial operational response to COVID19. These are to

	be introduced with COVID and non-COVID pathways in order to safely manage our patients. The overarching requirement to protect our staff and patients will have an impact on the flow of work through the hospital. The achievement of planned levels of activity will be effected by the implementation of social distancing measures and changes in the flow through the building in terms of out-patients, cath labs, theatres and critical care. Will take the opportunity to embed the developments that we have seen in the delivery of virtual clinics and support services that have been established in response to COVID19. We have developed new and effective treatment pathways between Trusts and treatment options that support our patients through remote monitoring in the community and will continue to look at the extension of these pathways where there is opportunity to do so. We will also plan changes to our support services and infrastructure to deliver improvement in the flow of patients through the Trust.
Sustainable financial Plan: Failure to deliver our financial plan on a sustainable basis, addressing the underlying the structural deficit and our contribution to the wider system.	The Trust is looking forward to how it manages the impact of COVID19 on the Trust and the wider system. There is a significant consequence across the NHS in terms of: The decision making processes across the local system and wider NHS as that might see central direction to disinvest in some areas and to develop services (that may not be economically viable within the current funding regimes). The Trust is working with partners to ensure that it is a party to these discussions and that it is able to influence planning for the benefit of its patients and the wider population. The impact of an expected reduction in tax take on exchequer funding and the consequence for the NHS. The Trust is ensuring that it delivers services in the most effective manner whilst addressing the additional measures required relating to social distancing and heightened infection control measures. These measures have an adverse impact on patient flow and will increase the cost base of the Trust. The commissioning and funding of the direct

	treatment costs of COVID19 some of which are high cost and not currently commissioned.
Cyber security and data loss: Failure to ensure that our services are resilient to cyber-attack and that residual risks to resilience are managed.	As a result of the Operational response to COVID19 the Trust has seen an accelerated move into new ways of working with staff working remotely and a significant increase in services that are delivered through virtual platforms. These services are being reviewed and established with appropriate safeguards in place. We have reviewed implemented a new backup solution for our system and have migrated off legacy servers. We are minimising the risk of Cyber threat, ensuring that our Board and our staff are trained and alert to the risk of Cyber-attack. We have an agreed digital strategy and we are Lorenzo digital exemplar site. We have prioritised investment to ensure that no application is more than one version behind latest release in order to reduce our vulnerability to cyber risk and run routine patches. We have also: • Upgraded to Virtual storage • Employed a dedicated Cyber Security role • Implemented new firewalls • Improved our surveillance measures • Implemented 'user' friendly reporting • Introduced Windows 10 with Advanced Threat Protection

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.

The production of this section of the Annual Report has been constrained performance against NHS standards has been adversely affected by the operational response to COVID19. Further information will be provided in our Quality Report which will be published later in the year.

Meeting Specialist Healthcare Needs

2019/20 has been an exceptional year for Royal Papworth Hospital and the specialist services provided by our dedicated staff. Activity figures reflect the hospital move to the Cambridge Biomedical Campus and the associated ramp down and ramp up in activity. In addition levels of activity were affected by the COVID19 pandemic which resulted in a significant decrease in activity in March 2020.

The number of patient episodes seen at the hospital was 115,749 (2018/19: 120,963 including Private Patients) and the tables below provide a breakdown of this demand across our services.

Inpatients and day cases

	2019/20	2018/19	2017/18
Cardiology	7,771	8,839	8,790
Cardiac Surgery	1,905	2,385	2,391
Thoracic Surgery (incl PTE)	1,023	991	924
Respiratory Support and Sleep Centre	6,042	6,155	6,403
Transplant/Ventricular Assist Devices	643	675	698
Thoracic Medicine	5,162	4,579	4,658
Total	**22,546**	**23,624**	**23,864**

Outpatients

	2019/20	2018/19	2017/18
Cardiology	38,826	42,380	37,141
Cardiac Surgery	5,510	3,885	4,727
Thoracic Surgery	1,030	1,293	1,393
Respiratory Support and Sleep Centre	20,705	23,739	23,724
Transplant/Ventricular Assist Devices	3,487	4,168	3,820
Thoracic Medicine	23,645	21,874	21,440
Total	**93,203**	**97,339**	**92,245**

Control of Infection

MRSA bacteraemia and C. difficile infection rates*

Goals 2017/18	Outcome 2017/18	Goals 2018/19	Outcome 2018/19	Goals 2019/20	Outcome 2019/20	Goals 2020/21
No MRSA bacteraemia	3 MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia
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	Total for the year 1 (1 C.diff case still to be reviewed by the CCG)	We have not been given our trajectory at present
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	95.5%	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 will be published in our Quality Report.

Performance of Trust against selected metrics

Throughout 2019/20 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-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	90.47%	90.28%	89.89%	88.94%	89.10%	90.86%	91.20%	91.60%	91.17%	91.52%	90.78%	87.13%	90.25%
62 day cancer wait *	>85%	66.7%	62.5%	60.0%	50.0%	80.0%	80.0%	66.7%	44.4%	60.0%	87.5%	100%	71.4%	67.0%
31 day cancer wait	>96%	84.6%	84.6%	96.0%	100%	96.0%	100%	100%	94.4%	95.5%	100%	100%	100%	95.6%
6 week wait for diagnostic	>99%	99.30%	99.30%	99.23%	99.30%	99.05%	99.66%	99.67%	99.84%	99.44%	99.65%	99.70%	99.44%	99.47%
C. difficile (sanctioned)	Less than 5	0	0	0	0	0	0	0	0	1	0	0	0	1
Number of patients assessed for VTE on admission	>95%	97.00%	90.00%	93.00%	97.00%	93.33%	90.00%	97.00%	100.00%	93.00%	97.00%	97.00%	96.60%	95.5%.

In 2019/20 these indicators have not been subject to independent assurance.
*The definition of this indicator can be found in Annex 4 to the Quality Report (to be published by 15 December 2020).

Care Quality Commission (CQC)

The last CQC inspection was undertaken in June & July 2019. The rating of the trust improved and it received an overall rating of Outstanding. It was rated it as outstanding because:

- Safe effective, caring, responsive and well-led were rated as outstanding at core service level.
- Medical care, surgery and diagnostic imaging were rated as outstanding overall.
- Critical care and outpatients, were rated as good overall.
- The rating reflected the previous inspection for end of life care services which was rated as good overall.

The aggregated rating for well-led at core service level was outstanding and the CQC rated well-led at trust-wide level as outstanding. When aggregated with the core services, this gave a rating of outstanding for the overall trust.

This outstanding achievement is a reflection of the dedication of the staff at RPH to get it right first time and every time for the patients within their care. RPH has a commitment to work in an open and transparent way with staff and patients and takes engagement very seriously ensuring that we continuously learn and develop.

There were areas identified in which Royal Papworth Hospital could improve and action plans have been put in place to address these.

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:

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

The full inspection report is available at https://www.cqc.org.uk/provider/RGM/reports

Patient Safety Incident Trends and Actions

There were a total of 3,571 patient incidents reported during the financial year compared to 2,628 in the previous year; an increase of 943 reports. In 2019/20 there were 3,066 actual incidents reported (2,278 in 2018/19) and 505 near miss incidents (350 in 2018/19).

There has been some fluctuation in the number of patient safety incidents reported during the financial year. Over the last 12 months the number of incidents graded as near miss (14%), and no/low harm (84%) 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 Serious Incident Executive Review Panel (SIERP).

The level of investigation carried out after a patient safety incident is determined by its severity. 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). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and monitored by the QRMG. Lessons learnt are shared across the organisation via the quarterly Lessons Learnt report on the intranet, local dissemination via Divisions and specialist meetings.

As at 29/04/2019 not all incidents for 2019/20 have been finally approved and grading confirmed for Q4 2019/20.

2019 National Adult Inpatient Survey

Royal Papworth Hospital performed very well in the latest National Inpatient Survey with an overall response rate of 60% (against an average of a 45%). Our survey results were better than most in 44 questions and about the same as other Trusts in 17 questions. There were no questions where our results were worse than most Trusts. Since the 2018 survey there were 17 questions in which responses were significantly higher and one in which responses was significantly lower.

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 2019/20 and this standard was not achieved. In year the Trust has experienced increased delays in access to PET CT and histology pathways and has worked with partners to identify and address delays.

Financial Review 2019/20

This part of the Annual Report provides a review of the financial performance for the year ending 31 March 2020.

Summary of financial performance

As at 31 March 2020, the Trust had delivered the following performance:

	Plan	Year end
EBITDA *	£15.0m	£14.3m
Year-end surplus	£11.6m	£2.3m
Cash Balance	£9.8m	£16.7m
Use of resources rating	3	3

*Earnings Before Interest, Tax and Amortisation

- The year-end surplus of £2.3m is below plan of £11.6m, by £9.3m due to the delayed sale of the old hospital site.
- The capital programme spend was £0.7m lower than plan due to £0.5m prior year adjustments relating to New Papworth equipping programme, and a further £0.2m due to underspends on 2019/20 projects
- The cash balance of £16.7m was favourable to plan by £6.8m due to lower capital expenditure, improved working capital position and the impact of the delayed land sale.

2019/20 Income by Commissioner and Service

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

2019/20 Income by Commissioner

	£'000
NHS England	107,160
Cambridgeshire and Peterborough CCG	13,674
West Suffolk CCG	4,093
West Norfolk CCG	2,990
Ipswich & East Suffolk CCG	1,347
Bedfordshire CCG	2,155
East and North Hertfordshire CCG	1,313
South Lincolnshire CCG	1,393
West Essex CCG	1,349
Other CCGs	4,418
Other NHS	2,780
Private patients	6,676
Other non-NHS	426
Total patient service income	**149,774**

2019/20 Income by Service

	£'000
Admitted patient care	
Cardiology	28,421
Cardiac surgery	25,437
Thoracic surgery	12,395
Respiratory Support and Sleep Centre	7,799
Transplant/Ventricular Assist Devices	18,793
Thoracic Medicine	12,831
Clinical and diagnostics	17,097
Total Admitted Patients	**122,774**
Outpatients	
Cardiology	5,093
Cardiac surgery	797
Thoracic surgery	201
Respiratory Support and Sleep Centre	3,657
Transplant/Ventricular Assist Devices	2
Thoracic Medicine	3,205
Diagnostics	3,439
Total Outpatients	**16,393**
Agenda for Change (pay award central funding)	
MFF (inpatients and outpatients)	6,825
Additional pension contribution central funding	3,782
Grand total (Inpatients and Outpatients)	**149,774**

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 Fopundation 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.

Stephen Posey
Chief Executive and Accounting Officer
17 June 2020

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 2019/20 financial year. No political donations were made in previous years.

Cost allocation and charging

During the year 2019/20, 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 2019/20 87.8% (2018/19 86.6%) of non-NHS invoices were settled within 30 days of invoice date and 73.9% (2018/19 69.9%) of NHS invoices. The Trust paid £0 (2018/19 £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 2019/20 was greater than the income from the provision of goods and

services for any other purposes. Private patient income was £6.68m (£8.12m 2018/19) or 6.45% (5.4% 2018/19) of total patient income.

Quality and Risk

Quality Strategy

Our Quality Strategy 2019-2022 builds on the foundations and achievements of previous Trust strategies. We have made excellent progress over the past three years and our 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. The strategy reflects the Board commitment to the Culture and Leadership Programme co-designed between NHS Improvement and the Kings Fund, phase one of this programme was completed in 2019 and the Trust is implementing phase two of the programme in 2020/21 and this will 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 month 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.

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 for Quality and Innovation (CQUIN) framework

A proportion of Royal Papworth Hospital NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Royal Papworth Hospital NHS Foundation Trust and NHS Commissioners, through the Commissioning for Quality and Innovation payment framework.

Further details of the 2019/20 national Specialised and non-specialised CQUINs are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/.

Due to the COVID19 pandemic, guidance was issued from NHSE/I that providers would not be required to submit Q4 CQUIN evidence. The guidance further advised that a pragmatic approach be taken to agreement of 2019/20 total achievement. Confirmation has been received that CCG CQUIN has been achieved at 99% and NHSE at 100%.

The amount of income available in 2019/20 conditional on achieving quality improvement and innovation goals was £1,132k. (2018/19: £2,650k). The amount expected to be achieved is £1,127k (2019/20: £2,560k (97%)).

Commissioning quality priorities 2019/20

The Commissioning Quality Priorities for 2019/20 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 2019/20 were as follows:

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

Commissioning quality priorities 2020/21

Further details of the NHSE specialised 2020/21 CQUIN schemes and 2020/21 non-specialised CCG will be included in the Quality Report which is due to be published later in the year.

Royal Papworth Hospital's Quality Account Priorities 2019/20

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

Further information will be included in the Quality Report.

The Trust's quality priorities 2020/21

To determine priorities for 2020/21 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 2020/21 reflect the domains of quality improvement and patient safety; clinical effectiveness and responsiveness; patient experience, and well led. They are:

- Quality Improvement & Patient Safety: QI Culture and using the SCORE
- Effective and Responsive services: Same day admissions; frailty; Length of Stay
- Well led: Culture and Leadership; STP leadership
- Patient experience: Communications; diabetic standards

Further information will be published in the Quality Report.

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.

In 2019 the Trust had a CQC Well Led review and was rated as Outstanding as a result of that review. However we recognise that there are still areas of improvement that we would want to focus on in particular improving our staff engagement and Workforce Race Equality Standard measures. In 2019 we introduced a new Board Performance Review framework and a Board development programme.

We have a Fundamentals of Care Board which oversees 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 multisource feedback, however as a truncated process was followed for 2019/20 this not included in all reviews in this year.

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 undertaken in November 2019 and is available at:

https://digital.nhs.uk/data-and-information/publications/statistical/patient-led-assessments-of-the-care-environment-place/england---2019

Further information will be available in the Quality Report.

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 has Patient and Carer Experience Group with membership and including patient and support group representatives and representation from Healthwatch. The PCEG group met on several occasion during the year and are represented on the PPI Committee.

The Trust continued in the last year 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.

The Cambridge Group of the BCPA closed in February 2019 and marked this with a donation for landscaping of the pond at our new hospital. The national group has also told us it is also in the process of closing in 2020 and has made a further donation to the Heart and Lung Research Institute.

Further information will be available in the Quality Report.

Complaints Handling

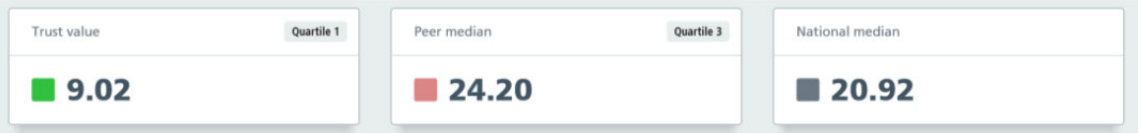
Listening to the patient experience and taking action following investigation of complaints is an important part of our quality improvement framework. In 2019/20 Royal Papworth Hospital received 74 formal complaints from patients. Of the 74 complaints reported (39 inpatient and 35 outpatient complaints) 70 related to NHS provided services and four 4 complaints related to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has increased from the numbers received during the previous year when 54 complaints were received (a 37% increase from 2018/19).

All formal complaints are subject to a full investigation, and throughout the year service improvements have been made as a result of analysing and responding to complaints. Not all complaints are upheld following investigation out of the 74 complaints received in 2019/20 55% were upheld or partly upheld following investigation (2018/19: 70%). The communication and information category continues to be one of the highest reasons for complaints from patients and/or families. However in 2019/20, we have seen an increase in the number of complaints associated with clinical care/clinical treatment with 37% of complaints received related to concerns regarding clinical waiting times, medical care, treatment, diagnosis and/or outcome.

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.

The Trust uses the Model Hospital Metric to bench mark the numbers of formal complaints. This is calculated by the number of written complaints made by or on behalf of patients about an organisation per 1000 staff (WTEs). This is reported monthly as part of the Papworth integrated Performance Report (PIPR). The overall Trust value for this metric is well below the peer and national median and the latest data from Model Hospital demonstrates that we are in the lowest quartile from National comparison.



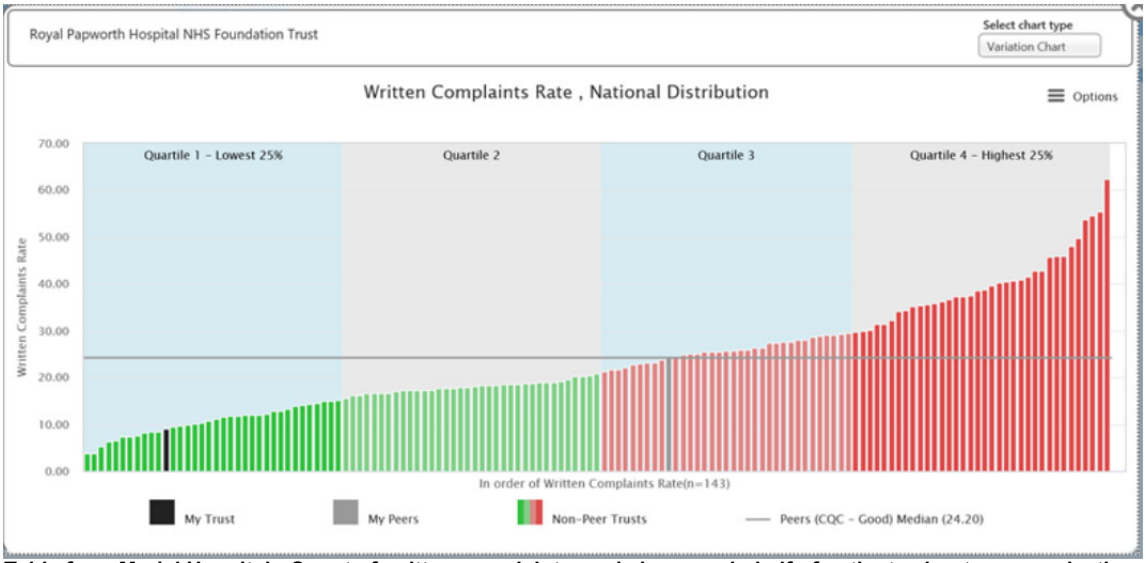


Table from Model Hospital: Count of written complaints made by or on behalf of patients about an organisation per 1000 staff (WTEs) - December 2019

Further Information on listening to the patient experience and complaints will be available in our Quality Report.

Other Highlights of 2019-20

Registering our new hospital with the Care Quality Commission (CQC)
The CQC undertook a registration visit for our new hospital be registered and were very impressed at the in-depth knowledge, pride, engagement and enthusiasm of all the people they met. They saw numerous examples of best practice and witnessed first-hand a comprehensive understanding of our cutover and transfer plans. The CQC described their time at Royal Papworth Hospital as incredibly positive and noted that it was a pleasure for them to spend time with our people.

Cath Lab team prepare for move with scenario training day
Royal Papworth Hospital and air ambulance charity Magpas came together on Saturday 13 April to trial the emergency heart attack pathway at our new hospital. The Magpas Air Ambulance landed at the Cambridge Biomedical Campus with an intubated and ventilated mannequin patient on board, accompanied by a concerned “relative”. The “patient” was then

transferred into one of Royal Papworth's new cath labs in a land ambulance via the dedicated route for emergency admissions.

The Hospital move
On Tuesday 23 April Royal Papworth Hospital began its move to the new hospital on the Cambridge Biomedical Campus. Over three weeks, services gradually closed at our old site in Papworth Everard and opened in our new hospital. Patients started to be admitted to the new hospital on Wednesday 1 May. Four operations took place on the first day of activity (Wednesday 1 May) – two thoracic cases and two cardiac cases – as well as eight procedures in Cath Labs. One of the first cardiology patients to be treated was fitted with four stents after suffering from angina, and the patient was well enough to be sent home later the same day.

Moving a hospital 16 miles down the road was a complex task and involved the dismantling, packing and unpacking of theatres, cath labs, critical care, and multiple ward areas, with more than 150 of the approximately 300 beds in the new hospital transferring from the old site. The move was completed two days ahead of plan on 7 May 2019.

We would like to note our thanks and praise the professionalism and care of the East of England Ambulance Service and Amvale, who ensured that our patients were safe and comfortable during the 16-mile journey to our new hospital.

Decommissioning and disposal of our old site
Our old buildings have been decommissioned pending sale of the site and handover to a future buyer. Security teams have remained on site throughout 2019/20. We know the future of our old hospital site is very important for those living and working in Papworth Everard. This is why over the year, we have kept local councillors, the Parish Council and residents up to date when we had news that we were able to share. We have not achieved the planned land sale in 2019/20 and will pursue this in 2020/21. Ahead of the land sale, we will be continuing to work with other public sector organisations such as Cambridgeshire Constabulary and Cambridgeshire Fire and Rescue Service to allow them to undertake training exercises on the site.

Royal Papworth Garden Party and Royal Papworth House first anniversary
As a thank you to all the staff who helped deliver the successful move, Royal Papworth Hospital Charity funded and organised (with support from colleagues in Communications and Workforce) a Garden Party with refreshments, music and a souvenir for every member of staff. This was held in The Green and The Gardens at the new site. It was wonderful to see so many staff enjoying the atmosphere and the sunshine together. There were also celebrations in Huntingdon to mark one year since the opening of Royal Papworth House, with a quiz, a buffet lunch and a 'Bake Off' competition.

Organ donation Service of Remembrance at Ely Cathedral
Our staff attended a special service to remember and give thanks to organ donors in May. The 'East Anglian Regional Transplant Service of Remembrance and Thanksgiving' was held at Ely Cathedral on Sunday 19 May. Staff from Royal Papworth Hospital's transplant team attended, along with one of our patients who lit a candle as part of the service.

STP Digital Enabling Group (DEG)
In May 2019 the DEG appointed Andy Raynes, Chief Information Officer at Royal Papworth as the new Chair of the STP digital group. The meeting comprises membership of Digital Leaders from across the community from Primary Care, LA and Trusts including partners at the SDU and EAHSN. The focus of the group is to drive the business case for resources and the delivery of the Local Health Care Record.

STP Joint Clinical Group
Josie Rudman was appointed as Vice Chair of the STP JCG. This is a subgroup of both the CCG and STP and replaces the Clinical Senate in the new CCG governance structure. This group provides a single clinical senior leadership forum across the STP and the membership and purpose allows for the JCG to have greater influence on the local NHS system than the current CAG by having Executive Clinical Director membership.

Medical Examiner Role
Dr Ellie Makings was appointed as our new Medical Examiner (ME). MEs roles are a new to the NHS, aiming to improve the quality of death certification, supporting the coronial system and improving the standard of family liaison. Ellie has been part of the pilot programme for the medical examiner system in Essex and has recently established a comprehensive service in Norfolk.

Clinical Reference Group Appointments
Mr David Jenkins and Dr Alain Vuylsteke have been successfully appointed to Clinical Reference Groups in Cardiac Surgery and in Adult Critical Care. These groups are very important in informing the NHS on the shaping of services and their membership means that Papworth continues to set the terms for future clinical strategy.

Culture and Leadership Programme
Early in 2019 the Trust Board approved the implementation of a Culture and Leadership Programme to review the prevailing culture of the organisation and to support the development of a leadership strategy to ensure that we consistently maintain a high quality care culture. This programme is based on extensive research with healthcare organisations undertaken by Professor Michael West, and has been co-designed by the Kings Fund and NHSI. This programme has three phases with the first one being diagnostic which was completed in 2019 with over 200 staff members interviewed as part of 36 focus groups. The Charity has approved funding to support the second phase of this programme in 2020/21.

Papworth Haemostasis Checklist: Improving patient care and saving money
Royal Papworth Hospital's surgical team has been nominated for a national patient safety award, thanks to the impact of the Papworth Haemostasis Checklist. The 21-bullet point list outlines a number of checks to be performed at the end of cardiac surgery. The whole process, if everything is ok, takes only a couple of minutes. It was designed to reduce the amount of bleeding and the number of patients who need to return to theatre after surgery, in turn reducing a patient's length of stay in hospital and improving their outcome.

Official Opening of Royal Papworth Hospital
On Tuesday 9 July, we were incredibly proud to have Her Majesty The Queen officially open our new hospital. As part of the ceremony, Her Majesty met with staff and patients throughout the hospital and visited some of our start-of-the-art facilities, including a bronchoscopy suite, cath lab and the Critical Care Unit, which is one of the biggest specialist intensive care units in the UK.

Accompanied by HRH Duchess of Gloucester, Patron of Royal Papworth Hospital, The Queen met with teams from respiratory, cardiology, surgery and nursing, Her Majesty also spoke to recent and former patients.

The Queen unveiled a plaque at the end of the tour, which proudly stands inside the main atrium of our hospital. Her Majesty was then waved on her way by staff, patients, members of the public and school children from Pendragon Community Primary School (Papworth Everard), Trumpington Park Primary School (Cambridge) and Stukeley Meadows Primary School (Huntingdon), to represent the three areas where the hospital has a presence; the old hospital, the current hospital and our corporate offices respectively.

Visit by the Chief Nursing Officer for England
On Thursday 18 July, we welcomed Dr Ruth May, Chief Nursing Officer (CNO) for England, to the new hospital. During her visit, Ruth presented three members of staff - Fiona Downie, Eamonn Gorman and Judy Machwenyika - with CNO Gold and Silver Awards for nursing excellence. The awards recognise individuals who go above and beyond the expectations of the job and serve as a way to say thank you on behalf of the nursing profession.

Fiona Downie, Consultant Tissue Viability Nurse, received the CNO Gold Award for her dedication to nursing, Royal Papworth and tissue viability care for many years. Eamonn Gorman, Chief Nursing Information Officer (CNIO) received a silver award for his work on the implementation of Lorenzo and for the dedicated support he provided for bedside nurses during the deployment of the system. Judy Machwenyika, Lead Advanced Nurse Practitioner received a silver award for her work supporting the Trust's equalities agenda.

Heart and Lung Research and Education Institute
In July 2019, Chris Skidmore, Minister for Universities, Science, Research and Innovation, announced a £30million award to the University of Cambridge to support the new Cambridge Heart and Lung Research and Education Institute (HLRI).

The award from the UK Research Partnership Investment Fund supports the HLRI along with the £10million funding committed to the institute by the British Heart Foundation (BHF). Further funding has been committee by the University, the Royal Papworth Charity and the Wolfson Foundation.

Building works commenced on the site next to Royal Papworth Hospital and are due to be completed by February 2022. The HLRI will be home to over 380 scientists and state-of-the-art laboratories in genomics, population sciences, research into cellular mechanisms of disease and translational science. It will also include a special ten bed facility where the first-in-patient studies of new treatments can be conducted.

Organ Donation and Transplantation Activity Report
New figures published by NHS Blood and Transplant show a record 1,600 people in the UK donated their organs after they died; saving or improving the lives of 3,941 transplant recipients. At Royal Papworth, teams performed more adult heart, heart-lung or lung transplants than any of the five other UK centres, with 88 organs transplanted (45 heart and 43 lung), which represents more than a quarter of the total cardiothoracic adult transplantation programme.

In September 2019 during Organ Donation Week, Royal Papworth Hospital NHS Foundation Trust and NHS Blood and Transplant urged people to talk to their families about organ donation to increase the number of lives that can be saved or transformed by an organ transplant. This year, the law around organ donation is changing in England. Known as Max and Keira's Law, from spring 2020, all adults in England will be considered as having agreed to donate their own organs when they die unless they record a decision not to donate or are in one of the excluded groups.

Inpatients experience at Royal Papworth as among the best in country
The Trust has been listed as one of the best-performing hospitals in the country for inpatient experience, according to a new report. The Care Quality Commission's (CQC) 2019 Adult Inpatient Survey looked at the experiences of adult inpatients across 143 NHS trusts. Patients at Royal Papworth experienced care that was 'better than the expected range' in 72% of the questions.

Cancer patients highly rate care at Royal Papworth
Royal Papworth Hospital has been rated one of the best hospitals in the country for its cancer care. In the 2018 National Cancer Patient Experience Survey, the Trust received an overall

score of 9.3 out of 10 and scored highly across a range of criteria including 92% of respondents said that, overall, they were always treated with dignity and respect while they were in the hospital.

Digital Update
Digital teams from Papworth and CUH have delivered another UK first, successfully connecting Epic Histopathology to Lorenzo enabling CUH laboratory staff to report on our samples in real time. The Trust also commenced its 16 month Digital Exemplar journey with road-shows taking place throughout the Trust September and October to showcase and help staff get the most out of the new hospital tech and learn about our exciting plans to be a Lorenzo digital exemplar.

Royal Papworth recruits 500th LuCID study patient
Our thoracic oncology research team has celebrated a big milestone, with the 500th participant recruited to the LuCID study. The Lung Cancer Indicator Detection (LuCID) study is examining whether exhaled breath can be used to diagnose lung cancer at an earlier stage. The first Royal Papworth patient joined the study in January 2016, and people will continue to be recruited until the end of 2020. The 500 Royal Papworth participants are part of 2,300 across Europe, with capacity to recruit up to 4,000.

Marking 40 years since the UK's first successful heart transplant
Forty years on from the UK's first successful heart transplant at Royal Papworth Hospital, the surgeon and the patient's son have been reunited. The operation was performed by Sir Terence English on 18 August 1979, with the 52-year-old patient Keith Castle living for more than five years post-transplant.

Sir Terence and Keith Castle Jr met at Royal Papworth's new hospital on Monday 19 August to mark the 40th anniversary of the pioneering transplant.

The first three heart transplants in the UK took place at the National Heart Hospital in London in 1968 and 1969, but the patient's only lived for a matter of weeks. With survival rates not improving, a moratorium was placed on heart transplantation. Ten years later, in 1979, Sir Terence began the transplant programme at Royal Papworth, and whereas the patient from the hospital's first heart transplant in January lived for just a few weeks, the next attempt in August saw Mr Castle discharged from hospital by the end of October before going on to live for five years post-transplant.

Royal Papworth wins 'Best Heart and Lungs Hospital' at Transplant Games
The Royal Papworth Transplant Sport team has once again emerged victorious in the British Transplant Games, with a total of 59 medals. It is the fourth year in-a-row that the team has claimed the 'Best Heart and Lungs Hospital' award at the Games, which this year were held in Newport from 25-28 July. Led by team manager Maggie Gambrill, it was the biggest-ever squad that the hospital has taken to the competition, with 37 athletes (including 11 new members) claiming 25 golds, 21 silvers and 13 bronzes between them.

2019 World Para Swimming Championships
Staff also cheered on Sgt. Elizabeth Marks at London 2019 World Para Swimming Championships. Some of the Critical Care team that looked after Paralympic swimmer Sgt. Elizabeth Marks at Royal Papworth Hospital in 2014 were invited to surprise her and cheer her on at the London 2019 World Para Swimming Championships, where she won gold in the S7 100m backstroke.

Royal Papworth Hospital rated 'Outstanding' by Care Quality Commission
On Wednesday 16 October The Care Quality Commission (CQC) announced that it had rated Royal Papworth Hospital NHS Foundation Trust as 'outstanding' overall, and across all five of the CQC domains; safe, caring, effective, responsive, and well-led. This was the first time

ever that an NHS hospital trust achieved an ‘outstanding’ rating across the five key questions that the CQC asks when it inspects hospitals. We were also the first NHS acute Trust to have gained an ‘outstanding’ rating in the ‘Safe’ category. The inspection took place in June and July, with a previous inspection in 2014 having rated the hospital as ‘good’.

In the report, the inspectors commended the hospital’s care and treatment of patients as well as the leadership and learning culture that exists at the hospital to deliver the best possible outcomes for patients.

To have been rated as ‘outstanding’ in all five CQC domains only two months after moving into our new building was testament to our skilled and dedicated staff whose work has created a culture which delivers the best possible care for our patients. The Board remains immensely proud of what was achieved and we thank all staff for their ongoing efforts and extraordinary commitment to the Trust.

Digital update
The Topol report (2019) identified a gap in current qualification, skills and knowledge of the Digital Workforce across the NHS. As part of an initiative to address this, the new CIO Topol 5 Leadership Programme at Royal Papworth aims to utilise part of our education budget to award five candidates from across the Trust with professional awards and training in Digital.

Allied Health Professional of the Year awards
There were over 140 nominations from across the hospital and a huge amount of interest regarding AHP day, which really helped meet our aim of raising awareness of the role of AHPs in the Trust and the unique and essential skills they provide to our patients. The AHP of the Year award was awarded to Occupational Therapist, Sarah Pethurst, for being an understated champion and advocating for the patient in all she does. She is supportive of her own and other teams and goes above and beyond to find out how she can best connect with her patients. She is innovative, always with the patient at the heart, and continues to develop professionally and in her own confidence.

Cell salvage: Returning a patient’s own blood during surgery
Royal Papworth Hospital's patients are benefiting from a technique that sees them receive their own blood back during cardiac, thoracic and transplant surgery.

Blood saves lives; it is a lifeline in an emergency, is vital in surgery and is essential for people on long-term treatments. That means we need donors from all backgrounds and blood types to ensure the right blood is available for patients who desperately need it.

However, there is a national shortage. Nearly 400 new blood donors are required each day to meet demand and around 135,000 needed each year to replace those who can no longer donate. Therefore, it is critical to make the best use out of the blood that we do have available. Cell salvage is a technique that does just that. It is the process of collecting all blood that is lost from the beginning of surgery, allowing patients to receive their own blood back during surgery. The chance of then needing bank blood is much reduced, although may still be necessary if some blood can’t be collected or bleeding is happening too quickly. Cell saver machines are run by perfusionists who are the specialists on the equipment.

Current strategy for international partnerships
Following guidance and advice from the Department of International Trade, the Trust has been focussing on growing its presence in the Asian markets, primarily Malaysia and China. The Trust has continued with its approach of establishing meaningful and trusted partnerships through first offering consultancy by our expert team, followed by educational opportunities with the possibility of long-term partnerships for those organisations that closely align to Royal Papworth’s vision and values.

Pioneering lung cancer surgery
This year we saw significant interest in pioneering non-intubated subxiphoid pneumonectomy (lung removal) performed at the hospital late last year. This procedure led to a great deal of media interest in the procedure which reached more than 20 million people across the world. I would like to thank Royal Papworth surgeon Mr Giuseppe Aresu, consultant anaesthetist Chinmay Patvardhan as well as our patient who all gave up their time to help raise awareness of this minimally-invasive surgery.

COVID19 Pandemic

Royal Papworth Charity COVID19 Appeal
We are extremely grateful to the public and business community for their support for the Royal Papworth Hospital Charity Appeal. Money raised is being used to fund the provision of food, drink and other items such as hand cream to staff working exceptionally hard at the moment. Funds will also be used towards psychological support for staff whose emotional wellbeing has been affected by the COVID19 crisis. The Trust would particularly like to thank members of the public who have supported the hospital by sewing scrubs for our staff members, given the increased number of staff who are wearing scrubs during the response to COVID19.

Long-term inpatient receives transplant during COVID19 outbreak
Despite the COVID19 outbreak, our Transplant team was able to carry out two transplants in April, which is a real tribute to their commitment to our transplant patients. One patient had been an inpatient at Royal Papworth for five months and had undergone eight surgeries before receiving his transplant. He is now recovering at home with his wife and two young children.

Media activity
In the last month, Royal Papworth Hospital has featured several times in the media, including two reports on BBC Look East about the hospital's response to the COVID19 outbreak and our concerns about urgent and emergency patients being too anxious to come to hospital. The Telegraph and other outlets also reported that the family of Professor Stephen Hawking had donated a ventilator the hospital, and the diary of one of our critical care doctors, Dr Chinmay Patvardhan, was published by The Sun. We have worked to keep our patients and the public updated with news from the hospital in the local media and via our website and social media channels.

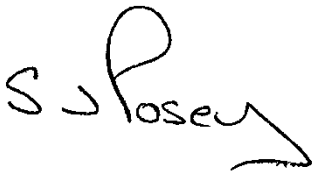
Anniversary of hospital move
Friday 1 May marked exactly a year since we began treating patients in our new hospital. This time last year, we could never have predicted that we would find ourselves at the centre of a global pandemic one year on. However, there is no doubt that our experience of moving a hospital and managing an ongoing 'command and control' centre has proved useful in recent weeks. The design of our new hospital – with its single patient rooms, air ventilation system and flexible layout – has been incredibly helpful in managing a highly infectious, airborne disease. Most importantly, our fantastic staff – who worked so hard to deliver a safe and successful move last year – have again shown their extraordinary commitment in responding to the challenges of COVID19. Our catering provider, OCS, baked 1,000 cup cakes to recognise our anniversary, and staff welcomed the messages from many patients who had sent in messages of support. The last 12 months will no doubt be remembered as a historic year for all of us at Royal Papworth Hospital.

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 2019/20 and our new Chief Finance and Commercial Officer:

Name	Title
John Wallwork	Chairman
Jag Ahluwalia	Non-Executive Director (from 1 November 2019 and designate NED from 1 September 2019)
Michael Blastland	Non-Executive Director
Cynthia Conquest	Non-executive Director (and Senior Independent Director from 20 November 2019)
David Dean	Non-executive Director
David Hughes	Non-executive Director and Deputy Chairman (to 31 October 2019)
Susan Lintott	Non-executive Director and Senior Independent Director (to 31 October 2019)
Nick Morrell	Non-executive Director (to 31 December 2019)
Gavin Robert	Non-Executive Director (from 1 November 2019 and designate NED from 1 September 2019)
Ian Wilkinson	Non-executive Director (from 1 January 2020)
Stephen Posey	Chief Executive
Roy Clarke	Chief Finance Officer (to 31 March 2020)
Roger Hall	Medical Director
Eilish Midlane	Chief Operating Officer
Oonagh Monkhouse	Director of Workforce and OD
Josie Rudman	Chief Nurse
Andrew Raynes	Director of Digital and Chief Information Officer
Tim Glenn	Chief Finance and Commercial Officer (from 14 April 2020)



Stephen Posey
Chief Executive and Accounting Officer
17 June 2020

2.2 Remuneration Report

During 2019/20 there were a number of changes to the Non-executive Directors (NEDs) on the Board. Three NEDs came to the end of their terms of office and three NEDs were appointed to the Board. The Trust Chair had their term of office extended by twelve months to provide continuity through the hospital move and to support the delivery of the Heart and Lung Research Institute.

NED appointments were subject to advertisement and recruitment processes agreed through the Appointments Committee of the Council of Governors.

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 2020.
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.
Diversity and inclusion	All senior managers	Remuneration Committee	Delivery of the NHS Workforce Race Equality Standard aspirational goals	WRES aspirational goals in TOR and reflected in the recruitment process.

Accompanying notes:

(1) There have been no additions or changes to the components of the remuneration package paid during 2019/20
(2) There are no significant differences in 2019/20 between the remuneration policy for senior managers and the general policy for employees' remuneration
(3) The remuneration policy for 2019/20 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. The procedure for determining the remuneration has been revised to bring it in line with the national guidance issued by NHS England and NHS Improvement 'Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts' in November 2019.
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 2019/20

		First Appointed	Re-appointed From	Expiry/End of Term of Office
John Wallwork	Chairman	1 Feb 2014	1 Feb 2017 31 Jan 2020	31 Jan 2021
Jag Ahluwalia	Non-executive Director	1 Nov 2019	-	31 Oct 2022
Michael Blastland	Non-executive Director	22 Mar 2019	-	31 Mar 2022
Cynthia Conquest[1]	Non-executive Director	1 Jan 2019	-	28 Feb 2021
David Dean	Non-executive Director	1 Nov 2018	-	31 May 2020
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
Nick Morrell	Non-executive Director	1 Jan 2014	1 Jan 2017	31 Dec 2019
Gavin Robert	Non-executive Director	1 Nov 2019	-	31 Oct 2022
Ian Wilkinson	Non-executive Director	1 Jan 2020	-	31 Dec 2022
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 (31 Mar 2020)
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

1 Cynthia Conquest's original term was stated incorrectly in the 2018/19 Annual Report. This has been corrected.

Attendance of Non-executive Directors at Executive Remuneration Committee Meetings

Name		13/06/19	05/12/19
John Wallwork	Chairman	✓	✓
Jag Ahluwalia	Non-executive Director		×
Michael Blastland	Non-executive Director	✓	✓
Cynthia Conquest	Non-executive Director	✓	✓
David Dean	Non-executive Director	×	✓
Dave Hughes	Non-executive Director	✓	
Susan Lintott	Non-executive Director	×	
Nick Morrell	Non-executive Director	×	×
Gavin Robert	Non-executive Director		✓
Ian Wilkinson	Non-Executive Director		

✓ Attended meeting × 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	19/06/19	20/11/19
Janet Atkins	Public	✓	✓
Barry Crabtree-Taylor	Public	✓	
Richard Hodder (Chair and Lead Governor)	Public	✓	✓
Glenn Edge	Public	✓	✓
Rob Graham	Public	✓	
Keith Jackson	Public	✓	✓
Graham Jagger	Public	✓	
Cheryl Riotto	Staff	×	✓
Alessandro Ruggiero	Staff	×	✓

✓ Attended meeting × Apologies received Not a member

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 2019/20 of £15,646 (2018/19: £19,550). Expenses to the value of £13,650 (2018/19: £14,477) 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 (2018/19: 17) serving Directors. 9 (2018/19: 8) Directors received expenses.

Governors received expenses of £3,416 for 2019/20 of (2018/9: £3,260). Expenses are a reimbursement of amounts directly incurred in the performance of an individual Governor's duties.

At March 2020 the Council consisted of 26 (2018/19: 26) Governors and due to changes in the year there were a total of 32 (2018/19: 31) serving Governors. 8 Governors received expenses (2018/19: 7)

Remuneration Report (Audited Information)

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.

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

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

Table 1: Year ended 31 March 2020 (audited information):

Name and Title	Salary and Fees1 (bands of £5,000)	Taxable Benefits2 (total to the nearest £100)	All Pension-related Benefits (bands of £2,500)	Total (bands of £5,000)
	£'000	£	£'000	£'000
Prof. J Wallwork – Chairman	45 - 50	100	-	45 - 50
Dr J Ahluwalia – Non-executive Director[10]	5 - 10	-	-	5 - 10
Mr M Blastland – Non-executive Director	10 - 15	-	-	10 - 15
Mrs C Conquest – Non-executive Director	10 - 15	-	-	10 - 15
Mr D Dean – Non-executive Director	10 - 15	1,000	-	10 - 15
Mr D Hughes – Non-executive Director (to 31 Oct 2019)	5 - 10	300	-	5 - 10
Dr S Lintott – Non-executive Director (to 31 Oct 2019)	5 - 10	300	-	5 - 10
Prof. N Morrell – Non-executive Director (to 31 Dec 2019)	5 - 10	-	-	5 - 10
Mr G Robert – Non-executive Director[10]	5 – 10	-	-	5 - 10
Prof I Wilkinson – Non-executive Director (from 1 Jan 2020)	0 – 5	-	-	0 - 5
Mr S Posey – Chief Executive[8]	160 - 165	-	-	160 - 165
Mr R Clarke – Chief Finance Officer (to 31 Mar 2020)	130 - 135	-	15 – 17.5	145 - 150
Dr R Hall – Medical Director [6]	175 - 180	-	-	175 - 180
Mrs E Midlane – Chief Operating officer	115 - 120	-	5 – 7.5	120 - 125
Mrs O Monkhouse – Director of Workforce and OD	110 - 115	-	10 – 12.5	120 - 125
Mrs J Rudman – Chief Nurse	110 - 115	-	-	110 - 115
*Mr A Raynes (Advisory non-voting member)	95 - 100	-	25 – 27.5	125 - 130

Notes to Table 1

1. Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts;
2. Taxable Benefits relate to a taxable benefit on home to HQ travel;
3. No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus;
4. No compensation payments were made to past Executive or Non-executive Directors;
5. No Executive Director served as a Non-executive Director elsewhere;
6. Salary and Fees includes £33,944 relating to clinical duties and £36,192 relating to a Clinical Excellence Award;
7. No performance related remuneration was paid in 2019/20;
8. Includes a 10% non-consolidated/non pensionable element at risk of claw-back.
9. Salary includes back-pay relating to 2018-19 for Mrs E Midlane
10. Appointed as Designate Ned from 1 September 2019 and substantive from 1 November 2019
11. The pension-related benefit has been calculated using the information provided by NHS Pensions and the Greenbury guidance

Table 2: Year ended 31 March 2019 (audited information):

Name and Title	Salary and Fees[1] (bands of £5,000)	Taxable Benefits[2] (total to the nearest £100)	All Pension-related Benefits (bands of £2,500)	Total (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 (to 31 Oct 2018)	5 - 10	-	-	5 – 10
Mrs C Conquest – Non-executive Director (from 1 Jan 2019)	0 - 5	-	-	0 - 5
Mr D Dean – Non-executive Director[9]	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 (to 31 Oct 2018)	0 - 5	1,500	-	5 - 10
Prof. N Morrell – Non-executive Director	10 - 15	-	-	10 – 15
Dr R Zimmern – Non-executive Director (to 28 Feb 2019)	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

Notes to Table 2

1. Salary and other remuneration excludes the employer's pension contribution and is gross of pay charges to other NHS Trusts;
2. Taxable Benefits relate to a taxable benefit on mileage;
3. No payments were made in respect of 'golden hellos', compensation for loss of office or for an annual/long term performance related bonus;
4. No compensation payments were made to past Executive or Non-executive Directors;
5. No Executive Director served as a Non-executive Director elsewhere;
6. Salary and Fees includes £34,755 relating to clinical duties and £36,192 relating to a Clinical Excellence Award;
7. No performance related remuneration was paid in 2018/19;
8. Includes a 10% non-consolidated/non pensionable element at risk of claw-back.
9. David Dean served from 1 November 2018 & Designate NED from 1 August 2018
10. The pension-related benefit has been calculated using the information provided by NHS Pensions and the Greenbury guidance

Table 3: Pension Entitlements of Senior Managers 31 March 2020 (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 2020	Lump Sum at pension age Related to Accrued Pension at 31 March 2020	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020
	(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	0 – 2.5	-	40 - 45	85 - 90	630	0	667
Mr R Clarke – Chief Finance Officer	0 – 2.5	-	35 - 40	75 - 80	497	6	532
Dr R Hall – Medical Director	0 – 2.5	0 – 2.5	35 - 40	115 - 120	-	-	-
Mrs E Midlane – Chief Operating officer	0 – 2.5	-	40 - 45	95 - 100	762	11	807
Mrs O Monkhouse – Director of Workforce and OD	0 – 2.5	-	35 - 40	80 - 85	686	15	732
Mrs J Rudman – Chief Nurse	-	-	40 – 45	95 - 100	755	-	754
Mr A Raynes (Advisory non-voting member)	0 – 2.5	0 – 2.5	15 - 20	15 - 20	198	14	231

Notes to Table 3

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 2.4%;
5. In calculating the actuarial value of the CETV as at 31 March 2020 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 20083 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.
8. The CETV for R Hall is zero because member is over 60.

Table 4: 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

Notes to Table 4

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 20083 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 (audited information)

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.

	2019/20		2018/19
Band of Highest Paid Director's Total Remuneration (£'000)	175-180	Band of Highest Paid Director's Total Remuneration (£'000)	165-170
Median Total Remuneration	30,401	Median Total Remuneration	29,608
Ratio	5.84	Ratio	5.66

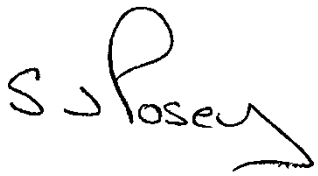
The mid-point of the banded remuneration of the highest paid Director in the Foundation Trust in the financial year 2019/20 was £177,500 (2018/19: £167,500). This was 5.84 times (2018/19: 5.66 times) the median remuneration of the workforce, which was £30,401 (2018/19: £29,608). 20 employees in 2019/20 (2018/19: 19) received remuneration in excess of the highest paid Director. Remuneration ranged from £184,310 to £395,389 (2018/19: £168,954 to £264,965).

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 2020. 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 2020. 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
17 June 2020

2.3 Staff Report

Recruitment and Retention

One of the Trust's most significant risks remains recruiting and retaining staff. There are local and national skills shortages, particularly in key groups such as registered nurses, cardiac physiologists and radiographer recruitment market in Cambridge is extremely competitive Since the move to the Biomedical Campus the Trust has seen some of the most significant organisational change in its history as a result of the move to our new sites and latterly as a result of the operational response to the COVID19 pandemic. This inevitably impacts on staff engagement and retention. In 2019/20 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. Since the move to the campus we have seen an improvement in our ability to recruit administrative and clerical staff and Healthcare Support Workers.

The Trust's 2020/25 Strategy sets out the following strategic workforce goal:

OFFER POSITIVE STAFF EXPERIENCE

We will seek to offer the best staff experience in the NHS, enabling staff to fulfil their potential by providing a working environment where they can feel valued for what they bring to the Trust, achieve a work life balance, and feel engaged in their work

Why is this goal relevant / important?

- Excellent and innovative patient care and outcomes can only be delivered by highly skilled, committed and caring staff
- Talent management, and developing and retaining our own talent, is essential to meet future skills requirements and providing rewarding careers for our staff
- We have an opportunity to be at the forefront of developing innovative roles and ways of working through co-operation with system and education providers, and with our partners on the campus
- Our position as a national and world centre for excellent and innovative cardiothoracic care can be a priceless asset in attracting the very best people; but it will only be effective if there is a foundation of good practice, strong culture and excellent support in place
- By sharing and collaborating with campus partners we can develop an increasingly attractive package for staff and enhance the experience of working here
- A strong, embedded culture of collective and compassionate leadership is the only way to develop and retain staff to deliver our world leading clinical services and outcomes
- A diverse and inclusive workforce means we better reflect our local and patient population and that we are accessing the widest pool of talent.

During 2020/21 we will continue to maximise the opportunities presented by our state of the art hospital and the positive media we attract as a result of our outstanding outcomes and CQC rating to attract staff. We have built effective working relationships with Cambridge University Hospital and undertake joint recruitment events on the campus and have combined our service coordinating and developing apprenticeship opportunities and engaging with schools and colleges on work experience programmes. As the Cambridgeshire and Peterborough STP develops we will increasingly look to develop system wide opportunities to attract and retain staff within the local health economy.

Staff Engagement, Consultation and Involvement

In 20/21 we focused on working with Staff Engagement Champions, the BAME Network and Staff side representatives to adapt our ways of working to the new environment and location. In 2019/20 we established a Staff Experience Committee we provide a coordinated approach to issues such as travel and transport, staff facilities, space allocation and office facilities. In 2019/20 we moved our monthly staff pulse survey to a quarterly one which has provided important staff feedback on concerns and levels of staff engagement. The weekly Staff Briefing meeting and electronic update continues to be an important vehicle for communicating with line managers and staff.

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 Compassionate and Collective Leadership programme.

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.

In 2019/20 we introduced Freedom to Speak up Champions who work with the Trust Freedom to Speak up Champion to provide an important route for staff to raise concerns and queries.

Valuing Staff/Celebrating Success

Demonstrating that the contribution of staff is recognised and valued is an important element of staff engagement. Sadly the 2019/20 Royal Papworth Staff Awards ceremony planned to take place in March 2020 had to be cancelled due to COVID19. We have developed an alternative approach that will enable us to celebrate the staff awarded in the various categories in a socially distanced way.

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

The Trust's Laudix system has grown in popularity as a way for staff and managers to say thank you to each other and to recognise good practice and staff going above and beyond. In 2019/20 there were 743 Laudix commendations made. A rollout of this initiative is planned through NHSI Innovation, with support from the Eastern Academic Health Science Network Innovation Exchange.

Staff Survey

As stated previously staff engagement is an important issue for the Trust. Having undertaken monthly staff surveys in the run up to the move we now undertake quarterly staff surveys 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 2019 the response rate from the Trust staff was 62%, 1,166 responses, which was above the average response rate of 58% for our peer group and a significant improvement on the 2018 response rate of 54%. This was an electronic survey open to all staff as had been the case in 2018.

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

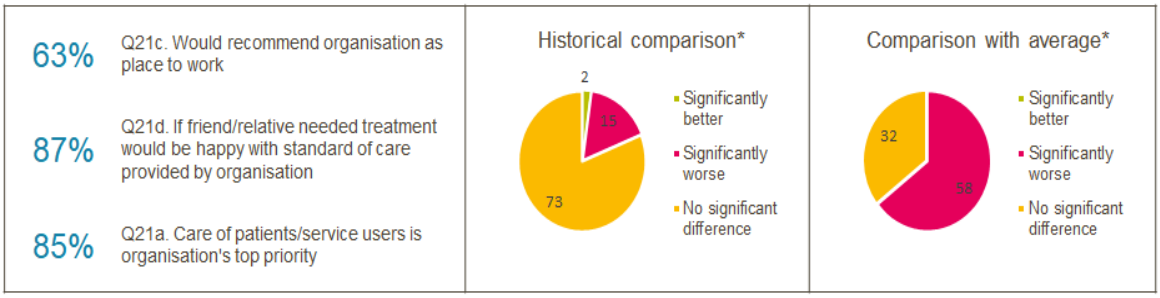
Scores for each indicator together with that of the survey benchmarking group, Acute Specialist Trusts, are presented below.

	2019/20	2019/20	2018/19	2018/19	2017/18	2017/18
	Trust	**Benchmarking Group (Nat)**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	**8.9**	**9.2 (9.0)**	**9.1**	**9.3**	**9.3**	**9.3**
Health and wellbeing	**5.8**	**6.3 (5.9)**	**6.0**	**6.3**	**6.3**	**6.3**
Immediate managers	**6.7**	**7.1 (6.9)**	**7.0**	**7.0**	**7.1**	**6.9**
Morale	**5.8**	**6.4 (6.2)**	**5.8**	**6.3**	**n/a**	**n/a**
Quality of appraisals	**5.6**	**5.8 (5.6)**	**5.4**	**5.7**	**7.4**	**7.7**
Quality of care	**7.4**	**7.9 (7.5)**	**7.4**	**7.8**	**7.4**	**7.7**
Safe environment – bullying and harassment	**8.1**	**8.3 (8.0)**	**8.2**	**8.2**	**8.4**	**8.4**
Safe environment – violence	**9.6**	**9.8 (9.4)**	**9.7**	**9.7**	**9.7**	**9.7**
Safety culture	**6.9**	**7.0 (6.8)**	**6.8**	**6.9**	**6.9**	**6.9**
Staff engagement	**7.1**	**7.5 (7.0)**	**7.2**	**7.4**	**7.3**	**7.4**
Team Working	**6.5**	**6.9 (6.6)**				

In 2019 our scores are below average compared to our peers and are below the national average in 7 themes:

- Equality, diversity and inclusivity
- Health and welfare
- Immediate manager
- Morale
- Quality of appraisals
- Safe environment: bullying and harassment
- Safe environment: violence

The comparison of our 2019 results with our results in 2018 is as follows:



There was a statistically significant reduction in our scores from last year in 3 themes:

- Equality, diversity and inclusivity
- Immediate managers
- Staff engagement

We improved scoring in two themes:

- Quality of Appraisals
- Safety Culture

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

- Morale
- Quality of care

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

- Health & wellbeing
- Safe environment: bullying and harassment
- Safe environment: violence
- Staff engagement
- Team working

The impact of the organisational change associated with the relocation of the hospital and staffing challenges has undoubtedly influenced the deterioration of scores across a range of questions. In particular responses to questions concerning staff feeling in control in their way of working, having sufficient staffing levels and feeling enthusiastic about their job have deteriorated since last year. The breakdown of responses by Directorates/Divisions indicates that Clinical Support Services, which incorporates Critical Care, and Digital Services are most negative against the total Trust average and Ambulatory Care is consistently in the top scoring areas across a range of themes.

The results have been shared with staff and leadership teams and the Compassionate and Collective Leadership Programme will be the main vehicle for addressing the areas highlighted in the responses. There is a high degree of overlap between the priority areas identified in Phase 1 of the Programme and the themes in the survey responses.

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 the Compassionate and Collective Leadership Programme.

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 2019/20 was 70 (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.

In 2019/20 we established a Disability Network to engage with staff with a disability or who have an interest in improving the working experience of staff with a disability. This Network will support the Trust with developing and implementing the Workforce Disability Equality System (WDES) action plan.

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 85% of front line staff received flu vaccinations, which was an improvement from the previous year (84%). 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 2019/20 we commissioned the provision of an Employee Assistance Programme from Health Assurance which provides staff and their families with access to support and advice on a wide range of subjects such as mental health and finances. 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 2020, of whom ten were male and four were female.

	Female	Male	Total
Directors (includes Non-executive Directors)	4	10	14
Senior Managers (as per occupation codes)	23	11	34
Other Employees	1569	531	2100
Total	1593	548	2141

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

2019/20 absence information can be found on line at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

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 2019/20 The Trust engaged Consultants to undertake work on a number of projects including: New Royal Papworth Hospital, outpatient flow optimisation; optimisation of the LORENZO Electronic Patient Record (EPR) system and development of the Trust's five year strategy.

Staff Exit Packages (audited information)

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 4 exit packages agreed in 2019/20.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000			
£10,00 – £25,000		2	2
£25,001 – £50,000		1	1
£50,001 – £100,000		1	1
£100,000 – £150,000			
£150,001 – £200,000			
>£200,001			
Total number of exit packages by type			
Total resource cost	0 (2018/19 0)	£130,726 (2018/19 0)	£130,726 (2018/19 0)

Exit packages: non-compulsory departure payments

	Agreements Number	**Total Value of Agreements £000**
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs		
Early retirements in the efficiency of the service contractual costs		
Contractual payments in lieu of notice	3	£60
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval	3	£70
Total	6 (2018/19 0)	£131 (2019/19 0)
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	1	£60

Reporting high paid off-payroll arrangements

Table 1: For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2020	1
Of which...	0
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.	1
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 6 April 2017.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
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	1
No. for whom assurance has been requested	1
Of which...	0
No. for whom assurance has been received	1
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 2019 and 31 March 2020

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0 (2018/19: 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**	**2019/20 Total £000**	**2018/19 Total £000**
Salaries and wages	78,287	1,878	**80,165**	**74,725**
Social security costs	7,751	-	**7,751**	**7,159**
Employer's contributions to NHS pensions	8,666	-	**8,666**	**8,274**
Apprenticeship levy	372	-	**372**	**347**
Agency/contract staff	3,782	-	**3,782**	
Total gross staff costs	-	5,104	**5,104**	**4,837**
Recoveries in respect of seconded staff	**98,858**	**6,982**	**105,840**	**95,342**
Total staff costs	-	-	**-**	**-**
Of which Costs capitalised as part of assets	**98,858**	**6,982**	**105,840**	**95,342**
	58	115	**173**	**330**

Table 5: Average number of employees (WTE basis – audited information)

	Group					
	Permanent Number	**Other Number**	**2019/20 Total Number**	**Permanent Number**	**Other Number**	**2018/19 Total Number**
Medical and dental	215	9	**224**	211	6	**217**
Administration and estates	383	26	**409**	371	35	**406**
Healthcare assistants and other support staff	355	37	**392**	349	31	**380**
Nursing, midwifery and health visiting staff	608	37	**645**	576	34	**610**
Scientific, therapeutic and technical staff	149	13	**162**	147	10	**157**
Healthcare science staff	68	8	**76**	75	7	**82**
Other	2	-	**2**	1		**1**
Total average numbers	**1,780**	**130**	**1,910**	**1,731**	**123**	**1,854**
Of which Number of employees (WTE) engaged on capital projects	1	3	4	1	5	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 twelve formal meetings in 2019/20. 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 and Chief Executive 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 "Freedom To Speak Up: Raising Concerns policy" 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 following the Framework for conducting annual appraisals of NHS provider chairs and the Provider Chair Competency Framework. This uses input from the Lead Governor and the Chief Executive along with input through a multisource 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 2020.

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. (UoC Appointment had agreed process of nomination)
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	See Director's Report

	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 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).	See Annual Governance Statement.
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: • 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 2019/20.
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	See Board of Director section and Council of

	available to members on the NHS foundation trust's website and in the annual report.	Governors section
Additional requirement of FT ARM	The annual report should include: • 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	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.'	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 Oversight Framework

NHS Oversight Framework

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

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

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

Segmentation

Royal Papworth Hospital NHS Foundation Trust is in Segment 2: Targeted support: support needs identified in Finance & use of resources and Operational performance. *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

This segmentation information is the trust's position as at 19 April 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20				2018/19			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	3	4	4	4	4	4	4	4
	Liquidity	1	2	3	3	4	2	1	1
Financial efficiency	I&E margin	1	2	4	4	4	4	4	4
Financial controls	Distance from financial plan	4	4	4	1	1	1	1	1
	Agency spend	4	4	4	4	4	4	4	4
Overall scoring		3	3	4	3	3	3	3	3

The Trust's deficit position results in a score of 3 or more across each quarter in 2019/20. For more information on our financial performance during 2019/20 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. In 2019 his term of office was extended by one year, to support continuity of leadership through the hospital move.

Professor Wallwork 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).

Dr Jag Ahluwalia
Jag is Chief Clinical Officer at the Eastern Academic Health Science Network.

Jag received his undergraduate training in medicine at Cambridge and London. He was appointed as a consultant neonatologist at CUHFT in 1996 where he was director of the neonatal service for many years as well as a practising clinician. Jag's leadership and management experience includes nearly 10 years as the Executive Medical Director at Cambridge University Hospitals with a portfolio including included professional medical governance and leadership for over 1400 doctors, executive lead for Research and Development, executive lead for Postgraduate Medical Education, lead for patient safety and Director of Infection Prevention and Control. He was co-Chief Operating Officer for over three years. He was Director of Digital at CUHFT until 2019, overseeing extensive development of their IT programmes and then nominated to be chair of the Cambridgeshire and Peterborough STP digital group.

In addition to his acute hospitals roles, Jag has had many years' experience leading, supporting and managing change and leadership and strategy challenges across the wider NHS. He is a highly experienced teacher and lecturer with a two decade track record of delivering lectures and training across the fields of clinical practice, developing future clinical leaders, managing large-scale change, and implementing clinical IT systems. He has published over 40 articles including articles on personal research. He continues to co-direct the highly regarded East of England Chief Resident programme, supporting the training and development of future clinician-leaders.

Outside of the immediate NHS, Jag currently sits as a Main Board Trustee of Macmillan Cancer Support, is a member of a number of regional forums focused on the interface between healthcare and technology and is an Honorary Fellow of the Cambridge Judge Business School, focusing on healthcare.

Mr Michael Blastland Non-executive Director
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 Cynthia Conquest Non-executive Director
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. Since September 2019 Cynthia has been part of a job share in the post of Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust.

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 was the Chair of the Audit Committee for a GP Confederation in London until January 2020. 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
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 ETL, 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 left the Trust on 31 October 2019. Further details of his expertise and experience can be found in our annual report for 2018/19.

Dr Susan Lintott, Non-executive Director
Susan left the Trust on 31 October 2019. Further details of his expertise and experience can be found in our annual report for 2018/19.

Professor Nicholas Morrell, Non-executive Director
Nick left the Trust on 31 December 2019. Further details of his expertise and experience can be found in our annual report for 2018/19..

Mr Gavin Robert, Non-executive Director
Gavin has many years' experience as a private practice lawyer specialising in competition law. He is currently a senior consultant with boutique competition law firm Euclid Law, and teaches competition law at Cambridge University as part of a Masters programme. Gavin was previously a Panel Member of the UK Competition & Markets Authority, where he decided complex merger, market and antitrust cases, for five years until March 2018. Before that, Gavin was a partner for 14 years with the international law firm Linklaters, advising senior executives and the boards of leading global companies and financial institutions on competition compliance and managing risk.

Gavin has an enduring interest in healthcare. He has advised global healthcare companies throughout his career, and his decisions at the UK Competition & Markets Authority included the merger of NHS Foundation Trusts.

Gavin is also Vice Chair of REAch2, the largest primary-only multi-academy trust in the country. It is a growing charitable organisation currently supporting around 60 primary academies across England.

Professor Wilkinson Ian Wilkinson, Non-executive Director
Ian is a Clinical Pharmacologist and Professor of Therapeutics in the University of Cambridge. He directs the Cambridge Clinical Trials Unit, and office of Translational Research, and leads the division of Experimental Medicine and Immunotherapeutics at the University of Cambridge. His main research interests are clinical/experimental studies designed to understand the mechanisms causing hypertension and cardiovascular disease, and to develop new treatments.

He is lead investigator on the MRC/BHF-funded AIMHY-INFORM trial, which will determine the most effective antihypertensive treatment for different ethnic groups in the UK, and a number of early phase trials run in collaboration with Industry partners.

Ian leads the Cambridge Experimental Medicine Training Initiative which aims to create the next generation of clinical researchers to develop the medicines of the future.

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 left the Trust on 31 March 2020. Further details of his expertise and experience can be found in our annual report for 2018/19.

Mr Tim Glenn Chief Finance and Commercial Officer
Tim joined Royal Papworth Hospital as Chief Finance Officer on 14 April 2020. He was previously with Cambridge University Hospitals NHS Foundation Trust where he was Director of Finance.

Tim is a chartered accountant with 15 years' of senior financial leadership experience working across community, acute and specialist NHS organisations as well as in the private sector.

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 [E]	Executive Remuneration [F]
Number of meetings 2019/20	12	5	12	12	9	2
J Ahluwalia[1]	4/5			3/5	2/2	0/1
M Blastland	12/12	1/1	4/7	10/12	2	2/2
R Clarke	10/12	5	9/12		7/9	
C Conquest	10/12	5/5	3/5		2	2/2
D Dean	11/12	5/5	10/12		4/7	1/2
R Hall	11/12	3	9	10/12	6/9	
D Hughes[1]	5/6		6/7		6/7	1/1
S Lintott[1]	6/6	3/3		6/7		0/1
E Midlane	11/12	1	12/12		9/9	
O Monkhouse	11/12	3	10/12	7	7/9	2
N Morrell[1]	4/9			4/9		0/2
S Posey	12/12	2	7/12	3	5/9	2
A Raynes	11/12		7	9	6/9	
G Robert	5/5	1/1	5/5			1/2
J Rudman	11/12	3	9	10/12	2/9	
J Wallwork	12/12	1		1		2/2
I Wilkinson	3/3			2/3	1/1	

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 Chief Executive, Chief Finance Officer, Director of Workforce and OD and Chief Operating Officer.

[D] Membership 3 NEDs plus Medical Director, Chief Nurse and from Feb 2020 Chief Executive Officer and Director of Workforce and OD.

[E] Membership 3 NEDS, all Executive Directors.

[F] Membership only Chairman and NEDs. See Remuneration section of Annual Report.

The dates of the Board of Directors' meetings in 2019/20 were:

2 May 2019	23 May 2019	6 June 2019	4 July 2019
1 Aug 2019	5 Sep 2019	3 Oct 2019	7 Nov 2019
5 Dec 2019	6 Feb 2020	5 Mar 2020	20 Mar 2020

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 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 2019/20 was:

David Dean (Chair)
Cynthia Conquest
Susan Lintott
Gavin Robert (from 1 November 2019 to 29 February 2020)
Michael Blastland (from 1 March 2020)

Meetings and Attendance of Members

Name	23 May 19	10 Jul 19	10 Oct 19	23 Jan 20	12 Mar 20
Cynthia Conquest	✓	✓	✓	✓	✓
David Dean (Chair)	✓	✓	✓	✓	✓
Susan Lintott	✓	✓	✓		
Gavin Robert				✓	
Michael Blastland					✓

✓ Attended meeting
× Apologies were received

To assist the Audit Committee in fulfilling its role the following are in attendance at all meetings: The Chief Finance Officer, 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 2019/20. 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 17 June 2020.

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 – 2019/20

During 2019/20, 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;
- Costing Transformation Programme (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 2019/20 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 officers of the Trust as listed in the Procedure, an identified Executive, and Non-Executive Director lead who also has regular review meetings with the FTSU Guardian. 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 Trusts 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. The Guardian is required to report all concerns raised with him to the National Guardian's Office on a quarterly basis. In 2019/20 the Guardian has reported 61 concerns. The concerns raised have included management style, staff frustration in HR outcomes and solutions, issues around the level of tasks/demands from mangers and a lack of recognition of support and workload pressures. In the last quarter of 2019/20 issues were raised around redeployment and support of staff during the COVID19 pandemic. In 2019/20 we introduced Speaking Up ambassadors who work with the Guardian to ensure staff are encouraged and know how to raise concerns. Over thirty staff expressed an interest in this role and we appointed twelve ambassadors to work across the Trust. We have also improved 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 £54,900 (2018/19: £47,500), excluding VAT. This is the fee for an audit in accordance with the Audit Code issued by Monitor in March.

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 2020:

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

Susan Bullivant
Following a research and academic career in applied/engineering mathematics, Susan established and ran an organisation and management development consultancy working with Government Departments and private sector companies. She supported women in STEM initiatives at national level. She was a Patient Governor of Addenbrooke's Hospital for 8 years and chaired the Director/Governor Forward Planning Group. Just elected she wants to find out more about RPH and where she can best contribute. She has lupus, a chronic illness.

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.

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

Julia Dunnicliffe
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 Beckers 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. He uses an electric wheelchair and understands the issues and needs of the less abled.

Trevor feels extremely privileged and honoured to undertake the role as a Governor for Suffolk. He has been reliant on the NHS since a child having spent 10 months in Great Ormond Street Hospital where his treatment gave him the gift of living and has had a close relationship with the NHS ever since. This has inspired him to succeed in life and share his experiences to inspire others. Trevor hopes to make a difference to the patients and the hospital by his input as a Governor and is committed to the role and regularly attends various meetings with a view to achieve Royal Papworth Hospital's vision and values.

Rodney Scott
Suffolk born, former chairman now vice chairman of The Desert Rats Association. Rodney was awarded the British Empire Medal for service to armed forces associations including 64 years Royal British Legion. His is the owner of two military museums. Rodney was elected as a Governor in September 2019.

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.

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.

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.

Pippa Kent
Pippa had a double lung transplant at Papworth in 2017 and so has witnessed first-hand the care provided by our teams. After growing up in Cambridge, Pippa now lives in London where she works in Public Relations. She has specific interests in public communications, fundraising and due to her personal and professional experience, food and catering within the hospital environment.

Simon Marner
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 is a returning Governor having 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

Caroline Gerrard – Admin and Clerical
Having started her career in research and development laboratories, Caroline joined Royal Papworth Hospital in 2000 working alongside the surgical and anaesthetic teams to successfully reduce blood product usage. From there she became the administrator of the system used in Critical Care for our patient documentation. Whilst in this role she joined CUH's Epic team to develop their electronic patient record. In 2015 she became the chief allied health professional information officer, representing clinical colleagues in the Digital department and is now the configuration developer within the patient record team.

Penny Martin, Allied Health Professionals
Penny is a qualified and registered social worker and has 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 she 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. She also has experience of working with young people who are homeless.

Penny loves working at Royal Papworth hospital as it allows her to use the skills that she has developed over her career and she enjoys the daily challenges it brings. She is proud to act as a staff governor.

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.

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.

Martin Ward, Estates
Having worked at RPH in a variety of roles since he left school in 1996 Martin is currently the Deputy Manager of Clinical Engineering where in addition to supporting the Head of Department in the day to day running of the department he's the specialist engineer supporting the Anaesthesia and Ventilation equipment of The Trust. Martin's involvement with RPH goes back many more years than that to 1985 when his father received a heart transplant here. Martin believes in delivering the best care possible to our patients and making RPH a great place to work. Outside of work he's a keen motorcyclist and enjoys playing guitar in a rock band.

Appointed Governors

Lorraine Szeremeta
Chief Nurse, Cambridge University Hospitals.

Cllr Linda Jones
Cambridgeshire County Council

Caroline Edmonds
Secretary of the School of Clinical Medicine, University of Cambridge

Cllr Alex Malyon
South Cambridgeshire District Council (SCDC covers Papworth Everard).

Terms of Office of Governors as at 31 March 2020

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
	Susan Bullivant	Sept 2019	n/a	Sept 2022
	Glenn Edge*	Sept 2014	Sept 2017	Sept 2020
	Gill Francis	Sept 2014	Sept 2017	Sept 2020
	Richard Hodder	Sept 2014	Sept 2017	Sept 2020
Suffolk	Julia Dunnicliffe	Sept 2019	n/a	Sept 2022
	Trevor McLeese	Sept 2017	n/a	Sept 2020
	Rodney Scott	Sept 2019	n/a	Sept 2022
	Vacancy	-	-	-
Rest of England and Wales	Janet Atkins	Sept 2017	n/a	Sept 2020
	Keith Jackson	Sept 2011	Sept 2014 Sept 2017	Sept 2020
	Pippa Kent	Sept 2019	n/a	Sept 2022
	Simon Marner	Sept 2017	n/a	Sept 2020
	Harvey Perkins	Sept 2016	Sept 2019	Sept 2022
Norfolk	John Fiddy MBE	Sept 2014	Sept 2017	Sept 2020
	Peter Munday	Sept 2014	Sept 2017	Sept 2020
	Bob Spinks	Sept 2013	Sept 2016 Sept 2019	Sept 2022
	Vacancy	-	-	-
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	Caroline Gerrard	Sept 2019	n/a	Sept 2022
Ancillary, Estates and Others	Martin Ward	Sept 2019	n/a	Sept 2022
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

UK Engage acted as the returning officer and independent scrutineer for the election process during 2019. There were vacancies for Governors in four of our public constituencies and three staff constituencies. The results of the elections are set out below:

Information on election results:

Cambridgeshire - one vacancy: twelve nominations - election held
Norfolk - one vacancy: four nominations – election held
Suffolk - three vacancies: two nominations - uncontested election
Rest of England and Wales - two vacancies: six nominations – election held
Administrative, Clerical & Management: one vacancy: two nominations – election held
Allied Health Professionals - no election in 2019/20;
Ancillary, Estates and Others - one vacancy: one nomination – uncontested election
Doctors - no election in 2019/20;
Nurses - one vacancy: no nominations – vacancy carried
Scientific and Technical - no election in 2019/20;

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; service developments and 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;
- Member engagement through PALS (Patient Liaison and Advice Service)
- Active Volunteer structure.

Table of Attendance of Directors at Council of Governors' Meetings

Council of Governors	19-Jun-19	18-Sep-19	20-Nov-19	18-Mar-20*
John Wallwork (Chairman)	×	×	✓	-
Stephen Posey	✓	✓	✓	-
Jag Ahluwalia			×	-
Michael Blastland	✓	×	✓	-
Roy Clarke	✓	✓	✓	-
Cynthia Conquest	✓	✓	×	-
David Dean	×	×	×	-
Roger Hall	✓	×	×	-
David Hughes	×	×		
Susan Lintott	×	×		
Eilish Midlane	✓	✓	✓	-
Oonagh Monkhouse[1]	✓	✓	×	-
Nick Morrell	×	×	×	-
Andy Raynes	×	×	×	-
Gavin Robert			×	-
Josie Rudman	✓	×	×	-
Ian Wilkinson				

✓ Indicates attendance at meeting. **× Indicates did not attend.** [1] **Part year membership**

* The meeting scheduled for the 18 March was postponed as a part of measures put in place to minimise risk to staff and patients and to support the operational response to COVID19.

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 a number of Board and Trust Committee meetings as attendees, where they contribute to discussions.

Table of Governor Attendance at Council of Governors' Meetings 2019/20

Council of Governors	19-Jun-19	18-Sep-19	20-Nov-19	18-Mar-20*
Atkins, Janet	✓	×	✓	-
Brown, Stephen	✓	✓	✓	-
Bullivant, Susan			✓	-
Crabtree-Taylor, Barry	×	×		
Dunnicliffe, Julia	×	✓	✓	-
Edge, Glenn	✓	✓	✓	-
Fiddy, John	✓	✓	✓	-
Francis, Gill	✓	✓	✓	-
Graham, Robert	✓	×		
Hodder, Richard (Lead)	✓	✓	✓	-
Jackson, Keith	✓	×	✓	-
Jagger, Graham	✓	✓		
Kent, Pippa			✓	-
Marner, Simon	✓	×	✓	-
McLeese, Trevor	✓	✓	✓	-
Moodey, Tony	×	×	×	
Munday, Peter	✓	✓	✓	-
Perkins, Harvey	✓	✓	✓	-
Scott, Rodney			✓	-
Spinks, Bob	✓	✓	✓	-
Gerrard, Caroline			✓	-
Martin, Penny	✓	✓	×	-
Oats, Katrina	✓	✓	×	-
Riotto, Cheryl	×	✓	✓	-
Rodriquez, Helen	✓	×		
Ruggiero, Alessandro	×	✓	✓	-
Ward, Martin			✓	-
Williams, Tony	×	×		
Edmonds, Caroline	×	✓	✓	-
Jones, Linda	✓	×	✓	-
Malyon, Alex	✓	✓	×	-
Szeremeta, Lorraine	✓	✓	×	-

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 2020:

Membership by constituency as at 31 March 2020		
Public Membership Profile	Number of Members	% of total
Cambridgeshire	2,238	36.62%
Norfolk	1,024	16.75%
Suffolk	899	14.71%
Rest of England & Wales	1,951	31.92%
Sub-total	6,112	100.00%
Constituencies – Staff*	Number of Members	% of total
Nurses	939	37.80%
Doctors	390	15.70%
Allied Health Professionals	250	10.06%
Scientific & Technical	135	5.43%
Ancillary, Estates & Others	205	8.25%
Administrative, Clerical & Management	565	22.75%
Sub-total	2,484	100.00%
Total Membership	8,596	100.00%
*Note: Numbers are individual members of staff, not whole time equivalent		

Membership Plans

Following the move to the new hospital the review of our Membership Strategy was started through the Governor Assurance Committee. The launch of the revised strategy was planned for summer 2020 but this timetable has been delayed as a result of the operational response to COVID19. The draft strategy underpins the Trust's membership model of governance. It sets out how the Council of Governors discharges its role and responsibilities with reference to the Governors' role of being responsible for representing the interests of the membership. The strategy includes direction on how Governors and the Trust can 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 18 September 2019. 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 Finance Officer and Deputy Chief Nurse, as well as an update on our new hospital, and clinical presentations on developments in Cardiology and the Transplant team's world first transplant of a DCD (Donation after Circulatory Death) heart-lung bloc.

Our first AGM on the Biomedical Campus was well attended with much interest in our move to the new site and the impact that had on our staff; our clinical developments and strategy and how we plan to work with partners on Cambridge Biomedical Campus.

Thanking our volunteers

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. During our move 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.

Since the move to the new site we have seen an increase in interest in becoming a volunteer with the Trust and have held two Inductions for a total of new 42 volunteers.

We have 73 active hospital volunteers, supporting clinics, wards, patient/carer meetings, Pharmacy, IT, Charity, proof reading and administration. Our volunteers have also supported the hospital teams during COVID19.

Our Volunteer Strategy supports 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.

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

Climate change is a significant issue from a global perspective and has long-term impacts on health and wellbeing, as well as being one of the most serious global environmental threats.

A commitment to sustainability and carbon reduction targets is now included within the NHS Long Term Plan to highlight the impact that working towards sustainable targets contributes to a “service fit for the future”. In addition, the Climate Change Act sets target reductions of 30% by 2030 and net zero percent by 2050 against a 1990 baseline and the Trust is reviewing ways in which the organisation can further contribute towards the target reduction on a local, regional and international level.

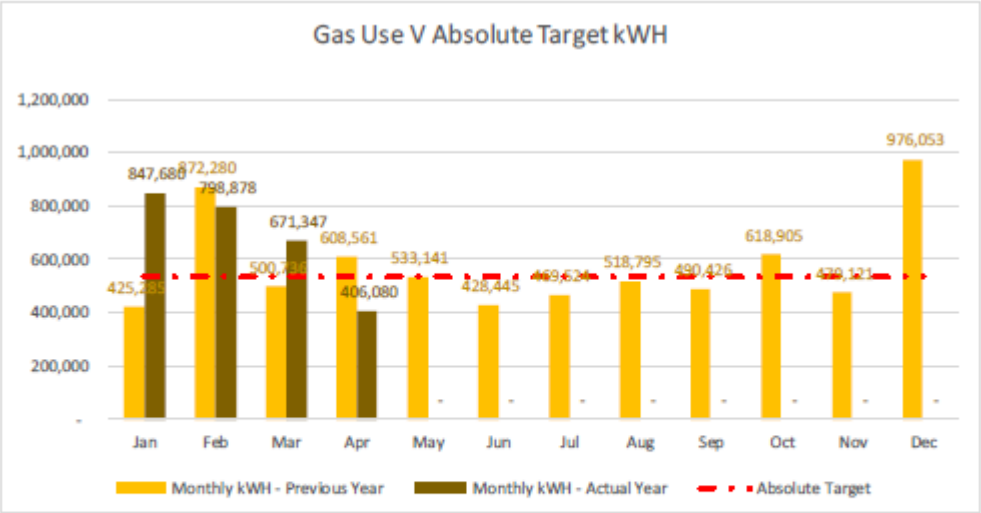
Planning activity for the Trust’s move to the Cambridge Biomedical Campus in May 2019 included a review of how the organisation undertook daily activity, including planning travel to the campus, greener travel options, and the streamlining of Estate and Facilities services with neighbouring partners investigate where adjacencies are in activity and a review of energy efficient opportunities in line with the PFI provider for the site, Skanska.

The anticipated number of ‘spend to save’ investment opportunities has reduced as expected, however a number of new opportunities can be explored to see how the Trust can improve on current sustainability activity on the new site.

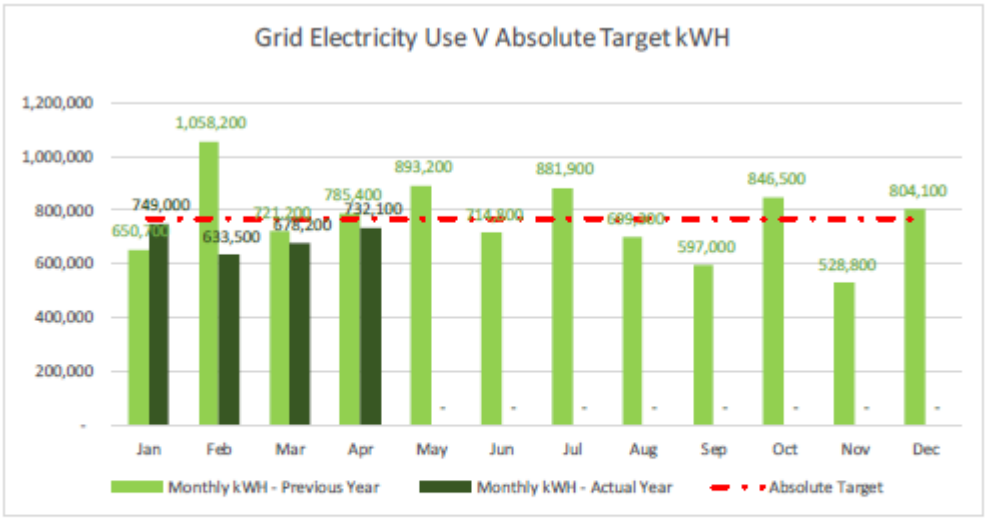
At the time of writing the Trust, along with all NHS organisations and society as a whole, is experiencing the challenges posed as part of the COVID19 pandemic. The changes to ways of working has been unprecedented in recent history, and present the Trust with options to review ways in which work is undertaken both from a clinical and administrative perspective.

The Trust is supported by the Digital Team in providing new ways of working for a number of colleagues who are shielding, and work is underway to review how this continues over the forthcoming months as a necessity, which has will contribute to the reduction of travel and transport emissions in relation to Trust activity.

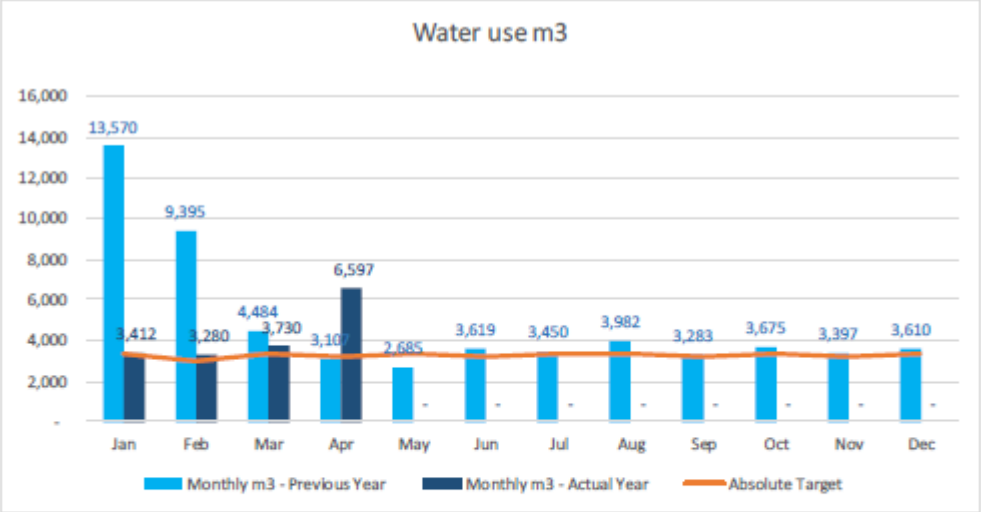
The hospital has a Combined Heat and Power (CHP) system to ensure that efficient processes are used to capture and utilise the heat as a by-product of the electricity generation process within the energy centre. The Trust works alongside Project Co. and Skanska with regards to the monitoring of energy consumption, including water. Data is submitted to the Trust on a monthly basis with an emphasis on better understanding and smarter usage. Below are graphs for Gas, Electricity and Water usage as well as the CHP use.



The above chart shows monthly gas use versus the annual gas target on a linear basis. April use was around 24% Below the target figure. This in part is due to reduced demand for a very mild month. When comparing to the previous year consumption is 33% Below 2019.

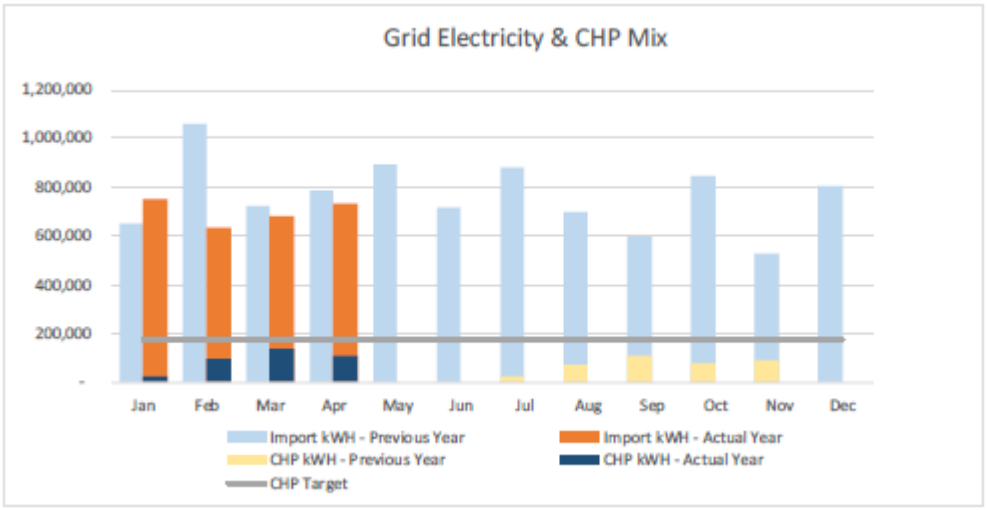


The above chart shows monthly electrical use of the main incoming electrical supplies (Feeder A & B) plotted against the design target on a linear scale. April use was around 5% Below the target figure. When comparing to the previous year consumption is 7% below the same month in 2019.



The above chart shows monthly water use plotted against the design target on a linear scale. April use was around 106% Above the target figure. When comparing to the previous year consumption is 112% Above April 2019.

This excessive use is thought to be due to additional handwashing in relation to COVID-19 requirements in combination with increased flushing of outlets due to mycobacteria concerns.



Future Projects

Development of a five-year strategy for sustainability is underway within the Trust, encompassing a number of strands relating to energy consumption, water usage, waste, green travel options, health and wellbeing and workforce. Advice from the Sustainable Development Unit will be sought to support activity within these workstreams, both on a regional and national level, and the Trust will encompass this activity within the development of the strategy to enable planning for future targets.

The Trust will continue to attend meetings with members of the Cambridge Biomedical Campus (CBC) as part of a Travel and Transport, and Sustainability working group and plans are in development to work with CUH to investigate ways in which RPH and CUH can support each other as neighbouring organisations in relation to sustainability.

Travel and Transport opportunities will require review as part of ongoing changes to services as part of the response to the pandemic, this will be reviewed alongside partner organisations CUH and Saba to review future options and planning.

The Trust continues to have a contract with LiftShare as the Trust's car share scheme that was launched as part of the Big Move and is available for staff working at the Trust and The House sites. However, this will be reviewed in line with the Government safer travel guidance, to include updated COVID19 travel advice.

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

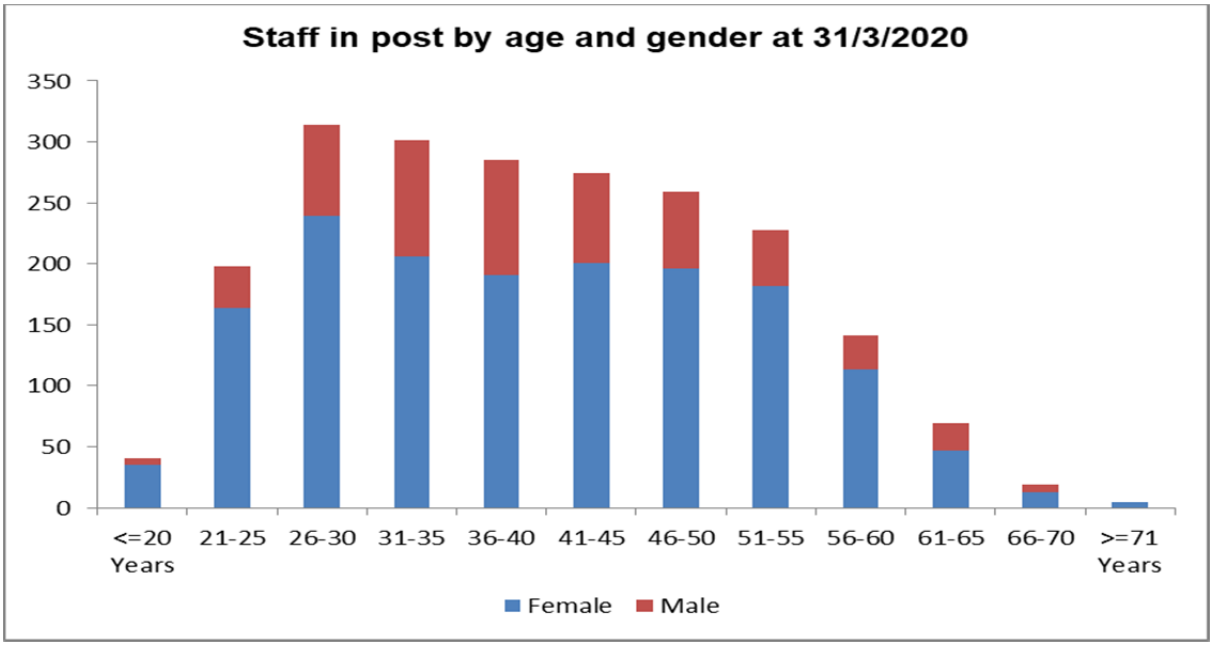
We publish information to demonstrate compliance with the general duty at least annually and prepare and publish equality objectives every 4 years.
The Trust takes due regard for equality by undertaking equality impact assessments for equality analysis when reviewing policies or when planning changes 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 the profile of our workforce and the actions we take to promote workforce and service equality and diversity across the Trust.

Workforce Profile – 31 March 2020
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.

The Hospital had 2134 employees at 31 March 2020, excluding hosted services, of which, 1570 were full time employees and 564 were part time.

Gender

Gender	Full Time		Part Time		Grand Total	
	Workforce	% of Full Time	Workforce	% of part time	Workforce	% of workforce
Female	1084	69.0%	508	90.1%	1592	74.6%
Male	486	31.0%	56	9.9%	542	25.4%
Grand Total	**1570**	**100.0%**	**564**	**100.0%**	**2134**	**100.0%**



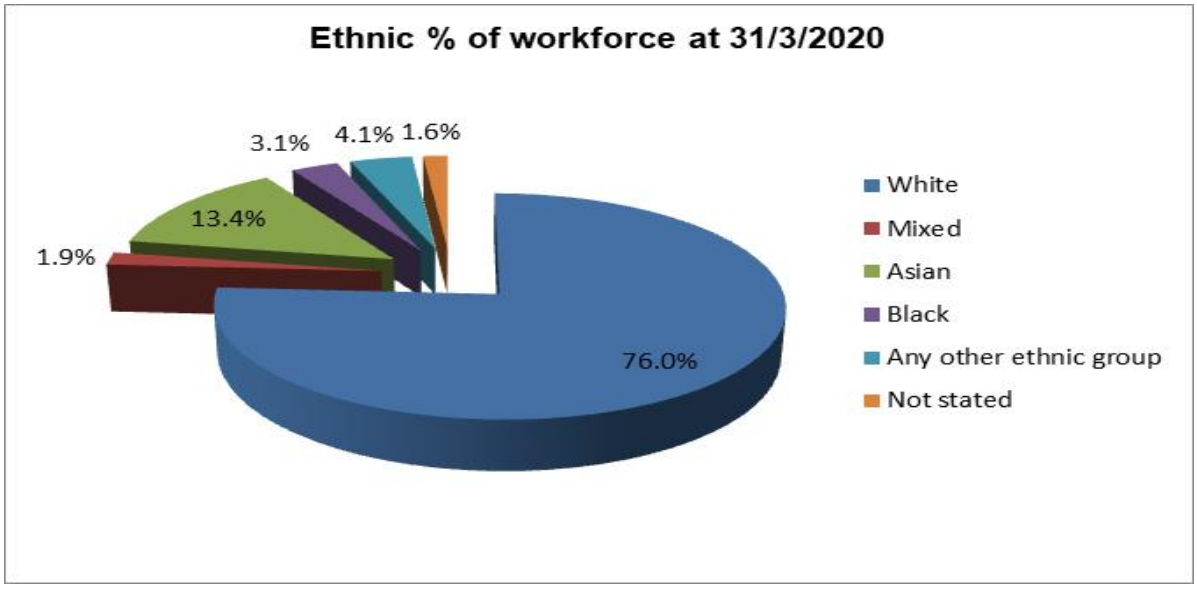
Age Band	Female		Male		Total	
	Workforce	female	Workforce	% Male	Total	%
<=20 Years	35	2.2%	6	1.1%	41	1.9%
>=71 Years	5	0.3%		0.0%	5	0.2%
21-25	164	10.3%	34	6.3%	198	9.3%
26-30	239	15.0%	75	13.8%	314	14.7%
31-35	206	12.9%	95	17.5%	301	14.1%
36-40	191	12.0%	94	17.3%	285	13.4%
41-45	201	12.6%	73	13.5%	274	12.8%
46-50	196	12.3%	63	11.6%	259	12.1%
51-55	182	11.4%	46	8.5%	228	10.7%
56-60	113	7.1%	28	5.2%	141	6.6%
61-65	47	3.0%	22	4.1%	69	3.2%
66-70	13	0.8%	6	1.1%	19	0.9%
Grand Total	**1592**	**100.0%**	**542**	**100.0%**	**2134**	**100.0%**

Gender Pay Gap

The Trust has complied with the 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.

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	
			Male	Female	Male	Female	Male	Female	Male	Female			Male	Female
	25.02%	7.84%	40.41%	59.59%	18.35%	81,65%	23.51%	76.49%	25.98%	74.02%	42.51%	66.67%	6.91%	0.73%

Ethnicity



Disability

	Female		Male		Grand Total	
Disability Category	Workforce	% of Full Time	Workforce	% of part time	Workforce	% of workforce
Learning disability/difficulty	1	0.1%	0	0.0%	1	0.0%
Mental Health Condition	1	0.1%	1	0.2%	2	0.1%
No	1095	68.8%	355	65.5%	1450	67.9%
Not Declared	158	9.9%	100	18.5%	258	12.1%
Other	1	0.1%		0.0%	1	0.0%
Physical Impairment	4	0.3%		0.0%	4	0.2%
Prefer Not to Answer	3	0.2%		0.0%	3	0.1%
Sensory Impairment	3	0.2%	1	0.2%	4	0.2%
Unspecified	278	17.5%	75	13.8%	353	16.5%
Yes - Unspecified	48	3.0%	10	1.8%	58	2.7%
Grand Total	**1592**	**100.0%**	**542**	**100.0%**	**2134**	**100.0%**

Sexual Orientation	Workforce	% of workforce
Heterosexual or Straight	1545	72.4%
Not stated (person asked but declined to provide a response)	363	17.0%
Unspecified	173	8.1%
Bisexual	23	1.1%
Gay or Lesbian	20	0.9%
Undecided	7	0.3%
Other sexual orientation not listed	3	0.1%
Grand Total	**2134**	**100.0%**

Religious Belief	Workforce	% workforce
Christianity	1014	47.5%
I do not wish to disclose my religion/belief	440	20.6%
Atheism	281	13.2%
Unspecified	174	8.2%
Other	143	6.7%
Hinduism	37	1.7%
Islam	31	1.5%
Buddhism	12	0.6%
Judaism	2	0.1%
Grand Total	**2134**	**100.0%**

NHS equality delivery system (EDS2)

The EDS has been developed by the NHS England Equality and Diversity Council to improve equality and diversity practice in the NHS as a tool to embed equality and diversity practice to meet the public sector equality duty. The last EDS audit was completed in 2017 and the outcomes are on our Trust website.

The Trust will take part in a System wide approach to the 2019/2020 Equality Delivery System audit - due to the unforeseen delays in the release of EDS3 which provides a more structured process for patient pathways and a greater emphasis on Leadership of the Equality and Diversity Agenda. This will include patient representative groups and peer challenge in order to provide meaningful reportable data. The format will be based on the current EDS2 process but utilising some discretion to ensure it is meaningful.

Annual reporting

The Workforce Race Equality Standard (WRES) and Workforce Delivery Equality Standard (WDES) are audits completed every July using data as at 31 March each year and for the annual staff survey and NHS Jobs. From the reporting the Trust compiles action plans that focus on issues highlighted. These action plans, once approved by the Board, are published externally on our Trust website.

Workforce Race Equality Standard (WRES)
This action plan is a standard agenda item for the BAME Network which meets bi-monthly and gets updated throughout the year as actions are completed/ added. This network is very active in driving the Equality Agenda and is sponsored by Cynthia Conquest, Non-executive Director who is instrumental in driving the actions. Consistent attendance has proved problematic at times due to clinical priorities of a number of the members. We continue to review attendance and change meeting times and dates to reflect this.

Workforce Disability Equality Standard (WDES)
Following the addition of the WDES to the auditing framework in July 2019 and the subsequent action planning, it was the intention of the Trust to set up a Network to review the actions and support delivery of them. Through various events including Mental Health Awareness week we now have a large group of staff members, either with lived experience or an interest in supporting staff living with a disability. We also have a Staff Governor who will be part of this Network due to be launched in April 2020.

LGBT+ Network
Whilst not reported on currently and so in the absence of any data, following the interest raised by the launch of the Rainbow Badge scheme in December 2019 it became very clear that there was an enthusiastic and engaged group of staff who wished to be part of a LGBT+ Network in order to raise awareness on issues and concerns that the Trust may not be aware of. The network launched on 7th February with a second meeting planned for April 2020. We are planning to have a Board/ Governor sponsor with an interest in staff and patient experience for this community.

The Equality, Diversity and Inclusivity Steering Group meets bi-monthly and reports to Quality and Risk Committee has been active throughout 2019, Chaired by the Chief Operating Officer and Director of Workforce and OD and all staff networks report into this committee.

Review planned of the Trust Accessible Information Standard in April 2020, looking in particular at the Lorenzo functionality.

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

We also use this section of our website to publish our WRES and WDES action plans: 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 Schedule 2 to The Trade Union (Facility Time Publication Requirements) Regulations 2017. The following data was published as required in 2019/20.

Eight employees were Relevant Union Officials during the relevant period (2018/19) and this equated to 7.8 FTE employees.

The percentage of time spent on facility time was:

a	0%	1
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	£35,450
b	Total pay bill	£89,166,553
c	Total pay bill spent on facility time	0.04%
d	Time spent on paid trade union activities as a percentage of total paid facility time hours	28.13%

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 Royal Papworth Hospital NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Royal Papworth Hospital NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health 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 and disclose any material uncertainties over going concern.

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

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

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

Signed:

Stephen Posey
Chief Executive
Date: 17 June 2020

2.13 Annual Governance Statement

Executive summary

My annual governance review of 2019/20 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 2020/21. 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 2020 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 sets 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;
- 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 reviewed by the Serious Incident Executive Review Panel and 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 (Trustee Board);

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 Strategic Projects Committee met nine times and the Quality and Risk Committee and the Performance Committee met twelve times. All Committees report to the Board through minutes and written Chair's reports.

During 2019/20 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;
- Research and Education Governance
- Information Governance;
- Non-financial Resource Governance;
- Clinical and Non- Clinical Risk Management;
- Quality Reporting to support assurance for the annual Quality Report/Accounts
- Data Quality; and
- Board Assurance Framework (BAF) to support the clinical/quality statements in the Annual Governance Statement (with the overarching responsibility for the BAF in

the remit of the Audit Committee as Committee BAF Risks are managed across all Board Sub Committees).

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.
- Committee BAF Risks

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.

Following the completion of the move to the new hospital the role of the Strategic Projects Committee was reviewed and updated. It provides assurance on the Trust's strategic projects/transformation plans in respect of the following programmes:

- New Papworth Hospital (NPH): closedown and Post Project Evaluation
- Hospital optimisation projects
- Cambridge Transition Programme (CTP)
- Sustainability and Transformation Partnership (STP)
- Biomedical Campus Research Strategy
- Heart and Lung Research Institute (HLRI aka Project Atria)
- Prioritised Digital projects
- Committee BAF Risks

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's Quality Strategy 2019-22 builds on its achievements 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 has seen more than 200 staff members interviewed as part of 36 focus groups. They were asked questions about a number of themes, including vision and values, teamwork, learning and innovation and compassion, to help us assess our organisation culture and supporting 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; the Trust has an 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 (Quality Compliance Officer) 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. 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 Quality and 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 business unit and divisional 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 principal risks (in-year and future) are summarised below together with mitigations.

Risk Description	Mitigation
COVID19 The global impact of COVID19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic.	Royal Papworth Hospital (RPH), as a nationally recognised centre of excellence for specialist cardiothoracic health care, has and continues to play a leading role in the national, regional and local response to this crisis. The Trust has taken roles in both an advisory capacity and in the direct

In the UK the response to this threat is being managed at national, regional and local tiers of the public sector (including but not limited to the NHS, Local Government, the Police Force and the Army). For the Trust the key risk factors include managing the impact across: • Keeping our patients and our staff safe • Balancing risks in the delivery of services for patients with COVID and non-COVID disease. • Manging the immediate and longer term impact of COVID19 on our workforce. • Managing the impact of COVID19 on the flow of work and the associated financial consequences. • Anticipating and planning for the longer term economic and financial forecasts for the local and wider NHS system. • The operational impact of managing any subsequent waves of COVID19.	provision services to the population. The Trust agreed and initiated its Critical Care Surge Plan in early April and moved into ECMO super surge. This was delivered by accelerated training and deployment of ward staff into critical care. The Trust trained over 300 staff to support critical care and redeployed 178 staff to critical care during the surge phase. Restarting postponed activity will require staff to move back to their speciality areas, with a consequential reduction in critical care capacity, but which could be reinstated in the event of a subsequent wave of pandemic. In line with other providers the Trust experienced a reduction in demand through emergency pathways during the initial COVID19 response. The Trust has subsequently experienced a re-bound effect as patients are presenting in a more acutely unwell state. This has been seen first in Cardiology but is anticipated across other specialities over time and plans are being developed to manage this demand. It is assumed that the levels of COVID related conditions post incident will reduce but there will be residual demand for at least 18 months or until an effective testing regime and vaccine is developed. As a “centre of excellence” for treatment of respiratory diseases it is anticipated that critical care capacity required to service this demand will be greater than planned provision pre-COVID19. Re-starting elective activity will only be safely done and, importantly, acceptable to patients when it is possible to clearly delineate between COVID and non-COVID areas across all functions that support care, wards, diagnostic and treatment functions. Ensuring that adequate PPE, medicines and consumables are available to undertake all necessary activities identified in the plan.
Workforce Recruitment and Retention Workforce, and the need to focus on recruitment and retention to support flow and our ability to deliver activity	The Trust has a Recruitment and Retention Strategy and has a very strong recruitment pipeline. Over the year significant work has been undertaken to improve the recruitment and retention of staff to support key areas across the

	Trust. As part of the COVID19 response we are using a rapidly developed streamlined recruitment and induction process we have recruited a total of 110 new staff since March 2020. We have establishing a steering group to oversee the medium term the challenges arising from COVID19 for our workforce, environment and organisational development plans. We have a process of risk assessment for our staff in relation to managing those staff with increased risk factors which has been refined and will support how we manage the impact of COVID19 on our staff going forward. We continue to focus on the themes that came out of our Compassionate and Collective Leadership Programme as we move into Phase II of the programme. All areas of the Trust are planning around the issues and opportunities arising from the COVID19 pandemic on matters such as: the impact of travel & transport; staff facilities & environment; digital support; office environment and IPC/social distancing; the organisation of clinical areas as well as the impact on individual staff through new working arrangements in terms of shifts & hours and how that impacts on teams.
Hospital Optimisation: Failure to optimise the new facility to deliver activity plans and meet patient demand.	Our Hospital optimisation programme had identified a number of opportunities to improve the flow of patients through the hospital and saw us implement improvement plans in outpatients, critical care and across the Trust. Whilst our Hospital Optimisation programme has been largely subsumed into the plans for the reshaping services to respond to COVID19. We recognise that the issues that we had identified will need to be addressed in the work that is now underway. We have established a living with COVID Steering group and are putting in place phased plans to reintroduce pathways across all services that had been reduced or suspended in the initial operational response to COVID19. These are to be introduced with COVID and non-COVID pathways in order to safely manage our patients. The overarching requirement to protect our staff and patients will have an impact on the flow of

	work through the hospital. The achievement of planned levels of activity will be effected by the implementation of social distancing measures and changes in the flow through the building in terms of out-patients, cath labs, theatres and critical care. Will take the opportunity to embed the developments that we have seen in the delivery of virtual clinics and support services that have been established in response to COVID19. We have developed new and effective treatment pathways between Trusts and treatment options that support our patients through remote monitoring in the community and will continue to look at the extension of these pathways where there is opportunity to do so. We will also plan changes to our support services and infrastructure to deliver improvement in the flow of patients through the Trust.
Sustainable financial Plan: Failure to deliver our financial plan on a sustainable basis, addressing the underlying the structural deficit and our contribution to the wider system.	The Trust is looking forward to how it manages the impact of COVID19 on the Trust and the wider system. There is a significant consequence across the NHS in terms of: The decision making processes across the local system and wider NHS as that might see central direction to disinvest in some areas and to develop services (that may not be economically viable within the current funding regimes). The Trust is working with partners to ensure that it is a party to these discussions and that it is able to influence planning for the benefit of its patients and the wider population. The impact of an expected reduction in tax take on exchequer funding and the consequence for the NHS. The Trust is ensuring that it delivers services in the most effective manner whilst addressing the additional measures required relating to social distancing and heightened infection control measures. These measures have an adverse impact on patient flow and will increase the cost base of the Trust. The commissioning and funding of the direct treatment costs of COVID19 some of which are high cost and not currently commissioned.
Cyber security and data loss: Failure to	As a result of the Operational response to

ensure that our services are resilient to cyber-attack and that residual risks to resilience are managed.	COVID19 the Trust has seen an accelerated move into new ways of working with staff working remotely and a significant increase in services that are delivered through virtual platforms. These services are being reviewed and established with appropriate safeguards in place. We have reviewed implemented a new backup solution for our system and have migrated off legacy servers. We are minimising the risk of Cyber threat, ensuring that our Board and our staff are trained and alert to the risk of Cyber-attack. We have an agreed digital strategy and we are Lorenzo digital exemplar site. We have prioritised investment to ensure that no application is more than one version behind latest release in order to reduce our vulnerability to cyber risk and run routine patches. We have also: • Upgraded to Virtual storage • Employed a dedicated Cyber Security role • Implemented new firewalls • Improved our surveillance measures • Implemented 'user' friendly reporting • Introduced Windows 10 with Advanced Threat Protection

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 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 with the appropriate skill mix. Our staffing model has been kept under review since our move in order to refine the requirements and respond to changed ways of working in our new building. In August 2019 we introduced SafeCare-Live (which is part of our current electronic HealthRoster system) to further inform appropriate deployment of our staff and it also allows us to identify and respond to staffing pressures in real time.

SafeCare supports us in ensuring that we have the right staff, with the right skills, in the right place at the right time in line with national best practice requirements. It allows us to match our patients' acuity and dependency against our staffing levels and skill mix. Three census periods during the day (linked to early, late and night shifts) enable a regular review of the data by the nursing and operational teams. These reviews occur as part of the Trust-wide safety briefing in the morning where safer staffing is discussed and addressed; and throughout the day by the Duty Matron in partnership with the clinical teams. For the areas where we identify any shortfall in staffing levels or skill mix, we are then able to make timely informed decisions, balanced with appropriate bed occupancy and the needs of our patients.

For the last nine years (introduced in 2011), the Trust has used 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, appropriately benchmarked, and 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 pre and post move. This is now an integral part of the way we use the SafeCare module.

During Quarter 4 (2019/20) we introduced a monthly Matrons audit of acuity and dependency. Each month the Matrons undertake a peer audit of each other's areas, in partnership with the ward team, to look at the acuity and dependency score allocated for each patient; then check to see if the assessment would be the same in their professional opinion. This is undertaken for every patient. This is to help validate the acuity and dependency scoring; help benchmarking and learning with peers; and assure that there is no under or over assessment as this has an impact on the SafeCare-Live rating. A red or amber rating indicates that a number of patients have been under or over scored regards their acuity and dependency needs. This information is shared at the CPAC meetings every month.

Royal Papworth Hospital remains compliant against the NHS Improvement guidance (formally National Quality Board guidance) for safe staffing and CHPPD. 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. Staffing levels are displayed on entry to every ward for patient and public information.

The Productive Ward series has been embedded and during 2019/20, activity audits were carried out quarterly to measure direct care time and reported in the monthly Papworth Integrated Performance Report (PIPR). Effective rostering for nursing is reported to the Clinical Professional Advisory Committee. 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. To help ongoing triangulation for safe staffing and skill mix, we also look at patient and public experience. Patient feedback is gathered through the Friends and Family questionnaire and is reviewed on a real time basis at the weekly Matron's meeting, and acted upon. This is also triangulated with complaints, accolades and PALS feedback. The action taken is also fed back on "you said, we did" boards in all areas. Patient and public experience is also reported in PIPR, with Safe Staffing, as part of the Chief Nurse sections of the report within 'Safe' and 'Caring'.

In response to the COVID19 pandemic our staffing models have been reviewed against national guidelines as required for surge planning. At times during the surge, assistance has been provided as part of the Regional COVID19 response, from our partners at Cambridge University Hospitals NHS Foundation Trust and North West Anglia NHS Foundation Trust, to support the Critical Care activity. As an example of this, prior to COVID19, we would staff a 30 bed Critical Care. This increased to 60+ beds during the COVID19 surge including a considerable increase in our ECMO patient numbers. Throughout the COVID19 response, we have continued to monitor safe staffing and skill mix through HealthRoster and also continued to gather feedback from patients where this has been possible.

Compliance Statements

The foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. The last CQC announced inspection was in June and July 2019 and this assessed the overall rating as 'Outstanding', with the five overall assessments rated as

'Outstanding'. Since completing the action plan from the visit the Trust has undertaken one internal mock CQC inspections and this -rated the organisation as 'Good'. This was undertaken in February 2020.

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

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights 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 2019/20 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 Control Total excluding land sales in 2019/20 and therefore unlocked c£15.45m additional Financial Recovery and Provider Sustainability Funding.

The Trust carried out a refresh of its Financial Strategy in 2019 which was reported to the Board of Directors in October 2019. The document reset the Trust's Financial Strategy for the 2019/20 Operational Plan and sets out the positive steps that the Trust will take to improve its financial position in the period following the move to the new hospital. The strategy 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 Operational Plan for 2019/20 and continue to be considered in the context of the COVID19

crisis and the consequential changes in the national financial architecture.

The Trust has and will continue to review its position with regard to Getting it Right First Time (GIRFT), Agency, Procurement and efficiencies highlighted by the Lord Carter review, as well as working closely with local and regional partners to deliver transformational changes that support the delivery of 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 Security and Protection 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 submitted its Data Security and Protection (DS&P) Toolkit in March 2019, which included requirements relating to the Statement of Compliance and all standards were declared as met. (Due to the impact on NHS organisations caused by COVID19 the 2020 DS&P toolkit submission deadline has been postponed until 30 September 2020 www.dsptoolkit.nhs.uk/News/74).

In 2019/20 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.

Data Quality and governance

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 Access and Data Quality report provides the Performance Committee with oversight of the Trust's performance against a selected group of access and data quality key performance indicators. The report is based on the indicators that are monitored through the Trust's Access and Data Quality Dashboard and reflects the information held in Lorenzo. The report highlights processes that are either not being consistently followed as expected on Lorenzo and/or are not being followed at the right pace. The report also highlights areas where the patient pathway is not being administered as expected.

Whilst we have seen improvements in a number of data quality metrics, the report has identified a need for further action at greater pace to improve performance against key access and data quality indicators. Targets have been set for the year by the Operational team to address a number of the indicators identified These are monitored regularly and additional actions agreed as and when appropriate. 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 is a part of the induction programme for new starters.

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 a new validation and reporting system Patient Pathway Plus (PP+) which enables 'real time' updates to the PTL (updated every 24 hours). This went live in May 2019.

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).

Annual Quality Report

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 which are set out in this Annual 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.

There were 11 patient safety incidents reported as serious incidents in 2019/20, one of which was a never event which related to a retained guidewire. 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 will be published in our Quality Report).

The Trust's Quality Report is to be published later in the year and will contain further information on performance against the 2019/20 priorities and our 2020/21 priorities.

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 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 2019/20 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, ten 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 2019/20 are given below.

Substantial Assurance:
HealthRoster System Part One
Contract Management
Key Financial Controls
Patient Experience

Reasonable assurance:
Compliance with HealthRoster Part Two
Sickness Management
Business Continuity and Disaster Recovery
Risk Management – Divisional Management of Risk

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

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 four 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. Where actions have been agreed by management, these have been monitored through the action tracking process. During the year progress has been reported to the audit committee, with the validation of the action status confirmed by internal audit on a rolling basis.

The recommendations and actions from the Risk Management audit which have been recently approved have been considered by the Executive Directors and actions will be monitored through the Quality and Risk Committee to improve the communication and understanding of risk across our Governance structure.

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 16 October 2019 which rated the Trust as "Outstanding";
- 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 Carer Experience Group 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 2020/21

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

Stephen Posey
Chief Executive
17 June 2020

Royal Papworth Hospital
NHS Foundation Trust

Group accounts for the year ended 31 March 2020

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

Independent auditor's report

to the Council of Governors of 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 2020 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statement of Changes in Equity and Group and Trust Statement 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 Trust's affairs as at 31 March 2020 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 2020 and the Department of Health and Social Care Group Accounting Manual 2020.

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 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: financial statements as a whole	£3.4m (2018/19:£3.1m) 1.8% (2018/19: 1.9%) of total revenues	
Risks of material misstatement		**vs 2018/19**
Recurring risks	Valuation of land and buildings	◀▶
	Revenue recognition	◀▶
	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 (unchanged from 2018/19):

	The risk	Our response
Valuation of Land and Buildings Land and buildings of £130 million (2018/19: £144 million) including £nil (2018/19: £119 million) of buildings in assets under construction. *Refer to pages 15-19 (accounting policy) and pages 40-41 (financial disclosures)*	**Subjective valuation** – Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them, they are valued on the basis of the cost to replace them with a modern equivalent asset (depreciated replacement cost or DRC). – During the audited year, the Trust moved to the new PFI hospital at the Cambridge Biomedical Campus. – The Trust's new PFI hospital was valued at DRC by an external valuer in the 2017/18 financial year when the asset was completed. – The Trust's policy is to carry out a full valuation every 5 years and an interim valuation every 3 years. No valuation has been carried out in 2019/20 on the basis that the assets are not subject to significant volatility. – The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. **Disclosure Quality** – There is a risk that uncertainties expressed by the Trust's valuer around the impact of the Covid-19 pandemic on the market-based values of land and buildings will be inappropriately disclosed.	Our procedures included: – **Challenging assumptions:** challenging management's assumption that the value of the PFI hospital had not materially changed. We considered appropriate BCIS property indices to assess whether values had moved materially; – **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in concluding whether there has been any material movement in the value of land and buildings since 31 March 2019. – Specifically we considered the adequacy of disclosures made around the uncertainty caused by the Covid-19 pandemic on market data used to underpin the valuer's assumptions, and management's consideration of these factors when arriving at the year-end valuation figures.

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

	The risk	Our response
Revenue recognition Operating income of £188 million (2018/2019: £168 million) *Refer to page 13-14(accounting policy) and page 29-32 (financial disclosures).*	**Subjective estimate:** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS Commissioners and to private patients which totals £150 million (2018/19: £142 million). An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances. The Trust reports patient care revenue of £150 million from NHS, private and overseas patients and £37.7 million of other operating income. Other operating income includes, amongst others, provider sustainability / financial recovery fund of £15.4m, education and training of £4.2 million and £4.1 million of transitional funding. There is a risk that the Trust recognises income to which it is not entitled.	Our procedures included: — **Test of detail:** we obtained the outcome of the agreement of balances exercise with other NHS bodies. Where there were material mismatches we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable; — **Test of detail:** we obtained copies of the signed contracts in place for the largest CCG commissioners and NHS England. For a sample of contracts, we reconciled the income per the contract to actual income recognised in the year and agreed variances to source documentation; — **Test of detail:** we agreed a sample of items relating to other income activities, including private patient income, to source documentation and agreed their accounting treatment. — **Test of detail:** we reviewed invoices and credit notes raised around the year end date to ensure the income had been recognised in the correct accounting period.
Non-pay expenditure recognition Accruals: £11.5 million (2018-19: £11.5 million) *Refer to page 13 (accounting policy) and page 46 (financial disclosures)*	**Effect of irregularities:** - There is a risk that the Trust may seek to improve it's financial position from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period through understatement of liabilities at year end). - 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 this was considered when planning and performing our audit procedures. - We consider the risk to specifically relate to accruals, as they represent the key mechanism for management to manipulate year-end outturn in order to achieve financial targets.	Our procedures included: — **Segregation of duties:** we have 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 (Finance Team) which helps to prevent fraudulent manipulation of expenditure; — **Test of detail:** We performed a year-on-year review of accruals, and sought explanation for significant movements; — **Test of detail:** We tested payments made and invoices received in April 2020 to identify whether the expenditure in the year was materially complete. We performed a sample test of accruals to supporting evidence to ensure these were accurate and measured appropriately.

3. Our application of materiality

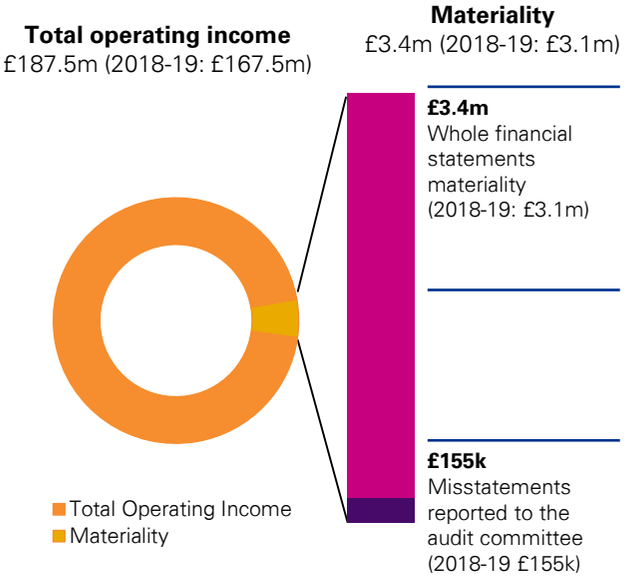
Materiality for the Group financial statements as a whole was set at £3.4 million (2018-19: £3.1 million), determined with reference to a benchmark of total operating income (of which it represents approximately 1.8% (2018/19: 1.9%)).

Materiality for the parent Trust's financial statements as a whole was set at £3.1 million (2018-19: £3 million), determined with reference to a benchmark of total operating income (of which it represents approximately 1.7% (2018/19: 1.8%)).

We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.155 million (2018-19: £0.155 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 £3.1 million (2018-19: £3.0 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 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 Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, and analysed how those risks might affect the 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 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 2019-20.

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 Trust'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 2019-20 is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

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6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 100, 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 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 Trust without the transfer of its 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 April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. 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 for securing 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 overleaf 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. The Trust made a surplus of £2.3 million (2018/19: deficit of £10.2 million) in the year.	Our work included: • Reviewing the Trust's performance against its agreed target year-end outturn and CIP target at year-end; **Our findings on this risk area:** - The Trust has prepared a financial strategy setting out its plans and initiatives to improve its financial position. - We are satisfied that the Trust had adequate arrangements for planning its finances and sustainable resource deployment.

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 Hospital NHS Foundation Trust for the year ended 31 March 2020 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.

SBeavis

Stephanie Beavis
for and on behalf of KPMG LLP

Chartered Accountants
Botanic House
100, Hills Road
Cambridge
CB2 1AR
24 June 2020

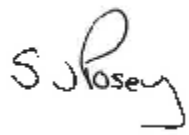
KPMG

FOREWORD TO THE ACCOUNTS

ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

These accounts for the year ended 31st March 2020 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: 17 June 2020

CONSOLIDATED AND TRUST STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 MARCH 2020

	NOTE	Group 2019/20 £000	Trust 2019/20 £000	Group 2018/19 £000	Trust 2018/19 £000
OPERATING INCOME					
Operating income from patient care activities	2	**149,774**	**149,774**	142,117	142,117
Other operating income	3	**37,728**	**35,917**	25,425	25,776
TOTAL OPERATING INCOME FROM CONTINUING OPERATIONS		**187,502**	**185,691**	167,542	167,893
Operating expenses	4-6	**(182,107)**	**(178,329)**	(172,655)	(171,343)
OPERATING SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS		**5,395**	**7,362**	(5,113)	(3,450)
Finance income	7	**298**	**134**	402	207
Finance expenses	8	**(5,350)**	**(5,350)**	(5,362)	(5,362)
Public Dividend Capital dividends payable	24	**(2,005)**	**(2,005)**	(1,640)	(1,640)
NET FINANCE COSTS		**(7,057)**	**(7,221)**	(6,600)	(6,795)
Gains/(losses) on disposal of non-current assets	9	**2,275**	**2,185**	(4)	-
Movement in fair value of investments	12	**(336)**	**-**	267	10
SURPLUS/(DEFICIT) FOR THE YEAR		**277**	**2,326**	(11,450)	(10,235)
OTHER COMPREHENSIVE INCOME					
Impairments	11	**(4,150)**	**(4,150)**	(1,033)	(1,033)
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**(3,873)**	**(1,824)**	(12,483)	(11,268)

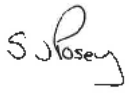
The notes on pages 11 to 57 form part of these accounts.

CONSOLIDATED AND TRUST STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2020

	NOTE	Group 31 March 2020 £000	Trust 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2019 £000
NON-CURRENT ASSETS					
Intangible assets	10	**3,392**	**3,392**	1,700	1,700
Property, plant and equipment	11	**159,296**	**159,296**	176,613	176,393
Investments	12	**4,536**	**-**	7,710	-
Trade and other receivables	14	**415**	**415**	114	114
Total non-current assets		**167,639**	**163,103**	186,137	178,207
CURRENT ASSETS					
Inventories	13	**5,327**	**5,312**	4,531	4,505
Trade and other receivables	14	**21,455**	**20,804**	9,473	9,214
Non-current assets for sale	16	**2,847**	**2,629**	0	0
Cash and cash equivalents	15	**17,924**	**16,650**	23,321	22,719
Total current assets		**47,553**	**45,395**	37,325	36,438
TOTAL ASSETS		**215,192**	**208,498**	223,462	214,645
CURRENT LIABILITIES					
Trade and other payables	17	**(27,465)**	**(27,446)**	(35,256)	(35,163)
Other liabilities	18	**(78)**	**(78)**	(248)	(248)
Borrowings	19	**(2,113)**	**(2,113)**	(2,112)	(2,112)
Provisions	20	**(1,723)**	**(1,723)**	(1,568)	(1,568)
Total current liabilities		**(31,379)**	**(31,360)**	(39,184)	(39,091)
TOTAL ASSETS LESS CURRENT LIABILITIES		**183,813**	**177,138**	184,278	175,554
NON-CURRENT LIABILITIES					
Borrowings	19	**(97,224)**	**(97,224)**	(94,334)	(94,334)
Provisions	20	**(768)**	**(768)**	(835)	(835)
Total non-current liabilities		**(97,992)**	**(97,992)**	(95,169)	(95,169)
TOTAL ASSETS EMPLOYED		**85,821**	**79,146**	89,109	80,385
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	25	**122,638**	**122,638**	122,053	122,053
Revaluation reserve		**1,100**	**1,100**	8,080	8,080
Income and expenditure reserve		**(44,592)**	**(44,592)**	(49,748)	(49,748)
OTHERS' EQUITY					
Charitable fund reserves	33	**6,675**	**-**	8,724	-
TOTAL TAX PAYERS' AND OTHER'S EQUITY		**85,821**	**79,146**	89,109	80,385

The financial accounts on pages 6 to 57 were approved by the Board on 17 June 2020 and signed on its behalf by:



Stephen Posey, Chief Executive
Date: 17 June 2020

CONSOLIDATED AND TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2020

	Trust				Charitable	Group
	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total Reserves	Fund Reserves	Total Reserves
	£000	£000	£000	£000	£000	£000
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	121,910	(39,513)	9,113	91,510	9,939	**101,449**
Total Comprehensive Expense for the year	-	(10,235)	-	(10,235)	(1,215)	**(11,450)**
Revaluation - 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**
Taxpayers' and others' equity at 1 April 2019	**122,053**	**(49,748)**	**8,080**	**80,385**	**8,724**	**89,109**
Changes in taxpayers' equity for 2019/20						
Total Comprehensive Income for the year	**-**	**2,326**	**-**	**2,326**	**(2,049)**	**277**
Impairment - Property, Plant and Equipment	**-**	**-**	**(4,150)**	**(4,150)**	**-**	**(4,150)**
Public dividend capital received	**585**	**-**	**-**	**585**	**-**	**585**
Transfer to retained earnings on disposal of assets	**-**	**2,830**	**(2,830)**	**-**	**-**	**-**
Taxpayers' and others' equity at 31 March 2020	**122,638**	**(44,592)**	**1,100**	**79,146**	**6,675**	**85,821**

The notes on pages 11 to 57 form part of these accounts.

CONSOLIDATED AND TRUST STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

	NOTE	**Group 2019/20**	Group 2018/19	**Trust 2019/20**	Trust 2018/19
		£000	£000	**£000**	£000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating surplus/(deficit)		**5,395**	(5,113)	**7,362**	(3,450)
NON CASH INCOME AND EXPENSE:					
Depreciation and amortisation	10/11	**7,088**	2,417	**7,086**	2,413
Net Impairments	5	**(25)**	1,557	**(25)**	1,557
Income recognised in respect of capital donations		**-**	-	**(80)**	(1,891)
(Increase) in inventories		**(807)**	(643)	**(807)**	(643)
(Increase)/decrease in receivables and other assets		**(11,979)**	1,570	**(11,892)**	2,492
Increase/(decrease) in trade and other payables		**(3,023)**	2,987	**(3,023)**	2,987
Increase/(decrease) and other liabilities		**(170)**	201	**(170)**	201
Increase in provisions		**88**	1,030	**88**	1,030
NHS Charitable fund – net movements in working capital, non-cash transactions, non operating cash flows		**2,644**	(111)	**-**	-
Net cash generated from / (used in) operating activities		**(789)**	3,895	**(1,461)**	4,696
Cash flows from investing activities					
Interest received		**144**	202	**144**	202
Payments for land, property, plant and equipment		**(7,235)**	(20,810)	**(7,235)**	(20,810)
Proceeds from disposal of property, plant and equipment		**7,383**	10	**7,383**	10
Payments for intangible assets		**(1,090)**	(1,225)	**(1,090)**	(1,225)
Net cash used in investing activities		**(798)**	(21,823)	**(798)**	(21,823)
Net cash outflow before financing		**(1,587)**	(17,928)	**(2,259)**	(17,127)
Cash flows from financing activities					
Public dividend capital received		**585**	143	**585**	143
Other loans received		**5,000**	-	**5,000**	-
Capital element of PFI payments		**(2,110)**	(2,006)	**(2,110)**	(2,006)
Interest paid		**(81)**	(57)	**(81)**	(57)
Interest paid on PFI obligations		**(5,268)**	(5,305)	**(5,268)**	(5,305)
PDC dividends paid		**(1,936)**	(3,153)	**(1,936)**	(3,153)
Net cash generated from financing activities		**(3,810)**	(10,378)	**(3,810)**	(10,378)
Increase / (decrease) in cash and cash equivalents		**(5,397)**	(28,306)	**(6,069)**	(27,505)
Cash and cash equivalents at 1 April		**23,321**	51,627	**22,719**	50,224
Cash and cash equivalents at 31 March	15	**17,924**	23,321	**16,650**	22,719

The notes on page 11 to 57 form part of these accounts.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

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 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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 surplus of £2.61m pre impairment and donated assets, with a bottom line surplus of £2.33m for the 2019/20 financial year;
- The Trust reported a closing cash position for the 2019/20 financial year of £16.65m;

Further, the going concern assessment is made in the context of the ongoing coronavirus outbreak. On 11 March 2020 the Chancellor of the Exchequer committed in Parliament, as part of the Budget 2020, that the NHS will receive all the resources needed to cope with coronavirus. This commitment was reaffirmed by Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard (NHS Chief Operating Officer, in a letter to NHS Chief Executive Officers on 17 March 2020.

Since these announcements NHS England and NHS Improvement has introduced revised funding arrangements as of 1 April 2020 designed to support NHS organisations throughout the coronavirus period. The operational plan framework has been suspended, however the national framework put in place to support the NHS in response to this crisis will mean that

NHS providers including the Trust, require cash assistance from the DHSC to support the additional equipment and resources required to provide services in response to Covid-19. This includes block support revenue and the reimbursement of Covid-19 related expenditure, with the expectation that providers are able to meet a cash backed, breakeven position for the length of the crisis. This provides a level of assurance for the expectations of continued service delivery and appropriate cash flows for the Trust for at least 12 months from the date of approval of the accounts (the going concern period).

Further national guidance is being developed for the 2020/21 financial year however given the Trust's cash position, it is not anticipated that this will limit the Trust's ability to continue as a going concern during the going concern period.

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 going concern period. 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).

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.

Revenue from NHS contracts

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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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.

Revenue from research contracts

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. Some research income alternatively falls within the provision of IAS 20 for government grants.

Revenue from the sale of non-current assets

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.

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

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

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.

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 11.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the NHS Foundation Trust.

Non-specialist assets on the site at Papworth Everard 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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment when it is brought into use, together with an equivalent 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 element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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

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 Years	Max Life Years
Buildings	35	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 Months	Max Life Months
Medical Equipment and Engineering Plant and Equipment	24	180
Furniture	60	180
Soft Furnishings	60	84
Office and Information Technology Equipment	42	60
Set-up Costs in New Buildings	60	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 when it meets the requirements set out in IAS 38.

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

Intangible assets are amortised 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 Months	Max Life Months
Software	42	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 30). 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the 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 20, 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 21 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.

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 and grant funded 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 2020 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 in which the Trust has no beneficial interest (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 (FReM). See note 30.

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 31.

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 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

1.26 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.

IFRS 16

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

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The NHS Foundation Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the NHS Foundation Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the NHS Foundation Trust's incremental borrowing rate. The NHS Foundation Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

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

The standards listed below are not expected to have an impact on the NHS Foundation Trust's accounts except where indicated.

IFRS 14

IFRS 14 Regulatory Deferral Accounts is not yet EU endorsed. It applies to first time adopters of IFRS after 1 January 2016 therefore it is not applicable to DHSC group bodies.

IFRS 17

The application of IFRS 17 Insurance Contracts is required for accounting periods beginning on or after 1 January 2021, but is not yet adopted by the FReM. The early adoption of this standard is not therefore permitted.

1.27 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 11.1.

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 14.2 and 14.3.

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 23, 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 2019, or the amounts charged through the Statement of Comprehensive Income.

Stock Levels

Due to the COVID 19 pandemic is has not been possible to physically count stock levels in a number of clinical areas. In these cases either reports from the stock system or estimates based on stock levels throughout the year have been used as a proxy.

2. OPERATING INCOME FROM PATIENT CARE ACTIVITIES

2.1 Income from patient care activities (by nature)

	2019/20	2018/19
	£000	£000
Elective income	**65,599**	62,370
Non-elective income	**34,692**	34,329
First outpatient income	**6,986**	7,254
Follow up outpatient income	**9,280**	8,762
High cost drugs income from commissioners	**5,551**	5,203
Other NHS clinical income	**16,782**	14,919
Private patient income	**6,676**	8,115
AfC pay award central funding	**-**	1,153
Other clinical income	**426**	12
Additional pension contribution central funding *	**3,782**	-
	149,774	142,117

* The additional pension contribution central funding relates to the additional 6.3% pension contributions paid by NHS England on behalf of the NHS Foundation Trust. The related expenditure is included in note 4.1 Operating expenses under staff costs.

2.2 Patient income by source

	2019/20	2018/19
	£000	£000
NHS Foundation Trusts	**1**	-
NHS England	**107,160**	98,473
Clinical Commissioning Groups	**32,732**	32,032
Department of Health and Social Care*	**4**	1,154
NHS Other	**2,775**	2,331
Non NHS:		
- Private patients	**6,676**	8,115
- Overseas chargeable patients	**426**	12
Total revenue from patient care activities	**149,774**	142,117

* For 2018/19 this 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. In 2019/20 funding for the AfC pay award was incorporated into the PBR/tariff rates.

Income of £374k relating to patient treatment spells which were partially complete at 31 March 2020 (£571k – 31 March 2019) has been recognised in the 2019/20 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 service lines: 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). These service lines are organised under three Directorates for operating management and governance purposes: Cardiology, Thoracic and Ambulatory, Surgery, Transplant and Anaesthetics.

The Foundation Trust's operating segments reflect the services that it provides. Income is reported to the Board on a regular basis by service:

Patient income by service

	2019/20			2018/19		
	Inpatients	**Outpatients**	**Total**	Inpatients	Outpatients	Total
	£000	**£000**	**£000**	£000	£000	£000
Cardiology	28,421	5,094	**33,515**	31,594	5,362	36,956
Cardiac surgery	25,437	796	**26,233**	24,488	635	25,123
Thoracic surgery	12,395	201	**12,596**	11,399	212	11,611
Respiratory support and sleep centre	7,799	3,657	**11,456**	7,070	3,898	10,968
Thoracic medicine	12,831	3,205	**16,036**	11,749	2,876	14,625
Transplant/Ventricular assist devices	18,793	2	**18,795**	18,387	-	18,387
Clinical and diagnostics	17,097	3,439	**20,536**	15,171	2,404	17,575
Total of income from reporting segments	**122,773**	**16,394**	**139,167**	119,858	15,387	135,245
2018/19 Agenda for Change pay award funding			-			1,153
Market Forces Factor (inpatients and outpatients)			**6,825**			5,719
Additional pension contribution central funding			**3,782**			-
Total revenue from patient care activities per note 2.1			**149,774**			142,117

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:

	2019/20	2018/19
	£000	£000
NHS England	**107,160**	98,473
Cambridgeshire and Peterborough CCG*	**13,674**	13,070
West Suffolk CCG	**4,093**	4,149
West Norfolk CCG	**2,990**	2,841
Bedfordshire CCG	**2,155**	2,194
Ipswich & East Suffolk CCG	**1,347**	1,606
South Lincolnshire CCG	**1,393**	1,348
West Essex CCG	**1,349**	1,223
East and North Hertfordshire CCG	**1,313**	1,165
Department of Health and Social Care	**4**	1,154
South Norfolk CCG	**516**	597
North East Essex CCG	**379**	419
Great Yarmouth and Waveney CCG	**238**	268
North Norfolk CCG	**368**	247
Other CCGs	**2,917**	2,906
Other NHS	**1,846**	1,165
Subtotal	**141,742**	132,825
Welsh Health Boards	**854**	881
Scottish Health Board	**35**	94
Northern Ireland Health Boards	**41**	190
Private patients	**6,676**	8,115
Other non-NHS	**426**	12
Total patient service income	**149,774**	142,117
Other patient related activity	**-**	**-**
Total revenue from patient care activities per note 2.1	**149,774**	142,117

* 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:

	2019/20	2018/19
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	**149,774**	142,117

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

	2019/20	2018/19
	£000	£000
Income recognised this year	**426**	12
Cash payments received in-year	**88**	18
Amounts added to provision for impairment of receivables	**43**	6
Amounts written off in-year	**-**	44

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**	
	2019/20	2018/19	**2019/20**	2018/19
	£000	£000	**£000**	£000
Research and development NHS Levy	**1,332**	1,757	**1,332**	1,757
Education and training	**4,173**	3,515	**4,173**	3,515
Provider sustainability fund/Financial recovery fund *	**15,453**	-	**15,453**	-
Charitable and other contributions to expenditure	**-**	-	**980**	2,613
Merit award funding	**1,530**	1,297	**1,530**	1,297
Staff lodging	**576**	667	**576**	667
Staff recharges **	**1,846**	2,659	**1,846**	2,659
Research and development gross up ***	**2,191**	2,167	**2,191**	2,167
NHS Charitable income:				
Incoming resource excluding investment income	**2,791**	2,262	**-**	-
Transitional funding ****	**4,050**	6,900	**4,050**	6,900
Other income	**3,786**	4,201	**3,786**	4,201
	37,728	25,425	**35,917**	25,776

* Provider sustainability fund/Financial recovery fund relates to the NHS Foundations Trust's ability to achieve its control total set by NHS England/Improvement.

** 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 received transitional funding of £4.05m (2018/19 - £6.9m).

4. OPERATING EXPENSES

4.1 Operating expenses comprise:

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£000	£000	**£000**	£000
Executive Directors' costs	**1,137**	1,071	**1,137**	1,071
Non-Executive Directors' costs	**128**	121	**128**	121
Staff costs	**104,531**	93,941	**104,531**	93,941
Drug costs	**5,903**	5,875	**5,903**	5,875
Supplies and services - clinical	**33,309**	36,552	**33,309**	36,552
Supplies and services - general	**1,676**	3,879	**1,676**	3,879
Establishment	**1,542**	1,613	**1,543**	1,613
Research & Development	**804**	1,291	**804**	1,291
Transport	**958**	810	**958**	810
Premises	**9,145**	7,575	**9,145**	7,575
Increase/(decrease) in provisions for impairments of receivables	**51**	(32)	**51**	(32)
Depreciation of property, plant and equipment	**6,549**	2,242	**6,547**	2,238
Amortisation of intangible assets	**539**	175	**539**	175
Impairments of property, plant and equipment	**(25)**	1,556	**(25)**	1,556
Impairments of intangibles	**-**	1	**-**	1
Audit services - statutory audit	**55**	47	**55**	47
Other auditors remuneration - other assurance services	**-**	7	**-**	7
NHS Charitable Funds - statutory audit services	**4**	4	**-**	-
Consultancy	**953**	1,750	**953**	1,750
Internal audit and counter fraud services	**59**	54	**59**	54
Clinical negligence	**1,079**	845	**1,079**	845
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes on IFRS basis	**6,315**	6,088	**6,315**	6,088
Other	**3,622**	5,874	**3,622**	5,886
NHS Charitable Funds - other resources expended	**3,773**	1,316	**-**	-
	182,107	172,655	**178,329**	171,343

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 £54,900 (2018/19: £47,500), excluding VAT. This is the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. £nil has been paid for other services in relation to the Quality Report opinion (2018/19: £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 (2018/19: £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

	2019/20	2018/19
	£000	£000
Minimum lease payments	**1,196**	1,403

Total future minimum lease payments

	2019/20	2018/19
	£000	£000
Payable:		
Not later than one year	**1,059**	1,479
Between one and five years	**3,358**	3,964
After five years	**15,673**	16,432
	20,090	21,875

The NHS Foundation Trust has a number of leases for land and property. The leases for medical equipment expired at the end of May 2019.

There are no (2018/19: 2) leases where the capital value of the equipment (including VAT) exceeded £250k. The lease rental is fixed at the outset of the leases.

The NHS Foundation Trust has 1 (2018/19: 4) lease relating to land used for the purpose of car parking at its Papworth Everard site. The lease is for a period of 10 years or less and expires on 18 June 2020.

The NHS Foundation Trust leases one (2018/19: 2) building used as office space. This 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.

5 IMPAIRMENT OF ASSETS

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus/(deficit) resulting from:		
Impairment reversal of New Papworth Hospital	**(25)**	-
Impairment of Papworth Everard site buildings, plant and equipment	**-**	1,556
Impairment of intangibles	**-**	1
	(25)	1,557

The NHS Foundation Trust obtained an independent appraisal on 16 January 2018 of its Papworth Everard site to inform decision making in respect of future land sales assuming suitability for residential development. The NHS Foundation Trust has considered the lower valuation of this appraisal to be a reasonable value of the land at its Papworth Everard site. This has resulted in an impairment of £4,150k which has been charged to the revaluation reserve. There was a part reversal of £25k (2018/19 £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	
		2019/20	2018/19	**2019/20**	2018/19
		£000	£000	**£000**	£000
Salaries and wages	*	**77,948**	72,634	**77,948**	72,634
Social security costs	*	**7,751**	7,159	**7,751**	7,159
Apprenticeship levy		**372**	347	**372**	347
Employer contributions to NHS Pensions Agency		**8,666**	8,274	**8,666**	8,274
Pension cost - employer contribution paid by NHSE on provider's behalf (6.3%)	**	**3,782**	-	**3,782**	-
Temporary staff (including agency)		**7,149**	6,598	**7,149**	6,598
Employee benefit expenses	*	**105,668**	95,012	**105,668**	95,012

* Excludes Non-Executive Directors' salary costs. These salary costs are included in note 4.1.

** The additional pension contribution central funding relates to the additional 6.3% pension contributions paid by NHS England on behalf of the NHS Foundation Trust. The related income is included in note 2 Operating Income.

All employee benefit expenses have been charged to revenue. The total employer pension contributions paid for the year is £8,666k (2018/19: £8,288k).

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 2020 is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

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

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

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 2019/20 was £11k (2018/19 £7k).

6.2 Staff Exit Packages

	2019/20		2018/19	
	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
£10,000-£25,000	2	2		
£25,001-£50,000	1	1	-	-
£50,001-£100,000	1	1	-	-
Total number of exit packages by type	**4**	**4**	-	-
		£000		£000
Total resource cost		**131**		-

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	
	2019/20 Total Number	2018/19 Total Number	**2019/20 Total Number**	2018/19 Total Number
Permanently Employed				
Medical and dental	**215**	211	**215**	211
Administration and estates	**383**	371	**383**	371
Healthcare assistants and other support staff	**355**	350	**355**	350
Nursing, midwifery and health visiting staff	**608**	576	**608**	576
Scientific, therapeutic and technical staff	**149**	147	**149**	147
Health care science staff	**68**	75	**68**	75
Other	**2**	-	**2**	-
Other				
Bank staff	**63**	55	**63**	55
Agency/contract staff	**58**	59	**58**	59
Other	**9**	10	**9**	10
Total	**1,910**	1,854	**1,910**	1,854

6.4 Retirements due to ill-health

In the year to 31 March 2020, there was 2 early retirement agreed on the grounds of ill-health (31 March 2019: 1). The estimated additional pension liability in respect of early retirements agreed on the grounds of ill-health is £33k (31 March 2019: £57k); 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	
	2019/20 Total	2018/19 Total	**2019/20 Total**	2018/19 Total
	£000	£000	**£000**	£000
Salary	**1,022**	992	**1,022**	992
Taxable benefits	**9**	20	**9**	20
Employer's pension contributions	**109**	79	**109**	79
Total	**1,140**	1,091	**1,140**	1,091

Further details of directors' remuneration can be found in the remuneration report.

7 FINANCE INCOME

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£000	£000	**£000**	£000
Interest revenue:				
Investments in listed equities	**159**	191	**-**	-
Short term investments and deposits	**5**	4	**-**	-
Bank accounts	**134**	207	**134**	207
	298	402	**134**	207

8 FINANCE EXPENSES

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£000	£000	**£000**	£000
Loans from the Department of Health and Social Care	**82**	57	**82**	57
Main finance costs on PFI scheme obligations	**4,808**	4,919	**4,808**	4,919
Contingent finance costs on PFI scheme obligations	**460**	386	**460**	386
	5,350	5,362	**5,350**	5,362

9 GAINS/(LOSSES) ON NON-CURRENT ASSETS DISPOSAL

	Group		Trust	
	2019/20	2018/19	**2019/20**	2018/19
	£000	£000	**£000**	£000
Gain on disposal of property, plant and equipment	124	8	124	8
Gain on disposal of assets held for sale	2,067	-	2,067	-
Loss on disposal of intangibles	(6)	-	(6)	-
Gain/(loss) on disposal of charitable funds asset	90	(4)	-	-
	2,275	4	**2,185**	8

10 INTANGIBLE ASSETS

2019/20	Computer Software Purchased £000	Intangible Assets Under Construction £000	Total Intangible Assets £000
Gross cost at 1 April 2019	3,396	1,557	**4,953**
Additions purchased - Trust	1,428	212	**1,640**
Reclassifications	2,154	(1,557)	**597**
Disposals	(29)	-	**(29)**
Gross cost at 31 March 2020	**6,949**	**212**	**7,161**
Accumulated amortisation at 1 April 2019	3,253	-	**3,253**
Provided during the year	539	-	**539**
Disposals	(23)	-	**(23)**
Accumulated amortisation at 31 March 2020	**3,769**	**-**	**3,769**
Net book value			
- Purchased at 31 March 2020	3,132	212	**3,344**
- Donated at 31 March 2020	48	-	**48**
Total at 31 March 2020	**3,180**	**212**	**3,392**

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**
Disposals	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**

11 PROPERTY, PLANT AND EQUIPMENT

11.1 Property, plant and equipment at the financial year end comprise the following elements:

2019/20	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
Cost/valuation at 1 April 2019	24,421	9,765	928	148,823	30,332	135	4,534	794	219,732
Additions purchased - Trust	135	88	-	(538)	1,572	-	370	286	1,913
Additions purchased - cash donations	-	-	-	-	35	-	-	45	80
Reversal of impairments credited to operating income	-	25	-	-	-	-	-	-	25
Impairments charged to revaluation reserve	(4,150)	-	-	-	-	-	-	-	(4,150)
Reclassifications		119,333	-	(148,271)	22,669	-	2,870	2,802	(597)
Transfer to assets held for sale	(7,806)	(9,766)	(928)	-	-	-	-	-	(18,500)
Disposals	-	-	-	-	(16,003)	(99)	(13)	(98)	(16,213)
At 31 March 2020	**12,600**	**119,445**	**0**	**14**	**38,605**	**36**	**7,761**	**3,829**	**182,290**
Accumulated depreciation at 1 April 2019	-	9,620	787	-	28,136	125	4,144	307	43,119
Provided during the year	-	2,304	8	-	3,206	2	605	424	6,549
Transfer to assets held for sale	-	(9,766)	(795)	-	-	-	-	-	(10,561)
Disposals	-	-	-	-	(15,907)	(95)	(13)	(98)	(16,113)
Accumulated depreciation at 31 March 2020	**-**	**2,158**	**0**	**-**	**15,435**	**32**	**4,736**	**633**	**22,994**
Net book value									
- Purchased at 31 March 2020 - Trust	12,600	536	-	14	20,832	-	2,853	3,115	39,950
- Purchased at 31 March 2020 - NHS Charity	-		-	-	-	-	-	-	0
- On-SoFP PFI contract at 31 March 2020	-	116,751	-	-	-	-	-	-	116,751
- Government granted at 31 March 2020	-		-	-	-	-	-	-	0
- Donated at 31 March 2020	-		-	-	2,338	4	172	81	2,595
Total at 31 March 2020	**12,600**	**117,287**	**0**	**14**	**23,170**	**4**	**3,025**	**3,196**	**159,296**

11.1 Property, plant and equipment at the financial year end comprise the following elements:

2018/19	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Total £000
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	-	-	-	-		-	-	-	-
Reclassifications	-	10	-	(261)	32	-	-	219	-
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	-	-	-	-		-	-	-	-
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**

In May 2019 the NHS Foundation Trust relocated to its new site on the Cambridge Biomedical Campus.

Papworth Everard site
The land at the Papworth Everard site was impaired to reflect its fair value prior to the land being transferred to assets held for sale during the year. A valuation of the Papworth Everard site was carried out in January 2018 by external organisation, DVS Property Specialists and was the basis for the impairment value. Buildings and dwellings at the Papworth Everard site were fully depreciated prior to being transferred to assets held for sale.

Due to the impending sale of the Papworth Everard site, in April 2020 the Trust received a desktop valuation at 31 March 2020 from DVS Property Specialists. The valuation exercise was carried out with a valuation date of 31 March 2020 and the valuation showed no material change.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The valuer's report states that "less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of this property under frequent review".

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The valuer has not indicated in the report the range of uncertainty and it is possible that the COVID-19 pandemic will affect the Trust's future assessment, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

New hospital site
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. Information about the impairment of assets reversal is contained in note 5.

Valuations are carried out by professionally qualified individuals in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

The Trust has not obtained an additional valuation report for this site in 2019/20. The Trust is aware that the Royal Institute of Chartered Surveyors (RICS) has issued a valuation practice notice which gives guidance to valuers where a valuer declares a materiality uncertainty attached to a valuation in light of the impact of COVID-19 on markets. As explained above, the Trust has not obtained a valuation report for 2019/20 but it should be noted that there may now be greater uncertainty in markets on which the valuation obtained in 2018 and reflected in these financial statements is based.

Given the judgements explained in preparing these 2019/20 financial statements, the Trust has not deviated from its existing accounting policy by obtaining an additional valuation to which a materiality uncertainty might be attached. It is possible that the COVID-19 pandemic will affect the Trust's future assessment, but as yet there is insufficient evidence to affect the assumptions used in the valuation.

12 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 2020 £000	31 March 2019 £000
Investment Managers		
Market value at 1 April	**6,614**	6,627
Add: Additions of shares	**1,337**	880
Less: Disposals at carrying value	**(3,842)**	(1,150)
Net gain on revaluation	**(336)**	257
Market value at 31 March (shares only)	**3,773**	6,614
Cash held with Investment Managers at 31 March	**763**	1,096
Total value of investments	**4,536**	7,710
Historic cost at 31 March (shares only)	**3,711**	4,847

The valuation of the investments is at 31 March 2020 and may not be realised at the date the investments are disposed of.

At 31 March 2020 2,000 (31 March 2019: 5,000) shares were held with a market value of £204,708 (31 March 2019: £462,052) in Findlay Park Funds American USD Dis., which represents 5.4% 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 2020 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.

13 INVENTORIES

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
Drugs	**533**	534	**533**	534
Consumables	**4,779**	3,971	**4,779**	3,971
NHS Charity - gift shop	**15**	26	**-**	-
TOTAL	**5,327**	4,531	**5,312**	4,505

The cost of inventories recognised as an expense and included in 'operating expenses' amounted to £23,184k (2018/19: £25,603k).

No inventories were recognised as a write-down expense during the year (2018/19: £5k).

Consumable stock levels were higher at the 31 March 2020 due to the impact of COVID 19 by £149k.

14 TRADE AND OTHER RECEIVABLES

Current	Group		Trust	
	31 March 2020	31 March 2019	**31 March 2020**	31 March 2019
	£000	£000	**£000**	£000
Contract receivables: invoiced NHS	**4,989**	1,538	**4,989**	1,538
Contract receivables: invoiced other	**2,758**	2,881	**2,874**	3,084
VAT receivables	**1,155**	1,349	**1,155**	1,349
Contract receivables: not yet invoiced *	**10,342**	1,278	**9,586**	816
Allowance for the impaired contract receivables	**(729)**	(680)	**(729)**	(680)
PDC dividend receivable	**471**	540	**471**	540
Prepayments other	**2,307**	2,512	**2,296**	2,512
Clinician pension tax provisions reimbursement funding from NHSE	**152**	-	**152**	-
Other receivables	**10**	55	**10**	55
TOTAL	**21,455**	9,473	**20,804**	9,214
Non-current				
Clinician pension tax provisions reimbursement funding from NHSE	**223**	-	223	-
PFI lifecycle prepayments	**192**	114	**192**	114
TOTAL	**415**	**114**	**415**	**114**

* Included within contract receivables not yet invoiced is accrued income for Provider sustainability fund/Financial recovery fund £5.41m (2018/19 £nil) and funding related to specific COVID 19 expenditure £1.5m (2018/19 £nil).

14.1 Provision for impairment of receivables

	Total trade receivables £000	**Other trade receivables £000**
At 1 April 2019	**680**	**680**
New allowance arising	**72**	**72**
Changes in the calculation of existing allowances	**8**	**8**
Receivables written off during the year as uncollectable	**(2)**	**(2)**
Reversals of allowances	**(29)**	**(29)**
At 31 March 2020	**729**	**729**

	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

IFRS 9 Financial Instruments as interpreted and adapted by the DHSC AGM was applied by the NHS Foundation Trust from 1 April 2018. Reassessment of allowances for credit losses under IFRS 9 resulted in a £477k increase in carrying value of receivables in 2018/19.

14.2 Analysis of impaired receivables

	31 March 2020 £000	31 March 2019 £000
Ageing of impaired receivables		
Current	**40**	8
0 - 30 days	**47**	7
30 - 60 days	**82**	2
60 - 90 days	**9**	3
90 - 180 days	**18**	137
Over 180 days	**533**	523
TOTAL	**729**	680

14.3 Analysis of non-impaired receivables

	31 March 2020 £000	31 March 2019 £000
Ageing of non-impaired receivables		
Current	**5,047**	2,931
0 - 30 days	**635**	210
30 - 60 days	**642**	(22)
60 - 90 days	**288**	411
90 - 180 days	**243**	173
Over 180 days	**21**	239
TOTAL	**6,876**	3,942

15 CASH AND CASH EQUIVALENTS

	Group		**Trust**	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
At 1 April	**23,321**	51,627	**22,719**	50,224
Net change in year	**(5,397)**	(28,306)	**(6,069)**	(27,505)
Balance at 31 March	**17,924**	23,321	**16,650**	22,719
Made up of:				
Government Banking Services	**16,222**	21,754	**16,222**	21,754
Cash at commercial banks and in hand	**1,702**	1,567	**428**	965
Cash and cash equivalents as in statement of cash flows	**17,924**	23,321	**16,650**	22,719

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 2020 £nil was held on short term deposit (31 March 2019: £nil) by the NHS Foundation Trust and £nil (31 March 2019: £0.2m) was held on short term deposit by the NHS Charity.

16 NON-CURRENT ASSETS FOR SALE

	Group	Trust
	Most recently held as:	
	Land or Dwellings £000	**Land £000**
Non-current assets for sale and assets in disposal groups at 1 April 2019	-	-
Plus assets classified as available for sale in the year	7,939	7,721
Less assets disposed of in the year	(5,092)	(5,092)
Non-current assets for sale and assets in disposal groups at 31 March 2020	**2,847**	**2,629**

In the year the NHS Foundation Trust reclassified the site at Papworth Everard, including the residential houses and nurses homes to assets held for sale when it vacated the site in May 2019.

In addition surplus land at the Cambridge Bio medical campus was reclassified when it was identified that this would be sold to the University of Cambridge to enable the building of the Heart and Lung Research Institute.

The items left to be sold at 31 March 2020 include the land at the Papworth Everard hospital site and two of the residential houses. The NHS Foundation Trust is actively marketing these for sale. See commentary at note 11 regarding the impact of Covid-19 on market valuations.

17 TRADE AND OTHER PAYABLES

Current	**Group**		**Trust**	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
NHS Payables - revenue	**1,654**	5,032	**1,654**	5,032
Other trade payables - revenue	**6,221**	6,453	**6,221**	6,453
Other trade payables - capital	**1,258**	5,952	**1,258**	5,952
Receipts in advance	**3,176**	2,972	**3,176**	2,972
Other taxes payable	**2,117**	2,058	**2,117**	2,058
Accruals	**11,734**	11,489	**11,715**	11,396
Other payables	**1,305**	1,300	**1,305**	1,300
TOTAL	**27,465**	35,256	**27,446**	35,163

Non-current

The Group has no non-current trade and other payables.

Outstanding pension contributions of £1,272k falling within one year are included within 'Other payables' for the year to 31 March 2020 (31 March 2019: £1,242k).

18 OTHER LIABILITIES

	Current	
	31 March 2020 £000	31 March 2019 £000
Deferred Income	**78**	248

19 BORROWINGS

	Current		Non-current	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
Loans from Department of Health	3	2	15,000	10,000
Obligations under PFI contract	2,110	2,110	82,224	84,334
	2,113	2,112	**97,224**	94,334

19.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	**PFI and LIFT schemes £000**	**Total £000**
Carrying value at 1 April 2019	10,002	86,444	**96,446**
Cash movements:			
Financing cash flows - payments and receipts of principal	5,000	(2,110)	**2,890**
Financing cash flows - payments of interest	(81)	(4,808)	**(4,889)**
Non-cash movements:			**-**
Impact of implementing IFRS 9 on 1 April 2018			**-**
Application of effective interest rate	82	4,808	**4,890**
Carrying value at 31 March 2020	**15,003**	**84,334**	**99,337**

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%.

20 PROVISIONS

	Pensions relating to other staff £000	Clinician pension tax reimbursement £000	Land and buildings £000	Other £000	Total £000
					31 March 2020
At 1 April 2019	**531**	**-**	**1,070**	**802**	**2,403**
Change in the discount rate	99	-	-	-	**99**
Arising during the year	-	375	46	486	**907**
Utilised during the year	(39)	-	(246)	(354)	**(639)**
Reversed unused	-	-		(279)	**(279)**
At 31 March 2020	**591**	**375**	**870**	**655**	**2,491**
Expected timing of cash flows:					
- not later than one year;	46	152	870	655	**1,723**
- later than one year and not later than five	145	49	-	-	**194**
- later than five years.	400	174	-	-	**574**
Total	**591**	**375**	**870**	**655**	**2,491**

	Pensions relating to other staff £000	Clinician pension tax reimbursement £000	Land and buildings £000	Other £000	Total £000
					31 March 2019
At 1 April 2018	506	-	852	15	1,373
Change in the discount rate	56	-	-	-	56
Arising during the year	-	-	397	787	1,184
Utilised during the year	(31)	-	(179)	-	(210)
At 31 March 2019	531	-	1,070	802	2,403
Expected timing of cash flows:					
- not later than one year;	48	-	1,070	450	1,568
- later than one year and not later than five	139	-	-	352	491
- later than five years.	344	-	-	-	344
Total	531	-	1,070	802	2,403

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 clinician pension tax reimbursement provision relates to a future contractually binding commitment that the NHS Foundation Trust has to compensate clinicians for an additional tax charge that they will incur on their retirement due to the 2019/20 Scheme Pay deduction.

Included within other provisions is the lease dilapidations provision which 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. It also relates to payments due to be made by the NHS Foundation Trust under one land operating lease until its termination date, as the NHS Foundation Trust no longer requires the associated asset. In addition other provisions include a provision for the calculation of holiday pay for staff who receive regular pay supplements, including enhanced pay for working outside of normal hours and two employment tribunal claims that are currently ongoing.

The amount included in the provision of NHS Resolution at 31 March 2020 in respect of clinical negligence liabilities of the NHS Foundation Trust is £13,509k (31 March 2019: £13,444k).

21 CONTINGENT ASSETS AND LIABILITIES

The value of contingent liabilities in respect of NHS Resolution legal claims at 31 March 2020 is £6k (31 March 2019: £17k).

There are no contingent assets.

22 CAPITAL AND CONTRACTUAL COMMITMENTS

The value of commitments under capital expenditure contracts at the end of the financial year was £0.77m (31 March 2019: £1.3m). There were no commitments under finance leases at the end of the financial year (31 March 2019: £nil).

These commitments relate to orders for IT equipment which is part of the NHS Foundation Trust's capital programme and medical equipment to support COVID 19 activity. The IT equipment will be funded from Trust resources in 2019/20. The NHS Foundation Trust will receive PDC funding in 2020/21 to cover the cost of the COVID-19 medical equipment.

The NHS Foundation Trust entered into a contract on the 5 February 2020 with the University of Cambridge to rent floor space in the Heart and Lung Research Institute building. The value of this contractual commitment is £1.9m.

Details of commitments in respect of operating leases can be found at note 4.3.1.

23 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 £6.32m (2018/19 £6.09m). The hospital was handed over to the NHS Foundation Trust in February 2018 and became 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).

23.1 PFI finance lease obligations

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
Gross PFI finance lease liabilities	**84,334**	86,444	**84,334**	86,444
Of which liabilities are due				
- not later than one year;	**2,110**	2,110	**2,110**	2,110
- later than one year and not later than five years;	**8,864**	8,578	**8,864**	8,578
- later than five years.	**73,360**	75,756	**73,360**	75,756
Finance charges allocated to future periods		-		-
Net PFI liabilities	**84,334**	86,444	**84,334**	86,444
- not later than one year;	**2,110**	2,110	**2,110**	2,110
- later than one year and not later than five years;	**8,864**	8,578	**8,864**	8,578
- later than five years.	**73,360**	75,756	**73,360**	75,756

23.2 PFI total unitary payments obligations

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
Total future payments committed in respect of the PFI arrangement	**516,545**	**531,488**	**516,545**	**531,488**
Of which liabilities are due				
- not later than one year;	**14,373**	14,184	**14,373**	14,184
- later than one year and not later than five years;	**60,958**	60,093	**60,958**	60,093
- later than five years.	**441,214**	457,211	**441,214**	457,211

23.3 Analysis of amounts payable to service concession operator

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	**31 March 2020 £000**	31 March 2019 £000
Unitary payment payable to service concession operator	**13,771**	13,475	**13,771**	13,475
Consisting of:				
- Interest charge	**4,808**	4,919	**4,808**	4,919
- Repayment of finance lease liability	**2,110**	2,006	**2,110**	2,006
- Service element and other charges to operating expenditure	**6,315**	6,088	**6,315**	6,088
- Contingent rent	**460**	386	**460**	386
- Addition to lifecycle prepayment	**78**	76	**78**	76
	13,771	13,475	**13,771**	13,475

24 EVENTS AFTER THE REPORTING YEAR

COVID 19 has had an impact on the Trust's operational environment and the financial framework under which the Trust operates.

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

2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment.

The Trust has one loan with DHSC which is the £15m bridging loan linked to the sale of the Papworth Everard Hospital site. At the time of writing the Trust has not received notification that this loan would fall under the new regime and therefore there are no changes made to the classification of this loan in the Trust's accounts.

25 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 £0.59m of PDC funding in 2019/20 to fund a Cyber Security upgrade and a pharmacy system upgrade. In 2018/19, the NHS Foundation Trust received £0.14m of PDC funding to fund the implementation of 2020 secondary care WiFi and a pharmacy system upgrade.

26 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 7 (2018/19: 6).

	2019/20	2018/19
	£000	£000
Remuneration payment	**1,029**	975
Employer contribution to the NHS Pension Scheme	**109**	79
	1,138	1,054

The remuneration payment relating to the highest paid director is £161k (2018/19: £169k). 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 J Ahluwalia joined the Board on the 1 October 2019 as a Non-Executive Director and holds an Honorary Appointment at the Judge Business School. Professor I Wilkinson joined the Board on the 1 January 2020 and is Clinical Pharmacologist and Professor of Therapeutics and is an employee of the University of Cambridge. 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. Dr S Lintott left the Trust on 31 October 2019. During the year the NHS Foundation Trust made payments to the University of Cambridge of £650k (2018/19: £385k) for staff recharges relating to medical staff. At the 31 March 2020 the NHS Foundation Trust has £177k (31 March 2019: £202k) owing to the University of Cambridge relating to staff recharges.

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 (2018/19: £103k) to the CUHP for its share of the CUHP running costs. At 31 March 2020 there was £26k owing by the NHS Foundation Trust to CUHP (31 March 2019: £26k). There were no amounts written off during the year and there are no provisions for doubtful debts at 31 March 2020 in respect of CUHP (31 March 2019: £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. Professor N Morrell also held the position of Director at CUHP (and was Non-Executive Director University nominee at the Trust until 31 December 2019).

Dr J Ahluwalia is a CUH Employee, seconded to Eastern Academic Health Science Network as Chief Clinical Officer. The NHS Foundation Trust is 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.

Dr J Ahluwalia is a Director for the East of England Chief Resident Training programme which is run through Cambridge University Hospital NHS Foundation Trust (CUH). During the year the NHS Foundation Trust made payments to CUH of £6,027k and had £2,244k owing to CUH at 31 March 2020. Dr J Ahluwalia is also an Associate at the Moller Centre. During the year the NHS Foundation Trust made payments to the Moller Centre of £14k and had nil owing to the Moller Centre at 31 March 2020.

Mr D Hughes, a Non-Executive Director, is a Non-Executive Director of Health Enterprise East (HEE). HEE works with the NHS and medtech companies to help turn innovative ideas into products and services that will benefit patients, the NHS and the wider economy. Mr D Hughes left the Trust on the 31 October 2019.

Professor I Wilkinson, a Non-Executive Director, is a Director of Cambridge Clinical Trials Unit (hosted at the Cambridge University Hospitals NHS Foundation Trust). The CCTU is part of the NIHR UKCRC Registered CTU Network and receives National Institute for Health Research CTU Support Funding.

Ms C Conquest joined the Board on the 1 January 2019 as a Non-Executive Director and held the post of Interim Deputy Director for Commercial Services and Business Intelligence until August 2019 from when she held the post of Deputy Director of Finance and Performance at the Norfolk Community Health & Care NHS Trust. During the year the NHS Foundation Trust made payments to the Norfolk Community Health & Care NHS Trust of £6k (2018/19 £7k) and had nil owing to the Norfolk Community Health & Care NHS Trust at 31 March 2020 (2018/19 £nil).

Mr D Dean joined the Board on the 1 November 2018 as a Non-Executive Director and holds the post of Chair/Executive Chair of ETL (formerly Essentia Trading Limited), a commercial subsidiary of Guy's and St Thomas' NHS Foundation Trust. During the year the NHS Foundation Trust made payments to Guy's and St Thomas' NHS Foundation Trust of £3k (2018/19 £nil) and had nil owing to the Guy's and St Thomas' NHS Foundation Trust at 31 March 2020 (2018/19 £nil).

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
	2019/20	2018/19	**2020**	2019
	£000	£000	**£000**	£000
NHS England	**126,343**	106,686	**10,434**	817
NHS Cambridgeshire and Peterborough CCG	**13,718**	13,070	**85**	-
NHS West Suffolk CCG	**4,093**	4,126	**55**	-
Health Education England	**4,052**	3,288	**-**	-
NHS West Norfolk CCG	**2,993**	2,841	**-**	-
NHS Bedfordshire CCG	**2,155**	2,194	**-**	-
NHS Ipswich and East Suffolk CCG	**1,350**	1,606	**-**	-
NHS South Lincolnshire CCG	**1,395**	1,348	**-**	26
NHS Blood and Transplant	**1,995**	1,298	**728**	147
NHS West Essex CCG	**1,349**	1,223	**-**	-
NHS East and North Hertfordshire CCG	**1,313**	1,165	**66**	-

The figures above differ from those in note 2.2 due to the inclusion of other operating income.

The related party organisations listed above are those where income for the year to 31 March 2020 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 Trust was in the process of contract negotiations for the provision of healthcare services for 2020/21 when the process was suspended by NHS England/Improvement due to the COVID 19 pandemic. The patient activity related income from April 2020 to July 2020 has been replaced by block income as defined by NHS England/Improvement, £57.94m.

	Expenditure		Current Payables	
			At 31 March	At 31 March
	2019/20	2018/19	**2020**	2019
	£000	£000	**£000**	£000
NHS Pension Scheme	**12,448**	8,274	**1,272**	1,242
HM Revenue & Customs - NI Contributions	**8,123**	7,506	**2,117**	2,058
Cambridge University Hospitals NHS Foundation Trust - medical, staffing, pathology and other services	**6,027**	4,617	**2,244**	1,319
NHS Resolution (formerly NHS Litigation Authority)	**1,079**	843	**-**	-
Public Health England (was Health Protection Agency)	**716**	579	**-**	176

The related party organisations listed above are those where expenditure for the year to 31 March 2020 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).

27 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. The Royal Papworth Charity holds equity investments which are managed by an Investment Management company. The portfolio is spread over fixed interest investments, worldwide equities and alternative investments and adopts an overall balanced risk. With the COVID-19 pandemic there is a potential for higher exposure to market risk. This is mitigated by the fact that 12.9% of the portfolio is held in fixed interest investments and 16.8% is held as cash and cash products.

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. Due to the COVID 19 pandemic the NHS Foundation Trust will receive block income from commissioning bodies for the first four months of 2020/21. Private patient activity has been suspended during the COVID 19 pandemic reducing any credit risk to the NHS Foundation Trust.

An analysis of the ageing of receivables and provision for impairments can be found at note 14 '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.

28 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	**4,831**	4,831	**4,831**	4,831
Receivables not yet invoiced	**10,717**	10,717	**9,956**	9,956
Other receivables (net provision for impaired debts)	**1,997**	1,997	**2,002**	2,002
Other investments	**4,536**	4,536	**-**	-
Cash at bank and in hand	**17,924**	17,924	**16,650**	16,650
Total at 31 March 2020	**40,005**	40,005	**33,439**	33,439
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

Financial liabilities

	Group		Trust	
	Total	Other financial liabilities	**Total**	Other financial liabilities
	£000	£000	**£000**	£000
Payables with DHSC group bodies	**1,648**	1,648	**1,648**	1,648
Other payables	**8,790**	8,790	**8,790**	8,790
Accruals	**11,734**	11,734	**11,715**	11,715
Provisions under contract	**2,491**	2,491	**2,491**	2,491
DHSC loans	**15,003**	15,003	**15,003**	15,003
Finance leases and PFI liabilities	**84,334**	84,334	**84,334**	84,334
Total at 31 March 2020	**124,000**	124,000	**123,981**	123,981
NHS payables	**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

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.

29 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	At 31 March 2020 £000	At 31 March 2019 £000	**At 31 March 2020 £000**	At 31 March 2019 £000
Less than one year	**26,008**	33,906	**25,989**	33,813
In more than one year but not more than two years	**17,087**	2,497	**17,087**	2,497
In more than two years but not more than five years	**6,973**	16,572	**6,973**	16,572
Greater than five years	**73,932**	76,100	**73,932**	76,100
	124,000	129,075	**123,981**	128,982

30 THIRD PARTY ASSETS

The NHS Foundation Trust held £968k cash at bank at 31 March 2020 (31 March 2019: £786k) 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 2020 (31 March 2019: £nil) was held by the NHS Foundation Trust on behalf of patients.

31 LOSSES AND SPECIAL PAYMENTS

	2019/20		2018/19	
	No. of cases	**Value of cases £000**	No. of cases	Value of cases £000
Losses:				
Overpayment of salaries	**5**	**2**	1	-
Fruitless payments	**-**	**-**	-	-
Private patients	**2**	**-**	4	58
Overseas visitors	**-**	**-**	3	44
Other	**24**	**64**	4	1
Total losses	**31**	**66**	12	103
Special payments:				
Loss of personal effects	**9**	**5**	4	1
Other employment payments	**2**	**66**	-	-
Special severance payments	**3**	**70**	-	-
Other	**9**	**2**	-	-
Total special payments	**23**	**143**	4	1
Total	**54**	**209**	16	104

These payments are calculated on an accruals basis but exclude provisions for future losses. There were no individual cases in 2019/20 (2018/19: nil) where a debt write off exceeded £100k.

32 FOREIGN CURRENCY

During the year income with a value of £nil was received in foreign currency (2018/19: £nil) and expenditure with a value of £141k was paid to suppliers in foreign currency (2018/19: £564k).

33 CHARITABLE FUND RESERVE

	Balance 1 April 2019 £000	Incoming Resources £000	Resources Expenses £000	Other movements £000	Balance 31 March 2020 £000
Restricted Fund Balance	3,527	1,904	(2,476)	(1,894)	**1,061**
Unrestricted Fund Balance	5,197	4,200	(5,677)	1,894	**5,614**
Total	**8,724**	**6,104**	**(8,153)**	**-**	**6,675**

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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