NHS

Royal Papworth Hospital

NHS Foundation Trust

Annual Report and Accounts

April 2020 to March 2021

Royal Papworth Hospital NHS Foundation Trust

Annual Report and Accounts

April 2020 to March 2021

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

Contents

The Quality Report for 2020/21 is to be published by 30 June 2021 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 03 June 2021.

Care | Innovation | Valued | Excellence

1. Performance Report

1.1 Overview of Performance

Statement from Chief Executive Officer

The year 2020/21 has been an extraordinary year for the National Health Service and we at Royal Papworth Hospital have been proud to play our part in the country's response to the most serious public health emergency in a generation.

The coronavirus (COVID-19) pandemic has presented huge challenges for our staff and services but it has also highlighted the important role that Royal Papworth Hospital plays in supporting other hospitals and providing specialist cardiothoracic services to patients from across the UK.

In March 2020, we established a command and control centre in the hospital to manage our response to the pandemic and this has run throughout the year, working in partnership with our Clinical Decision Cell (CDC), which has co-ordinated the care of our COVID-19 patients and provided advice to other NHS clinicians. Our command and control centre and CDC have worked closely together to manage the first and second wave of COVID-19 while also keeping urgent and emergency services running. Although, like other hospitals across the country, we have had to pause elective services for periods of time where the number of COVID-19 patients in our hospital was very high, I am proud of the way our staff have worked to provide elective services wherever possible and ensure that waiting patients are prioritised according to clinical need.

During both the first and second wave of the pandemic (in spring 2020 and winter 2020/21), we have had to reconfigure the layout of our new hospital in ways we could not have imagined doing before. At times, our critical care unit has grown to twice its usual size; during the second wave of the pandemic, we also expanded our respiratory wards to allow us to take additional ward-level patients from neighbouring hospitals. The pandemic has certainly tested the design of our new hospital but our staff and patients have benefitted from its flexible design, single patient rooms and sophisticated air ventilation system which have no doubt contributed to our very low nosocomial (hospital acquired) infection rate.

However, it is our staff who have made the most significant difference to our COVID-19 response. Thanks to their incredible compassion, commitment and professionalism, we have now cared for more than 300 COVID-19 patients, including some of the most seriously ill patients in the region. We have also kept our urgent and emergency services running (including our very busy cardiology and transplant services) and exceeded targets to restore our elective services after both the first and second wave. We also set up a COVID-19 vaccination hub which has provided first doses of the AstraZeneca vaccine to more than 8,400 health and care workers.

To respond to changing patient demand, many of our staff members were redeployed to our critical care department, which became one of the busiest critical care units in the region, offering four times as many beds as usual to patients requiring extracorporeal membrane oxygenation (ECMO) for severe respiratory failure. We do not underestimate the pressure

that COVID-19 has placed on our staff in the last year – many have been dealing with new and sometimes relentless challenges at work while also managing caring responsibilities, school and nursery closures, financial worries and concerns for loved ones.

Improving our staff experience and supporting staff health and wellbeing was one of the key priorities outlined in our five-year strategy for 2020-25. Now, after such a challenging 12 months, this is more important than ever. In the last year, we have invested in schemes to support our staff wellbeing thanks to funds raised by Royal Papworth Charity. We have employed a staff wellbeing practitioner and an equality, diversity and inclusion manager, organised a debrief project to gather staff feedback from working during the pandemic and introduced support schemes, including a financial hardship fund and reward and recognition scheme. Looking after our staff will remain a huge priority for us in the year ahead because we know that if we look after our people, they will be able to focus on looking after our patients.

Despite the challenges of COVID-19, I am hugely impressed by the way our staff have continued to strive for excellence and develop innovative solutions to tackle heart and lung disease. Our clinicians have been involved in more than 50 COVID-19-related research papers and have introduced pioneering new projects such as the new paediatric donation after circulatory death (DCD) heart retrieval service that our transplant team has developed with Great Ormond Street Hospital.

In the year ahead, we face some significant challenges. We will need to help our staff restore their physical and mental wellbeing and realign our services to meet the demand from our patients. We will have an important role to play in developing the new Cambridgeshire and Peterborough Integrated Care System, address the significant health inequalities in our region and work closely with partners to provide safer, more efficient services to patients who need our care.

However, our vision – to provide tomorrow's treatments to today's patients – remains unchanged. Whatever challenges the next 12 months bring, we will remain committed to delivering excellent, compassionate care to patients with heart and lung disease.

Stephen Posey
Chief Executive
03 June 2021

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.

2020/21 saw a realignment of Trust services in response to the global pandemic along with the management of waiting patients making effective use of our available capacity in order of clinical priority. The Trust delivered expanded capacity to support the regional and national response in Critical Care, ECMO and Respiratory services, and established The Royal Papworth (RPH) Critical Care transfer service to support the transfer of Critical Care patients in the East of England Critical Care Network region.

The Hospital treated 15,390 inpatient/day cases and delivered 82,855 outpatient contacts in 2020/21 from across the UK. To date the Trust has received 331 confirmed COVID19 cases.

Royal Papworth Hospital's services are internationally recognised and include cardiology, respiratory medicine, cardiothoracic surgery and transplantation.

Royal Papworth Hospital

Royal Papworth Hospital is located on the Cambridge Biomedical Campus and 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) have seen 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 has continued throughout 2020/21. It is due to be completed and handed over in 2022. 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 Trust and the UoC 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 and are working through the future governance to ensure that it delivers against the ambitions of the development.

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 2020/21 we enrolled 3,400 participants across a balanced portfolio of 49 studies that were open to recruitment with 10 of these being urgent public health studies being run to investigate the diagnosis, treatment, genetics and immunology of COVID-19 (see the Quality Accounts for further information). In addition to this new recruitment activity we managed the follow up visits for over 100 ongoing studies.

Royal Papworth Hospital ranked as the top recruiting site in the UK for over 50% of the interventional studies we supported. The fantastic recruitment figures are in spite of the pandemic, with R&D staff redeployed across the hospital to support the clinical teams.

R&D Highlights

- Dr Helen Baxendale, in collaboration with Prof J Heeney from the University of Cambridge, was awarded at £1.4m grant for the HICC study: Humoral Immune Correlates for COVID19: Defining protective responses and critical readouts for Clinical Trials of

Vaccines and Therapeutics. This was designated an Urgent Public Health study. Royal Papworth recruited over 700 participants to this study, and an additional 1200 to other COVID related research studies.

- Dr Charles Haworth and Prof Andres Floto have been awarded over £0.5m to carry out a Phase II clinical trial of a nebulised nitric oxide generating solution (RESP301) to treat chronic infection with Mycobacterium abscessus in patients with cystic fibrosis.
- Royal Papworth Charity has agreed to fund a £250K per year Innovation Fund for Royal Papworth Staff to support feasibility or pilot work to facilitate applications for external, peer-reviewed research grant funding and other well designed self-contained projects. The scheme launched in May 2021.
- 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.

Research Impact and Publications

Over 350 papers with Royal Papworth Hospital authors were published during 2020 across a breadth of clinical disciplines and published in a range of journals, a 9% increase from 2019.

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

Royal Papworth Hospital NHS Foundation Trust is the Corporate Trustee of Royal Papworth Hospital Charity (1049224). The Corporate Trustee of Royal Papworth Charity via the Trustee Board, has complied with the duty in Section 17 of the Charities Act 2011 and has paid due regard to Charity Commission guidance on public benefit in deciding what activities the Charity should undertake.

Royal Papworth Charity had an extremely challenging year as COVID-19 impacted a number of the scheduled fundraising activities in particular those based around the community. The Charity team worked hard to mitigate the impact of COVID-19 refocussing their resources in new and engaging ways online. The resourcefulness of the Charity's supporters to continue to raise money in aid of the hospital has been phenomenal and the dedication to showing their support has been inspirational for everyone at Royal Papworth.

The Royal Papworth Hospital COVID-19 Appeal has raised £1.4 million in donations and gifts in kind. The Charity received daily packages of food, drinks and small essentials to distribute across the hospital to support our staff as they cared for critically ill patients. Although it has been a truly difficult year, the Charity has raised over £2.77 million thanks to the generosity and commitment of the Charity's supporters including members of the public, patients and their families. We are especially grateful to those who pledge the most personal of gifts by remembering the hospital in their will.

The Charity worked hard to attract additional funding into the hospital, by supporting those who fundraise in the community, co-ordinating events, securing partnerships and applying for grants to fund larger projects. This year a priority for the Charity has been to provide additional funding for initiatives which support the wellbeing of all staff and have provided a suite of welfare services, including a dedicated wellbeing practitioner and support team of link nurses to help staff on the wards, mental health and wellbeing training courses, awareness courses and provided wellbeing rooms to help staff in their moments of greatest need.

A key milestone for the Charity this year was reaching the £5 million target towards the Heart and Lung Research Institute (HLRI). Heart and lung diseases are the leading causes of

premature death worldwide – killing 26 million people a year. The University of Cambridge and Royal Papworth Hospital are tackling this global challenge head on through the creation of the HLRI. In the past, pioneering medicine and innovative surgical advances supported by Royal Papworth Charity have not only transformed the lives of hundreds of thousands of patients but also helped shape cardiothoracic medicine internationally. The HLRI will provide the vital facilities to carry out more research, integrate our discoveries and expedite the translational sciences for the benefit of our patients and patients worldwide.

Royal Papworth Charity is proud to have funded 127 grants for a variety of projects across the hospital in 2020/21, many of which have had a direct and immediate impact on our patients, their families and our staff. The unwavering support received from the community has undoubtedly made a tremendous difference.

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 2022 deadline.

Further information on Royal Papworth Charity is available at: royalpapworthcharity.com

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 2020/21

ICNARC study into outcomes for COVID-19 patients in critical care

The Intensive Care National Audit and Research Centre (ICNARC) has published a number of reports on COVID-19 in critical care from hospitals across the UK, including several with about the specific activity here at Royal Papworth Hospital. The latest report is about patients admitted with COVID-19 between 1 September 2020 and 31 March 2021, and who have completed their episode of care. The report is about 98 patients admitted during that period and who have completed their episode of case, while some are still receiving care. The data shows that over 95% of our patients in this second wave had very severe respiratory failure, and this is explained as our ECMO Service supports those patients not responding to conventional therapy from anywhere in the country. It shows that these very sick patients required intensive care for at least twice as long as what is seen in other ICUs. So far, around half of them have survived even if ECMO was often seen as the last option left to patients in intractable severe acute respiratory failure.

Royal Papworth Charity COVID-19 Appeal

During 20/21, Royal Papworth Charity set up a COVID-19 appeal to help support our staff and patients during the pandemic. £1.4 million in donations and gifts in kind was raised thanks to the generous support of the national business community, our patients and supporters and local organisations. Money raised was used to fund the provision of food, drink and other items for staff working exceptionally hard during the pandemic. The charity has also funded psychological support for staff whose emotional wellbeing has been affected by the COVID-19 response, as well as setting up a staff reward and recognition scheme and a financial hardship fund for staff.

Anniversary of hospital move

1 May 2020 marked exactly a year since we began treating patients in our new hospital. Although the pandemic meant we could not celebrate this milestone as planned, we marked the occasion by thanking staff for their extraordinary efforts during the first peak of the pandemic. The anniversary also gave us a chance to reflect on how the preparation for the move, and the experience of running a 'command and control' centre over several weeks, had helped us manage the COVID-19 response. We also reflected on how the design of our new hospital – with its single patient rooms, air ventilation system and flexible layout – had been incredibly helpful in managing a highly infectious, airborne disease.

Staff Awards 2020

Unfortunately, we had to take the difficult decision to cancel our staff awards ceremony which was due to take place in March 2020 due to the COVID-19 outbreak. Instead, we decided to hold a 'socially distanced' staff awards ceremony in June 2020 to recognise our award winners. Throughout the day, we surprised the nominees in their place of work and held a presentation in the hospital's atrium later in the day, with staff who were working at home joining via video conferencing. We involved staff who were working at home or shielding by sending them gift packs and cards in the post, and in one case even visited a staff member on their doorstep to let them know they had won an award. Despite the challenges of organising an event in the current climate, we received excellent feedback from staff who appreciated being recognised in this way.

New ventilator sharing device developed by clinicians at Royal Papworth Hospital

In spring/summer 2020, clinicians at Royal Papworth Hospital worked with volunteers from the Institute for Manufacturing (IfM), University of Cambridge and Cambridge Design Partnership to develop a device that, if needed in an emergency, could be attached to a ventilator to enable two patients to receive tailored respiratory support. The new device – which is still in testing and not yet approved for clinical use – illustrates that it is possible to split the air flow from one ventilator to mechanically support the breathing of two sedated patients with different lung capacity and changing breathing needs. This system could be used to provide emergency support to hospitals in other countries which are still facing significant challenges with the COVID-19 pandemic, or for longer-term use in countries that have ongoing ventilator capacity shortages.

First MitraClip procedure performed

At the end of July 2020, clinicians at Royal Papworth performed the hospital's first percutaneous mitral valve leaflet repairs, otherwise known as the MitraClip procedure – a minimally invasive treatment option for patients with mitral regurgitation who may be unsuitable for open-heart surgery. The potential benefits of the procedure include a much shorter recovery time, which often means just one or two days in hospital after the device is inserted. The procedure also enables higher-risk patients with severe mitral regurgitation or who are older in age to receive treatment and experience a significant improvement in symptoms and quality of life. We hope to be able to offer this treatment to patients from across the East of England in the future.

Royal Papworth featured in series three of Surgeons: Edge of Life

In September and October 2020, series three of the award-winning series 'Surgeons: At the Edge of Life' showed pioneering procedures performed at Royal Papworth Hospital and Cambridge University Hospitals in Cambridge. The series helped to raise awareness of the innovative procedures we carry out at Royal Papworth, including the pulmonary endarterectomy (PTE) procedure for patients with chronic thromboembolic pulmonary hypertension.

Pioneering DCD programme increases transplants by almost half

The pioneering donation after circulatory death (DCD) transplant programme developed at Royal Papworth Hospital has increased adult heart transplant activity here by 48% in five years. Writing in The Journal of Heart and Lung Transplantation in December 2020, our transplant team explained how DCD heart transplants – also referred to as non-beating heart transplants - have also delivered similar survival rates when matched against traditional transplants.

Honours for Royal Papworth colleagues

Our Chief Nurse Josie Rudman was awarded an MBE in the Queen's Birthday Honours list in October 2020, in recognition of her contribution to nursing, patient experience and patient safety.

Two members of staff at Royal Papworth Hospital received honours in the New Year Honours List for 2021. Our Medical Director Dr Roger Hall received an OBE and Nurse Consultant Judith Machiwenyika received an MBE in recognition of their outstanding commitment to the NHS, in particular during the COVID-19 pandemic.

Critical care transfer service

In January 2021 we launched our critical care patient transfer service, provided by Royal Papworth on behalf of the East of England region. This service was extremely busy at the beginning of the year, playing a vital role in the COVID-19 response by transferring critically ill patients between hospitals.

Participation in research into possible treatments for COVID-19

By the end of March 2021, staff at Royal Papworth Hospital had authored or contributed to more than 50 COVID-19-related research papers – about one a week for the past year. Research included publications in leading medical titles such as The Lancet, Nature, and The New England Journal of Medicine. Royal Papworth Hospital is also, alongside the University of Cambridge, leading on a national project which is investigating the antibody response in two groups of people – NHS workers and hospitalised patients - who have contracted coronavirus.

Royal Papworth Hospital has also signed-up to a number of national and international projects, such as the RECOVERY Trial which is the world's largest clinical trial for COVID-19 treatments. More than 110 patients at Royal Papworth Hospital have been recruited to the study out of a UK-wide total of 39,000. The trial has saved 22,000 lives in the UK and one million worldwide by using an inexpensive and widely available steroid, dexamethasone, as an effective treatment for COVID-19. Another study to which Royal Papworth is contributing is examining patients who have been discharged from hospital after COVID-19 treatment, some of whom may have long COVID. Called PHOSP-COVID, it is being run out of Leicester with hospitals across the UK working together to understand and improve long-term health outcomes for patients and tracking their recoveries.

We have also continued to recruit to other important studies not related to COVID-19. Despite the pandemic the hospital recruited 493 patients into 31 non-COVID studies during 2020/21. These included a wide variety of disease groups including lung cancer, atrial fibrillation, cardiac surgery and idiopathic pulmonary fibrosis. The Trust continues to sponsor a number of single and multi-centre studies.

World-first paediatric heart transplant technique carried out in partnership with Great Ormond Street Hospital

In 2020/21, Great Ormond Street Hospital (GOSH) and Royal Papworth Hospital (RPH) collaborated to introduce a world-first paediatric heart transplant technique that has successfully expanded the donor pool and increased the number of transplants for eligible children in the UK by 50%. The donation after circulatory death (DCD) heart transplant programme was previously only widely available to adults. For the first time ever, by restarting the donor heart outside of the body using a portable organ perfusion system called the TransMedics heart Organ Care System (OCS), the technique has now been made available for children, paving the way for six life-saving heart transplants for young patients at GOSH in 2020. It is the biggest and most successful paediatric DCD heart transplant programme in the world.

Cardiovascular Outcomes – NICOR report 2016-2019

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 >98.5%, and was above the national average. During that time, Royal Papworth performed 5201 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 2016 and 2019.

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 2020.

The report identified that the national 30 day rate of survival following adult heart transplantation was 91.5%, which ranged from 87.8% to 94.4% across centres (RPH 93.1% risk-adjusted). The national 90 day survival rate was 87.3%, ranging from 80.8% to 91.4% across centres (RPH 90.3% risk-adjusted). The national 1 year survival rate was 83.2%, ranging from 77.1% to 86.7% across centres (RPH 86.7% risk-adjusted). The national 5 year survival rate was 69.9%, ranging from 59.6% to 78.3% across centres (RPH 78.3% risk-adjusted). At 5 years, there was some evidence of a significantly higher rate at Papworth in comparison to the national rate.

The report noted that Royal Papworth's survival rates fell above the upper 99.8% confidence limits at one and five years respectively, indicating significantly high survival from listing at these time points.

For lung transplant the 90-day post-transplant Papworth had a rate of 91.6% (risk adjusted). This was statistically consistent with the national rate of survival which was 90.9%. The national 1 year survival rate was 82.6%, ranging from 74.3% to 87.4% across centres (RPH 80.4% risk-adjusted), with no significant outliers. The national 5 year survival rate was 55.3%, ranging from 32.1% to 59.6% across centres (risk-adjusted). The 5 year survival rate at Papworth was 59.1% (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

We reported last year that we were preparing to launch our new five year strategy for the years 2020-25. We were then faced with a global pandemic: for several months, tackling COVID-19 and saving as many lives as possible became our absolute priority.

In the summer of 2020 we re-examined the strategy that we had previously written with involvement from our staff, patients and partners. What was striking was that, although COVID-19 would change the way we do some things and brought some of our plans forward, our key priorities for the future remained the same. The Board agreed to launch the Trust Strategy in September 2020. This strategy will guide our work through the next five years, as we recover from the pandemic and focus again on our core purpose: to bring tomorrow's treatments to today's patients. The strategy 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 get where we are today and remain at the heart of everything we do. But how we do things is just as important, and our strategy is clear about improving our staff experience and building meaningful partnerships with organisations who share common goals. Despite the challenges, we feel full of energy and enthusiasm for the journey ahead. The global COVID-19 crisis has reinforced the importance of our work and made us more determined to tackle the heart and lung conditions that affect so many lives.

We are also excited about the completion and opening of the Heart and Lung Research Institute, being built right next door to our new Hospital. This facility will complete our building transformation but also enable the delivery of our plans for enhanced education and research over the next five years and a major element of this will be the Royal Papworth School.

We know that the expertise, commitment and compassion displayed by our staff during the pandemic will continue to make a huge difference to patients here and across the world over the next five years.

Our 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 2021/22 as set out in the table below together with the method of measurement:

Strategic Objectives

2021/22 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 with our ICS and wider system partners, an effective restoration and reset plan balancing the needs of our staff and patients • 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 Integrated Care System partners (ICS) to support the delivery of our collective system plan
3. Offer a positive staff experience	To provide an open and inclusive working environment where we understand, encourage and celebrate diversity, making the NHS a place where all feel they belong and are respected, we will: • Continue to make the wellbeing of our staff a priority and invest in and implement our 'Compassionate and Collective' leadership programme to ensure that we build a positive culture that creates the best possible staff experience and ensures the delivery of high quality and safe care. • Integrate equality, diversity and inclusion into everything we do, so it becomes embedded as a natural part of everyday practice.
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 will 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. • Launch a new Research Innovation fund, supported by the RPH Charity
6. Achieve sustainability	To establish a sustainable operational and financial position, we will: • Deliver our financial plan, continuing the Trust's return to financial sustainability • Develop and implement our environmental sustainability plan

For further information on the Trust Strategy 2020-25 is published at: https://royalpapworth.nhs.uk/our-hospital/royal-papworth-hospital-strategy-2020-25

Further regulatory information about Royal Papworth Hospital NHS Foundation Trust is published at: https://www.england.nhs.uk/publication/royal-papworth-hospital-nhs-foundation-trust/

Key issues and risks for 2021/22 are:

The principal risks faced by the Trust are summarised below. In 2020/21 RPH alongside the whole of the NHS has seen its usual business activities and objectives overshadowed by the management of the operational response to COVID19. Whilst this has had a fundamental impact on service delivery and delivery of our strategic objectives, we have also seen positive changes and opportunities arising from the response to the pandemic.

Our need to respond to COVID19 and service recovery has placed increased pressures on all of our staff. One of the key priorities outlined in our five-year strategy for 2020-25 was supporting staff health and wellbeing, and this is now more important than ever. During both the first and second wave of the pandemic (in spring 2020 and winter 2020/21), we have had to reconfigure the layout of our new hospital in ways we could not have imagined doing before. At times, our critical care unit has grown to twice its usual size; during the second wave of the pandemic, we also expanded our respiratory wards to allow us to take additional ward-level patients from neighbouring hospitals. This required the redeployment of staff across the Trust and our command and control centre and CDC have worked closely together to ensure the safe management of staff and services throughout the first and second wave of COVID-19. All areas of the Trust are planning around the issues and innovations 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.

We have seen and accelerated move into new ways of working with many staff now working remotely and a significant increase in services that are delivered through virtual platforms and this carries risks relating to Cyber security. We have minimised the risk of Cyber threat by ensuring that our Board and our staff are trained and alert to the risks and have implemented technical measures to bolster system security. We also have a Cyber Security communications plan to ensure current themes are regularly and consistently shared across our organisation through our top leaders.

The Trust is also working closely with the developing Integrated Care System (ICS) to ensure that there is alignment of objectives and priorities, and to assess any impact on the Trust's five year strategy. This along with changes to specialist commissioning arrangements could have an adverse impact on funding flows which could impact on sustainability and future performance.

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

Principal Risks
PR1 COVID19 PandemicCOVID19 pandemic and the need to sustain operational effort and resources to the COVID19 readiness and response.
PR2 Workforce Workforce, and the need to focus on recruitment and retention to support flow and our ability to deliver activity.
PR3 Hospital Optimisation: Failure to optimise the new facility to deliver activity plans and meet patient demand.
PR4 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.

PR5 Cyber security and data loss: Failure to ensure that our services are resilient to cyber-attack and that residual risks to resilience are managed.

Other factors not set out 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.

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.

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

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.

This section of the Annual Report provides a more limited report on our services than usual. This is in line with the NHS FT annual reporting manual for 2020/21. In addition it should be noted that our performance against NHS standards has been adversely affected by the operational response to COVID19. Further information will be provided in our Quality Accounts.

Meeting Specialist Healthcare Needs

2020/21 has been an exceptional year for Royal Papworth Hospital and the specialist services provided by our dedicated staff. Activity figures reflect the impact of the COVID19 pandemic which has resulted in limitations on activity throughout 2020/21 as a result of the need to respond to the increased demand for critical care and ECMO services and the need to introduce measures to manage the requirements of infection prevention and control.

The number of patient episodes seen at the hospital was 98,245 (2019/20: 115,749 including Private Patients) and the tables below provide a breakdown of this demand across our services.

Inpatients and day cases

	2020/21	2019/20	2018/19
Cardiology	6,587	7,771	8,839
Cardiac Surgery	1,288	1,905	2,385
Thoracic Surgery (incl PTE)	827	1,023	991
Respiratory Support and Sleep Centre	3,897	6,042	6,155
Transplant/Ventricular Assist Devices	524	643	675
Thoracic Medicine	2,267	5,162	4,579
Total	**15,390**	**22,546**	**23,624**

Outpatients

	2020/21	2019/20	2018/19
Cardiology	36,908	38,826	42,380
Cardiac Surgery	5,514	5,510	3,885
Thoracic Surgery	1,071	1,030	1,293
Respiratory Support and Sleep Centre	15,052	20,705	23,739
Transplant/Ventricular Assist Devices	3,067	3,487	4,168
Thoracic Medicine	21,243	23,645	21,874
Total	**82,855**	**93,203**	**97,339**

Control of Infection

MRSA bacteraemia and C.difficile infection rates*

Goals 2018/19	Outcome 2018/19	Goals 2019/20	Outcome 2019/20	Goals 2020/21	Outcome 2020/21	Goals 2021/22
No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	No MRSA bacteraemia	1 MRSA bacteraemia	No MRSA bacteraemia
No more than 4 *C.difficile* cases **	Total for the year = 2	No more than 11 C.difficile	Total for the year 11 only one was attributed to Royal Papworth	No more than 11 C.difficile	Total for the year = 8 all cases are now counted toward RPH's objective	We have not been given our trajectory at present
Achieve 100% MRSA screening of patients according to agreed screening risk assessment	97.2%	Achieve 100% MRSA screening of patients according to agreed screening risk assessment	95.5%	Achieve 100% MRSA screening of patients according to agreed screening risk	97.5%	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.

**All C.difficile cases are now counted towards Royal Papworth Hospital's objective. Root cause analysis are completed and reviewed internally for any C.difficile incidence that occurs 3 or more days into admission. The Clinical Commissioning Group (CCG) are informed of all cases but, will only review a case if there are causes for concern or if an outbreak has been declared.

Mycobacterium Abscessus

We reported in our Quality Report for 2019/20 that we had become concerned about a small number of our lung transplant patients testing positive for Mycobacterium abscessus infection. We have carried out extensive investigations and, although we cannot be sure, we believe our water supply could be a credible source of the bacteria.

We continue to work with partners to better understand the disease and reduce the risk to patients. We hope that sharing what we have learnt so far will also help other healthcare professionals trying to respond to this relatively new disease.

The response to the M.abscessus outbreak is coordinated by our M. Abscessus Oversight Committee and an epidemiological study has been commissioned by RPH on the advice of PHE in order to look for potential causes. No new positive transplant or respiratory patients have been identified in recent months. Hospital water is tested for Mycobacteria monthly by Estates, results showed that M.abscessus colony counts have decreased significantly but M.abscessus is still present in the water. The Trust has implemented stringent measures to ensure that only filtered tap water is used for patient care for vulnerable groups and is monitoring compliance.

COVD19 nosocomial Infections

Five patients were identified as acquiring healthcare associated COVID-19 whilst an inpatient at Royal Papworth Hospital. There have been no nosocomial acquisitions since April 2020. COVID-19 acquisitions continue to be closely monitored by the Trust, Microbiology and Infection Control on a monthly basis.

Further information will be published in our Quality Report.

Performance of Trust against selected metrics

In 2020/21 the Trust was called to respond to the COVID19 pandemic and rapidly established new ways of working to respond to COVID-19 demand; protect our patients and staff, and best support our regional and national partners. The RPH response to the COVID19 pandemic has been effective and comprehensive. Positive feedback has been received from local, regional and national stakeholders and positive outcomes have been delivered for our patients. However the response to COVID19 has inevitably had an impact on performance against our operational performance metrics. The Trust has continued to measure and report to the Board against our quality and performance metrics but performance should be considered in the context of the operational response to COVI19. The Table below sets out 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-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD actual
18 weeks Referral to Treatment (RTT)*	>92%	79.06%	68.71%	54.72%	50.41%	60.43%	74.06%	86.26%	91.17%	90.55%	85.84%	80.36%	78.47%	78.47%
62 day cancer wait *	>85%	53.80%	41.70%	10.00%	100.00 %	66.70%	33.30%	100.00 %	100.00 %	85.70%	38.50%	75.00%	100.00 %	66.70%
31 day cancer wait	>96%	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %
6 week wait for diagnostic	>99%	97.72%	96.70%	96.80%	90.59%	97.63%	98.79%	99.24%	98.92%	98.69%	90.23%	90.03%	89.19%	95.38%
Monitoring C.Diff (toxin positive)	Less than 8	0	1	0	1	0	1	0	0	1	2	0	1	7
Number of patients assessed for VTE on admission	>95%	100.00 %	93.30%	96.60%	96.60%	100.00 %	100.00 %	96.60%	96.60%	96.60%	96.60%	96.60%	96.60%	96.60%

In 2020/21 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 30 June 2021).

Equality of service delivery

The issue of equality of service delivery has been considered through both our Quality and Risk Committee and through our Clinical Ethics Committee and this was of particular significance in the management of our response to the COVID19 pandemic. In November the Quality and Risk Committee considered analysis performed by the Trust's Business Intelligence team exploring inequalities in access to health services here at Royal Papworth Hospital. The paper provided data analysis, rather than providing clinical advice or direction. The Committee was reassured that there were no apparent social inequalities of outcomes identified; however inequality of access to treatment was still a concern.

As a receiving tertiary service it was challenging to reconcile RPH data with that of referral services and to be assured that there was not an unintended bias at an early stage of referral pathways, preventing equal access to RPH services. It was recognised that further work will be undertaken to look at how we interrogate current available data at a Trust and a system level; also that a gap in the capture of ethnicity data of patients had been identified which needed to be investigated and understood in order to improve collection of this data.

RTT and Waiting List Prioritisation

In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The fundamental principle underpinning this is that all decisions about a patient's waiting time should be made with the patient's best clinical interests in mind and in accordance with national legally binding RTT Rules.

As a result of COVID-19 and the restrictions on capacity, there has been greater focus on the clinical prioritisation of patients waiting for treatment (be it planned follow-up care or otherwise). The Trust has undertaken a significant piece of work to clinically assess and prioritise patients on the RTT waiting list. Partner trusts in the STP have undertaken a similar exercise. Each month the Trust is required to report on this via a national submission. The work to date has focussed on the RTT pathway; work is ongoing to review the clinical prioritisation of patients on a planned care pathway and to define some meaningful metrics that can be used to measure performance.

Standard operating procedures are being drawn up to outline the process of continued validation and to ensure the priority codes badged against each waiting list are accurate and up to date with clinical changes in condition. This includes defining triggers for review, escalation processes and definitions of priority codes to ensure consistency.

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 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. There were seven “should do” actions (there were no “must do” actions) and progress has been made against all of the actions, monitored by the trust Quality Compliance Officer.

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

During 2020/21, Royal Papworth Hospital was invited to take part in a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Thematic Review in December 2020; and a Provider Compliance Review (PCR) for cancer, in March 2021. These have been as part of national reviews and no specific actions have been identified for Royal Papworth Hospital. We have been advised by the CQC that we will not receive an individual report for either of these reviews.

Patient Safety Incident Trends and Actions

There were a total of 2599 patient incidents reported during the financial year compared to 3,571 in the previous year; a decrease of 972 reports. In 2020/21 there were 2,230 actual incidents reported (3,066 in 2019/20) and 369 near miss incidents (505 in 2019/20).

Fluctuating numbers of patient safety incidents have been reported during the financial year linked to the COVID pandemic. Over the last 12 months the number of incidents graded as near miss (14%), and no/low harm (83%) demonstrates a continued readiness to report and learn from all types of incidents. The Trust culture ensures staff 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 the level of severity. All moderate harm incidents and above have investigations and associated action plans which are managed by the relevant divisions and monitored by the Quality & Risk Management Group (QRMG). All Serious Incidents (SIs) require a Root Cause Analysis (RCA) and are led by an appointed investigator and supported by the Clinical Governance and Risk Team. The (*) signifies a discrepancy in the total number of incidents awarded a

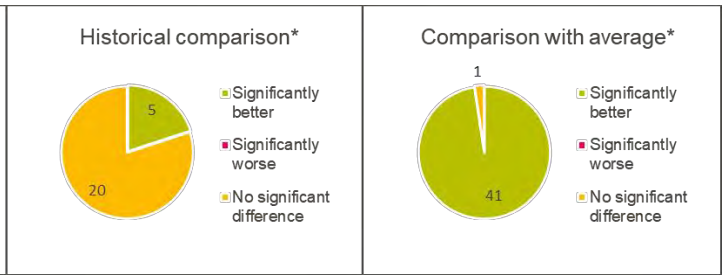
severity grading and the total amount of patient incidents in quarter; not all incidents have been finally approved and grading confirmed as at 10/05/2021. Lessons learnt are shared across the organisation and with associated stakeholders in addition to quarterly Lessons Learnt reports via the intranet, presentations and local dissemination via Divisions and specialist meetings.

2020 National Adult Inpatient Survey

Royal Papworth Hospital performed very well in the latest National Inpatient Survey with an overall response rate of 68% (against an average of a 45% for similar organisations). Our survey results were better than the Picker average in all 42 questions (and in one question the data was suppressed as it was below the threshold for publication). In 14 questions the results were better than last year and 9 were worse than last year. 18 did not have any comparative data available. There has been a significant improvement in the number of patients being asked to give views on the quality of care during their stay, which increased by 10% since the last survey, and 95% of our patients rated their overall experience as 7/10 or more.

1250	1217	**68%**	45%	60%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (825)	Average response rate for similar organisations	Your previous response rate

95%	Q46. Rated overall experience as 7/10 or more
100%	Q45. Treated with respect and dignity overall
99%	Q16. Had confidence and trust in the doctors



Further information will be available in the Quality Report.

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 and in 2020/21 and this standard was not achieved. In year the Trust has experienced increased delays in access to PET CT and has continued to work with partners to identify and address delays.

Financial Review 2020/21

This part of the Annual Report provides a review of the financial performance for the year ending 31 March 2021.

Summary of financial performance

As at 31 March 2021, the Trust had delivered the following performance:

	Plan	Year end
EBITDA *	£12.5m	£16.4m
Year-end surplus / (deficit)	(£1.4m)	£2.8m

*Earnings Before Interest, Tax and Amortisation

The plan figures represent the Trust's plan following the national planning submission undertaken in September 2020.

The year-end surplus of £2.8m is favourable to plan by £4.2m. The favourable position is a result of the reduced costs of business as usual activity throughout the winter period as the Trust responded to the second COVID-19 surge.

Total capital programme spend in year was £4.1m. £2.2m of this was in response to COVID-19 and was supported by central department funding. The majority of the remaining £1.9m was spent on medical equipment as part of the Trust's planned replacement programme.

The end of year cash balance was cash balance was £56.1m. This is an increase of £39.4m from the prior year and is driven by a change in the timing of payments received from commissioners under the national emergency financial framework.

2020/21 Income by Commissioner and Service

The following table shows total income for the year broken down by Commissioner.

2020/21 Income by Commissioner

	£'000
NHS England	136,816
Cambridgeshire and Peterborough CCG*	15,037
Norfolk & Waveney CCG	4,397
West Suffolk CCG	4,016
Bedfordshire CCG	2,284
Lincolnshire CCG	1,706
Ipswich & East Suffolk CCG	1,348
West Essex CCG	1,327
East and North Hertfordshire CCG	1,308
North East Essex CCG	206
Other CCGs	561
Other NHS	2,742
Private patients	4,203
Other non-NHS	86
Total patient service income	**176,037**

2020/21 Income by Service

The measure of clinical income by segments (services) was not reported due to the financial framework in place 2020/21.

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

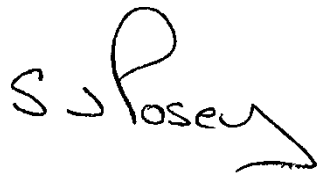
Board to inform and involve staff of the Trust's anti-fraud stance as well as seeking the prevention and detection of fraud. Any concerns reported are investigated at the earliest opportunity by the Local Counter Fraud Specialist (LCFS), in conjunction with the Trust Management. The LCFS provides reports 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
03 June 2021

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 one non-voting Associate Non-executive Director and seven Executive Directors (EDs), one of whom is the Chief Executive and one of whom is non-voting. 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 2020/21 financial year. No political donations were made in previous years.

Cost allocation and charging

During the year 2020/21, 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 2020/21 92.8% (2019/20 87.8%) of non-NHS invoices were settled within 30 days of invoice date and 82.3% (2019/20 73.9% of NHS invoices. The Trust paid £0 (2019/20 £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 2020/21 was greater than the income from the provision of goods and

services for any other purposes. Private patient income was £4.2m (£6.7m 2019/20) or 2.4% (4.5% 2019/20) of total patient income.

Quality and Risk

Quality Strategy

Our Quality Strategy 2019-2022 builds on the foundations and achievements of previous Trust strategies. In May 2019 we successfully moved our hospital services to a new Royal Papworth Hospital on the Cambridge Bio-Medical Campus. This was a major achievement in our history made possible by the enormous effort from staff at all levels of the organisation along with the support from our stakeholders and partners. Through campus networking and a collaborative approach to working with health, university and industry partners we continue to deliver excellence in care which supports and delivers achievement of our Quality Strategy Ambitions. Our focus during after the move was to establish our services at the new site and embed new ways of working to support the delivery of excellence in the care and treatment we provide for our patients

Early in 2020 we saw the first wave of the COVID 19 Pandemic and throughout 2020/21 we have been challenged and tested as we respond to the huge demands on our specialist services. Whilst we have demonstrated organisational resilience in our ability to provide the specialist care and treatment our patients need it has necessarily impacted on our ability to develop and meet some of the ambitions set out in our Quality Strategy. This is also reflected at a national level with some requirements to meet quality measures and performance indicators suspended. The Trust continues to remain vigilant and agile to ensure continuous delivery of safe and effective care for our patients in these challenging times. Through our ongoing governance and performance monitoring structures and underpinned by the commitment and hard work of staff at all levels of the organisation, we have maintained a high quality and safe service throughout this difficult time. Many of our Quality Strategy ambitions will therefore need to continue through to the next full review due in 2022 to provide the opportunity to embed and develop our continuous quality improvement approach.

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

In non COVID times, under normal commissioning a proportion of Royal Papworth Hospital NHS Foundation Trust's income would be 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 (CQUIN) payment framework.

Due to the pandemic, CQUIN was suspended. As a result there were no specific CQUIN schemes and therefore no requirement for the Trust to achieve specific goals relating to quality improvement and innovation.

Royal Papworth Hospital's Quality Account Priorities 2020/21

- 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
- Digital Quality Improvement

Further information will be included in the Quality Report.

The Trust's quality priorities 2021/22

To determine priorities for 2021/22 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, Quality and Risk Committee and the Patient & Public Involvement Committee, which includes Governor and patient representatives, to determine our priorities for 2021/22. The priorities for 2021/22 reflect the domains of quality improvement and patient safety; clinical effectiveness and responsiveness; patient experience, and well led. They are:

- Priority 1: Build and develop QI capability within the QI team and across the organisation.
- Priority 2: Improved diabetes management: Making Hospitals Safe for People with Diabetes
- Priority 3: Compassionate & Collective Leadership
- Priority 4: Digital Quality Improvement

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. Whilst some of the Board Development programme has been on hold in 2020/21 we commenced an Equality Diversity and Inclusion development programme with the Board in May 2021 and will be taking this work forward in year through the relaunch of our Values and Behaviours framework and the implementation of the second phase for our Compassionate and Collective Leadership 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 and a key area for development is the support to our line managers.

The performance review cycle for the Board ensures that all Executive 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 cycle includes gathering multisource feedback and in 2020/21 twelve of our Directors received feedback from 137 participants providing valuable commentary and insight on their role from staff and individuals across the local system.

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 on the PLACE Programme was included in our Quality Report for 2019/20. Programme visits were suspended during 2020/21.

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 also has a Patient and Carer Experience Group with membership including patient and support group representatives and representation from Healthwatch, and they are represented on the PPI Committee.

In response to the COVID19 pandemic the PPI Committee and PCEG group moved to holding virtual meetings to allow continued working during the year. Whilst many support group activities have been curtailed or have moved to virtual events as a result of the pandemic the Trust continues to have strong relationships with patient support groups including:

- Norfolk Zipper Club
- Pulmonary Hypertension Support Group;
- Transplant Patient Support Group
- Transplant Sport UK

Further information on our patient support groups is available at:
https://royalpapworth.nhs.uk/patients-and-visitors/pals/patient-support-groups

This year saw the closure of the British Cardiac Patients Association (BCPA) which had a long relationship with the Trust and provided help, support, and information for cardiac patients, carers and supporters; as well as providing the patients and carers independent voice.

Further information will be available in the Quality Report.

Listening to Patient Experience and Complaints

Listening to the patient experience and taking action following investigation of complaints is an important part of our Quality Improvement framework. In 2020/21 Royal Papworth Hospital received 37 formal complaints from patients. Of the 37 complaints reported (25 inpatient and 12 outpatient complaints) 34 related to NHS provided services with 3 complaints related to private patient services at Royal Papworth Hospital. The overall numbers of complaints received has decreased by 50% compared to the previous year. (2019/20 74 complaints received).

Where a patient and/or family member wish to escalate their concerns in a more formal way but do not wish to register their concern as a formal complaint, we log these concerns as "Enquiries". Investigation of the issues raised follows the same robust process as a formal complaint and a written response, including any actions identified as a result of raising their concern, is provided. The Trust received 16 enquiries in 2020/21, a significant decrease from the previous year (33 in 2019/20).

National benchmarking

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) as a rolling 3 month average of the number of written complaints per 1000 WTE.

April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021
7.8	6.2	4.1	4.6	4.6	5.0	4.0	4.5	3.0	3.6	6.9	5.9

The overall Trust value 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.

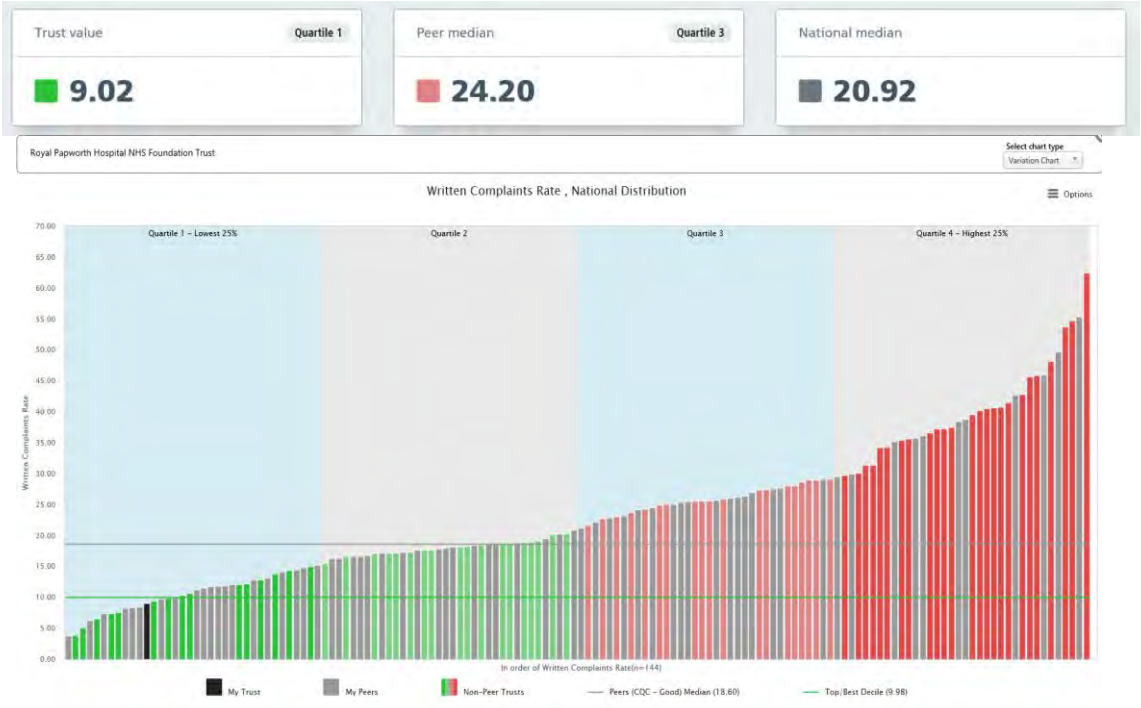


Table from Model Hospital: Count of written complaints made by or on behalf of patients about an organisation per 1000 staff (WTEs) – March 2021

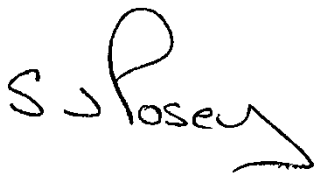
Further Information on listening to the patient experience and complaints will be available in our Quality Report.

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 2020/21:

Name	Title
John Wallwork	Chairman
Jag Ahluwalia	Non-Executive Director
Michael Blastland	Non-Executive Director and Deputy Chair (Deputy Chair from 17 June 2020)
Cynthia Conquest	Non-executive Director and Senior Independent Director
David Dean	Non-executive Director (to 31 May 2020)
Amanda Fadero	Non-Executive Director (from 1 December 2020)
Gavin Robert	Non-Executive Director
Ian Wilkinson	Non-executive Director
Diane Leacock	Associate Non-Executive Director (from 1 December 2020)
Stephen Posey	Chief Executive
Tim Glenn	Chief Finance and Commercial Officer (from 14 April 2020)
Roger Hall	Medical Director
Eilish Midlane	Chief Operating Officer
Oonagh Monkhouse	Director of Workforce and Organisational Development
Josie Rudman	Chief Nurse
Andrew Raynes	Chief Information Officer
Ivan Graham	Acting Chief Nurse (28 September 2020 to 31 March 2021)



Stephen Posey
Chief Executive and Accounting Officer
03 June 2021

2.2 Remuneration Report

During 2020/21 there were a number of changes to the Non-executive Directors (NEDs) on the Board. One NED resigned from the Board and one NED and one Associate NED were appointed to the Board. The Trust Chair had his term of office extended by twelve months to 31 January 2022 to provide continuity in the delivery of the Heart and Lung Research Institute and to reduce the burden of operating the recruitment process during the operational response to COVID19.

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.[5]
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 2021.
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 2020/21
(2) There are no significant differences in 2020/21 between the remuneration policy for senior managers and the general policy for employees' remuneration
(3) The remuneration policy for 2020/21 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
(5) The Chief Nurse was seconded to the DHSC to support the NHS Track & Trace.

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 was 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. This is usually 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 2020/21

		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	31 Jan 2022
Jag Ahluwalia	Non-executive Director	1 Nov 2019	-	31 Oct 2022
Michael Blastland	Non-executive Director	22 Mar 2019	-	31 Mar 2022
Cynthia Conquest	Non-executive Director	1 Jan 2019	1 March 2021	29 Feb 2024
David Dean	Non-executive Director	1 Nov 2018	-	31 May 2020
Amanda Fadero	Non-executive Director	1 Dec 2020	-	30 November 2023
Gavin Robert	Non-executive Director	1 Nov 2019	-	31 Oct 2022
Ian Wilkinson	Non-executive Director	1 Jan 2020	-	31 Dec 2022
Diane Leacock	Associate Non-executive Director	1 Dec 2020	-	31 May 2022
Stephen Posey	Chief Executive	14 Nov 2016	Not Applicable	6 month notice period
Tim Glenn	Chief Commercial and Finance Officer	14 April 2020	Not Applicable	6 month notice period
Roger Hall	Medical Director	22 May 2015	Not Applicable	6 month notice period
Eilish Midlane	Chief Operating Officer	24 Apr 2017	Not Applicable	6 month notice period
Oonagh Monkhouse	Director of Workforce and OD	1 Oct 2017	Not Applicable	6 month notice period
Josie Rudman	Chief Nurse	18 Mar 2014	Not Applicable	6 month notice period
Andrew Raynes (Advisory Non-Voting Member)	Chief Information Officer	01 April 2018	Not Applicable	6 month notice period
Ivan Graham	Acting Chief Nurse	Acting Chief Nurse (28 September 2020 to 31 March 2021)		

Attendance of Non-executive Directors at Executive Remuneration Committee Meetings

Name		28/05/20	01/10/20
John Wallwork	Chairman	✓	✓
Jag Ahluwalia	Non-executive Director	✓	✓
Michael Blastland	Non-executive Director	✓	✓
Cynthia Conquest	Non-executive Director	✓	✓
David Dean	Non-executive Director	✓	
Gavin Robert	Non-executive Director	✓	✓
Ian Wilkinson	Non-Executive Director	✓	✓
Amanda Fadero	Non-Executive Director		
Diane Leacock	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	20/05/20	11/11/20
Janet Atkins	Public	✓	✓
Richard Hodder (Chair and Lead Governor)	Public	✓	✓
Glenn Edge	Public	×	×
Keith Jackson	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 2020/21 of £50 (2019/20: £15,646). Expenses to the value of £50 (2019/20: £13,650) 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 15 Directors (including two non-voting Directors), due to changes in the year there were a total of 17 (2019/20: 17) serving Directors. 2 (2019/20: 9) Directors received expenses.

Governors received expenses of £63 for 2020/21 of (2019/20: £3,416). Expenses are a reimbursement of amounts directly incurred in the performance of an individual Governor's duties.

At March 2021 the Council consisted of 25 (2019/20: 26) Governors and due to changes in the year there were a total of 33 (2019/20: 32) serving Governors. One Governor received expenses (2019/20: 8)

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 two non-voting Directors (*) who have 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 2021 (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	40 - 45	-	-	40 - 45
Dr J Ahluwalia – Non-executive Director	10 - 15	-	-	10 - 15
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 (to 31 May 2020)	0 - 5	-	-	0 - 5
Ms A Fadero – Non-executive Director (from 1 Dec 2020)	0 - 5	-	-	0 - 5
*Ms D Leacock – Non-executive Director (from 1 Dec 2020)	0 – 5	-	-	0 - 5
Mr G Robert – Non-executive Director	10 - 15	-	-	10 - 15
Prof I Wilkinson – Non-executive Director	10 – 15	-	-	10 - 15
Mr S Posey – Chief Executive[8]	170 - 175	-	37.5 - 40	205 - 210
Mr T Glenn – Chief Finance & Commercial Officer (from 14 Apr 2020)	105 - 110	-	32.5 – 35	140 - 145
Dr R Hall – Medical Director[6]	185 - 190	-	35 – 37.5	220 - 225
Mrs E Midlane – Chief Operating officer	105 - 110	-	67.5 – 70	175 - 180
Mrs O Monkhouse – Director of Workforce and OD	110 - 115	-	15 – 17.5	125 - 130
Mrs J Rudman – Chief Nurse & Director of IPC[10]	120 - 125	-	87.5 - 90	210 - 215
Mr I Graham – Chief Nurse (from 28 Sept 2020 to 31 Mar 2021)	50 - 55	-	32.5 - 35	80 - 85
*Mr A Raynes (Advisory non-voting member)	110 - 115	-	30 – 32.5	140 - 145

Notes to Tables 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 £39,935 relating to clinical duties and £36,192 relating to a Clinical Excellence Award;
7. No performance related remuneration was paid in 2020/21;
8. Includes a 10% non-consolidated/non pensionable element at risk of claw-back.
9. The pension-related benefit has been calculated using the information provided by NHS Pensions and the Greenbury guidance
10. Gross salary cost. On secondment for four days a week between 25 September 2020 to 31 March 2021 but continued Director of IPC role for 1 day a week.

Table 2: 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	1000	-	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 Tables 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 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 3: Pension Entitlements of Senior Managers 31 March 2021 (audited information):

Name and Title	Real Increase in Pension at pension age (bands of £2,500) £'000	Real Increase in Pension Lump Sum at pension age (bands of £2,500) £'000	Total Accrued Pension at pension age at 31 March 2021 (bands of £5,000) £'000	Lump Sum at pension age Related to Accrued Pension at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000
Mr S Posey – Chief Executive	0 – 2.5	10 – 12.5	45 - 50	95 - 100	667	25	716
Mr T Glenn – Chief Finance & Commercial Officer	2.5 - 5	-	20 - 25	-	187	12	220
Dr R Hall – Medical Director	2.5 - 5	7.5 - 10	40 - 45	125 - 130	-	-	-
Mrs E Midlane – Chief Operating Officer	2.5 - 5	2.5 - 5	45 - 50	100 - 105	807	68	904
Mrs O Monkhouse – Director of Workforce and OD	0 – 2.5	-	40 - 45	80 - 85	732	19	779
Mrs J Rudman – Chief Nurse & IPC Director	2.5 - 5	7.5 - 10	45 - 50	105 - 110	754	79	863
Mr I Graham – Chief Nurse	0 – 2.5	2.5 - 5	25 - 30	55 - 60	377	25	445
Mr A Raynes (Advisory non-voting member)	0 – 2.5	-	15 - 20	15 - 20	231	17	268

Notes to Tables 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 1.7%;
5. In calculating the actuarial value of the CETV as at 31 March 2021 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.
9. The start date for T Glenn was 14 April 2021.
10. Graham was in post as the Chief Nurse between 28 Sep 2020 to 31 Mar 2021.

Table 4: Pension Entitlements of Senior Managers 31 March 2020 (audited information):

Name and Title	Real Increase in Pension at pension age (bands of £2,500) £'000	Real Increase in Pension Lump Sum at pension age (bands of £2,500) £'000	Total Accrued Pension at pension age at 31 March 2020 (bands of £5,000) £'000	Lump Sum at pension age Related to Accrued Pension at 31 March 2020 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2020 £'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 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 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.

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.

	2020/21		2019/20
Band of Highest Paid Director's Total Remuneration (£'000)	185-190	Band of Highest Paid Director's Total Remuneration (£'000)	175-180
Median Total Remuneration	31,328	Median Total Remuneration	30,401
Ratio	5.99	Ratio	5.84

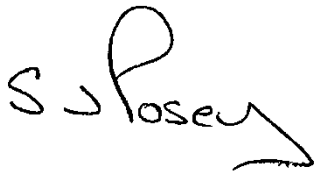
The mid-point of the banded remuneration of the highest paid Director in the Foundation Trust in the financial year 2020/21 was £187,500 (2019/20: £177,500). This was 5.99 times (2019/20: 5.84 times) the median remuneration of the workforce, which was £31,328 (2019/20: £30,401). 18 employees in 2020/21 (2019/20: 20) received remuneration in excess of the highest paid Director. Remuneration ranged from £187,902 to £263,615 (2019/20: £184,310 to £395,389.

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 2021. 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 2021. 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
03 June 2021

2.3 Staff Report

Recruitment and Retention

One of the Trust's most significant challenges remains recruiting and retaining staff. There are local and national skills shortages, particularly in key groups such as registered nurses, cardiac physiologists and radiographers and the recruitment market in Cambridge is extremely competitive The COVID -19 pandemic has had a very significant impact on staff wellbeing despite the support provided by the Trust. The medium and long-term impact is as yet unknown but there is a risk that it impacts on staff engagement and retention. In 2020/21 we recruited additional staff through fast-track processes to support the increase in the number of critical beds required during the first and second surge in patient numbers. We strengthened the wellbeing support for staff including practical aspects such as the provision of free drinks and meals, additional rest facilities and free car parking and increased provision of mental health services for staff.

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 2021/22 we will be focusing on implementing the second phase of our Compassionate and Collective Leadership Programme which will continue our journey to build a high quality care culture. We will revise our values to reflect better the feedback from staff on what matters to them and our patients and implement a behaviour framework that will guide staff on how we can ensure that all staff have a positive experience at work. We will continue to work with system partners, in particular Cambridge University Hospital, to develop apprenticeship opportunities and engage with schools and colleges on work experience programmes and promoting the NHS as an employer of choice.

Staff Engagement, Consultation and Involvement

During 2020/21 our focus was on ensuring that we provided staff with timely information and updates on the emergency response to the pandemic and critical issues such as PPE, risk assessment processes, health and wellbeing support and the vaccination programme. We worked closely with our Staff Networks, in particular our BAME Network, to ensure that we were listening to the concerns and feedback from staff and then responding to this in our communications. A Health and Wellbeing Collaborative was established which has enabled staff from across the organisation that have an interest in this area to be involved and engaged with how we support staff. The weekly Staff Briefing and electronic updates which during the height of the first surge were daily continue to be an important vehicle for communicating with line managers and staff. We undertook an extensive debrief process involving staff from across the organisation after the first surge in COVID-19 patients to learn lessons about our response and how we better support staff. This ensured that we were better prepared for the second surge and the feedback was that staff did feel better supported. A second debrief process will be undertaken and again used to improve our engagement and will feed into our Compassionate and Collective Leadership Programme.

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, , and the Compassionate and Collective Leadership programme.

Our Freedom to Speak up Champions who work with the Trust Freedom to Speak up Guardian (FTSUG) to provide an important route for staff to raise concerns and queries. There is a quarterly report from the FTSUG to the Trust Board and there is a staff story bimonthly at the Trust Board both of which ensure that the Board receive feedback and insights on the experience of staff.

Valuing Staff/Celebrating Success

Demonstrating that the contribution of staff is recognised and valued is an important element of staff engagement. Sadly the 2020/21 Royal Papworth Staff Awards had to be cancelled due to COVID19. We will be reintroducing this in 2021/22 and it will be focused on celebrating staff and teams who have been exemplars of the staff values. During 2020/21 we introduced a Recognition and Appreciation scheme which provides funding for managers to use to show appreciation to staff or teams in a flexible and timely 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 2020/21 there were 1,614 Laudix commendations made.

Staff Survey

As stated previously staff engagement is an important issue for the Trust. In addition to the annual national staff survey we undertake quarterly staff surveys. These surveys help the Trust measure staff engagement and develop plans to address key themes. In 2020 the response rate from the Trust staff was 65%, 1,337 responses, which was above the average response rate of 64% for our peer group This was an electronic survey open to all staff.

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

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

	2020/21	2020/21	2019/20	2019/20	2018/19	2018/19
	Trust	Benchmarking Group (Nat)	Trust	Benchmarking Group (Nat)	Trust	Benchmarking Group
Equality, diversity and inclusion	8.9	9.2 (9.0)	8.9	9.2 (9.0)	9.1	9.3
Health and wellbeing	6.1	6.5 (6.1)	5.8	6.3 (5.9)	6.0	6.3
Immediate managers	6.9	7.1 (6.9)	6.7	7.1 (6.9)	7.0	7.0
Morale	6.2	6.4 (6.2)	5.8	6.4 (6.2)	5.8	6.3
Quality of appraisals			5.6	5.8 (5.6)	5.4	5.7
Quality of care	7.7	7.9 (7.5)	7.4	7.9 (7.5)	7.4	7.8
Safe environment – bullying and harassment	8.2	8.4 (8.1)	8.1	8.3 (8.0)	8.2	8.2
Safe environment – violence	9.6	9.8 (9.5)	9.6	9.8 (9.4)	9.7	9.7
Safety culture	7.1	7.0 (6.8)	6.9	7.0 (6.8)	6.8	6.9
Staff engagement	7.3	7.4 (7.0)	7.1	7.5 (7.0)	7.2	7.4
Team Working	6.5	6.8 (6.5)	6.5	6.9 (6.6)		

In 2020 we saw a statistically significant improvement in our scores for:

- Health and welfare
- Morale
- Quality of appraisals
- Safety culture
- Staff engagement

In the other 5 domains there was no change in our results from 2019. We recognise that results remain below the national average in some areas and these provide a focus for further action which is set out below and the EDI section of this report.

The results have been shared with staff and leadership teams and the Compassionate and Collective Leadership Programme will be the main vehicle for driving further improvement in the experience of staff.

Future priorities and targets

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 2020/21 was 84 (3.7%) of the workforce. Further information in connection with Equality and Diversity can be found in the Equality and Diversity section of the Annual Report.

The Disability and Difference Network 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.

The Trust continues to be committed to providing a comprehensive flu vaccination programme for staff. The uptake for "frontline" staff 2020/21 83% of front line staff received flu vaccinations, which was a slight deterioration from the previous year (85%). This remains an important patient and staff safety measure.

We stood up a COVID-19 vaccination hub to vaccinate our own staff and other NHS and Social Care staff across Cambridge and Peterborough. This was an incredible whole hospital effort with staff volunteering from all departments to support the

clinics. This was supported with a proactive communication campaign with a particular focus on providing information and reassurance to staff who had concerns about vaccination. 93%% of staff have been vaccinated thereby protecting themselves, their families and their patients.

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.

We provide access for all staff to an Employee Assistance Programme provided by Health Assurance. This 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.

COVID-19 has had a very significant impact on the health and wellbeing of staff. In response we have introduced a number of new services for staff which are in addition to a wide-range of services being provided at a national, regional and system level. We have appointed a Wellbeing Practitioner who provides first line counselling for staff and co-ordinates a range of other services available to staff. We anticipate that enhanced support will be needed for future years and will continue to engage and listen to the feedback from staff on what they need to support their physical and mental health and wellbeing.

Diversity and inclusion policies, initiatives and longer term ambitions

The business and moral case for having a culture that has Equality, Diversity and Inclusivity (EDI) at its centre is comprehensive and clearly aligned to our corporate strategic objectives as a Trust. Our Trust is known for its medical excellence; it is important that the Trust also focuses on going above and beyond the minimal requirements set out by law or our regulators and achieving excellence in our leadership. The Trust's EDI work should seek to create a culture of continuous improvement in reducing health inequalities and tackling discrimination. The Trust has an Equality and Diversity Policy. The Equality, Diversity and Inclusion Steering Group reports to the Quality and Risk Committee and oversees compliance with the Equality and Diversity Policy and the development and implementation of the Workforce Race Equality Scheme and Workforce Disability Equality Scheme. The Trust has established three staff networks (Black Asian and Minority Ethnic Network, Disability and Difference and LGBT+) and they play an important role in ensuring that the experience of staff guides our priorities.

The Trust appointed an EDI Manager at the end of 2020, funded by the Royal Papworth Charity, to provide expertise and capacity to progress this strategic priority. The emergency situation impacted on our work plan and we have focused on those issues that have particularly come to the fore at this time such as COVID-19 risk assessments and ensuring that all staff are supported to get vaccinated. As we recover and restore services we will be focusing on improving career development and progression opportunities for staff from a BAME background and addressing discrimination.

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 15 members of the Trust Board at the end of March 2021, of whom ten were male and four were female.

	Female	Male	Total
Directors (includes Non-executive Directors)	6	9	15
Senior Managers (as per occupation codes)	20	10	30
Other Employees	1660	575	2235
Total	1686	594	2280

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.
4. Non-Executive Directors includes one non-voting Board member.

Sickness absence rate of staff

2020/21 absence information can be found on line at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Maintaining low levels of absence and supporting the health of staff remains a key priority for the Trust. . 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

Staff Turnover

Information on staff turnover can be found at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Expenditure on consultancy

The expenditure on consultancy in 2020/21 was £1,558k. During 2020/21 the Trust engaged Consultants to undertake work on a number of projects including: Estates and PFI matters including technical advice and independent reviews; optimisation of the LORENZO Electronic Patient Record (EPR) system; medical device development and the Clinical Administration Project.

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 0 exit packages agreed in 2020/21.

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			
£25,001 – £50,000			
£50,001 – £100,000			
£100,000 – £150,000			

£150,001 – £200,000			
>£200,001			
Total number of exit packages by type			
Total resource cost	0 (2019/20 0)	0 (2019/20 £131k)	0 (2019/20 £131k)

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		
Exit payments following Employment Tribunals or court orders		
Non-contractual payments requiring HMT approval		
Total	0	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		

Reporting high paid off-payroll arrangements

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater

No. of existing engagements as of 31 March 2021	1
Of which...	0
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

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

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021 Of which:	2
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	2
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0 (2019/20: 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.	19

Table 4: Staff costs

	Group			
	Permanent £000	**Other £000**	**2020/21 Total £000**	**2019/20 Total £000**
Salaries and wages	87,605	2,429	**90,034**	**80,165**
Social security costs	8,326	0	**8,326**	**7,751**
Employer's contributions to NHS pensions	10,009	0	**10,009**	**8,666**
Employer's contributions to NHS pensions paid by NHSE	4,335	0	**4,335**	**3,782**
Apprenticeship levy	416	0	**416**	**372**
Agency/contract staff	2,895	0	**2,895**	**5,104**
Total gross staff costs	**113,586**	**2,429**	**116,015**	**105,840**
Recoveries in respect of seconded staff	**0**	**0**	**0**	**0**
Total staff costs	**113,586**	**2,429**	**116,015**	**105,840**
Of which Costs capitalised as part of assets	**0**	**0**	**2895**	**173**

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

	Group					
	Permanent Number	**Other Number**	**2020/21 Total Number**	**Permanent Number**	**Other Number**	**2019/20 Total Number**
Medical and dental	234	12	**246**	215	9	**224**
Administration and estates	419	21	**440**	383	26	**409**
Healthcare assistants and other support staff	414	37	**451**	355	37	**392**
Nursing, midwifery and health visiting staff	682	34	**716**	608	37	**645**
Scientific, therapeutic and technical staff	166	22	**188**	149	13	**162**
Healthcare science staff	76	9	**84**	68	8	**76**
Other	1		**1**	2	-	**2**
Total average numbers	**1992**	**134**	**2126**	**1,780**	**130**	**1,910**
Of which Number of employees (WTE) engaged on capital projects				1	3	4

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 2020/21. 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. An informal NED and Governor briefing has also been established in 2021 and this has been well received.

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 was planned for 2020 however this was not taken forward in year.

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 was a Partner Governor on the Council of Governors of Cambridge University Hospitals NHS Foundation Trust (CUH) until September 2020. NHS Improvement has been advised of this arrangement and considers it acceptable.

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. 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 was 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.

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 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

	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.	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 has an 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).	Governors have not exercised this power.

	** As inserted by section 151 (6) of the Health and Social Care Act 2012) "	
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	See Remuneration Report section.
B.6.2	Where there has been external evaluation of the board, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	External review 2015/16. See earlier in this section.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and 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 Director's 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.	The Council of Governors accepted a recommendation to appoint External Auditors from 2015/16 audit and in 2020 to award a 5th and final Audit cycle to the 31 August 2021
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 2020/21.
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	See Council of Governor section.

	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.	
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See Foundation Trust Membership section.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	See Board of Director section and Council of Governors section
Additional requirement of FT ARM	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: 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://www.england.nhs.uk/financial-accounting-and-reporting/single-oversight-framework-segmentation/

This segmentation information is the Trust's position as at 15 April 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 was re-appointed for further three years in 2017. The Council of Governors approved two 12 month extensions to his term of office in 2019 and 2020 to support continuity of leadership through the hospital move and the response to the COVID19 pandemic.

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
Dave left the Trust on 31 May 2020. Further details of his expertise and experience can be found in our annual report for 2019/20.

Mrs Amanda Fadero Non-executive Director
Amanda joined the Board on the 1 December 2020 having enjoyed an extensive, varied and rewarding career in the NHS for over 40 years. Her career started in London where she trained and worked as a Paediatric and general nurse, moving into senior nursing leadership and management roles before moving into general management in 1992. Amanda undertook an MBA and held a variety of senior management roles before moving into a strategic joint leadership role across the acute, community and primary care sector in 2005.

She has held a number of Executive roles including leading the commissioning system in Sussex as the Chief Executive of NHS Sussex. She has worked as part of the senior team in NHS England as the Area Director for Surrey and Sussex before returning to the provider sector in 2014 as the Deputy Chief Executive and Director of Strategy of a large University Hospitals Trust where she also acted as the Chief Executive.

Amanda possess valuable experience in leading transformation, managing complexity, using problem solving and conflict resolution to progress and manage change. She values relationships and partnerships which she believes to be essential, supported by strong governance, rigorous assurance processes and using appreciative enquiry, to secure safe, effective and efficient services for the members of the public who require them.

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.

Ms Diane Leacock, Associate Non-Executive Director
Diane is a qualified accountant with extensive business experience. She has held Finance Director roles at various commercial organisations including the information and publishing group Informa UK, insurance broker Willis Towers Watson and the regional law firm, Ellisons where she has streamlined, grown and transformed various business units. Currently, Diane works as an independent finance consultant, supporting businesses experiencing challenging situations.

Diane has a keen interest in healthcare and has served as a non-executive director within the NHS. She also sits on the Board of Trustees at the East of England's award-winning contemporary visual arts gallery, Firstsite.

An Economics graduate of the University of Waterloo (Canada), Diane holds a Master's in Business Administration from Henley Business School and is a Fellow of the Association of Chartered Certified Accountants.

Diane is a non-voting member of the Board.

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 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 Master's 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 2020/21	12	7	12	12	6	2
J Ahluwalia	11/12			12/12	6/6	2/2
M Blastland	12/12	7/7		12/12		2/2
C Conquest	12/12	7/7	12/12	2		2/2
D Dean [1]	3/3	0/0	2/2			1/1
A Fadero [1]	2/2			3/3		
T Glenn	11/11	7	12/12			
I Graham [1]	4/4	2	5	10/12	3/4	
R Hall	11/12	5	10	10/12	5/6	
D Leacock [1]	2/2	3/3	3/3			
E Midlane	12/12		12/12		6/6	
O Monkhouse	11/12	5	10/12	10/12	2/6	
S Posey	12/12	4	11/12	5/12	5/6	
A Raynes	9/12	4	5	10/12	2/6	
G Robert	12/12	2/2	11/12		5/6	2/2
J Rudman	7/9	2	5	6/6	2/2	
J Wallwork	12/12	2	1	1		2/2
I Wilkinson	9/12			7/12	3/6	

Not members of the Committee, however Directors attend meetings of committees of which they are not members either as regular attendees or as required.	A All Directors are members.
1 Part year membership.	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, 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 2020/21 were:

2 April 2020	17 April 2020	7 May 2020	4 June 2020
17 June 2020	2 July 2020	6 August 2020	3 Sept 2020
17 Sept 2020	1 Oct 2020	3 Dec 2020	2 Feb 2021

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 Cynthia Conquest, Diane Leacock and David Dean 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 2020/21 was:

Cynthia Conquest (Chair from 1 June 2020)
Michael Blastland
David Dean (Chair to 31 May 2020)
Diane Leacock (from 1 January 2021)

Meetings and Attendance of Members

Name	04.06.20	17.06.20	16.07.20	08.10.20	21.01.21	18.02.21	18.03.21
Cynthia Conquest	✓	✓	✓	✓	✓	✓	✓
Michael Blastland	✓	✓	✓	✓	✓	✓	✓
Diane Leacock					✓	✓	✓

✓ 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. For a period in 2020/21 the Committee operated with two NED members. During this period all Committee meetings were quorate and had a NED member who had relevant financial experience.

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 2020/21 the contract for Internal Audit and Counter Fraud services was renewed for a further three years being awarded to BDO following a formal tendering process under the NHS Shared Business Services framework agreement: SBS/20/MA/ZY/10024. BDO 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. In 2020/21 the Council of Governors approved the award of a fifth and final Audit cycle to KPMG up to the 31st August 2021 under the NHS SBS Framework which permits single year awards directly.

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 2020/21. 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 03June 2021.

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 – 2020/21

During 2020/21, 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 and the External Auditors' ISA 260 (including letter of representation and formal independence letter);
- The Quality Accounts 2019/20: As these were not subject to External Audit they were reviewed by the Audit Committee through a joint meeting with the Quality and Risk Committee. This was undertaken in line with the revised national reporting timetable set for 2019/20.
- The Annual Governance Statement (AGS);

- The Internal Audit Annual Report and Head of Internal Audit Opinion;
- The External Audit Plan for the Foundation Trust;
- 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 2020/21 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 Trust's Freedom to Speak up Guardian proactively promotes his role across the Trust by meeting all new starters in the Trust and by undertaking regular walkabouts both in the Hospital site and at Royal Papworth House. He meets regularly with the Director of Workforce and the Chief Executive Officer to discuss themes emerging from the concerns raised with him. The Guardian is required to report all concerns raised with him to the National Guardian's Office on a quarterly basis. In 2020/21 the Guardian has reported 84 concerns. This has been a very difficult and challenging year for our staff with significant concerns attributed to the COVID19 pandemic. The nature of reporting has reflected workload pressures; the transparency of the redeployment process; the anxiety that staff have felt and some significant issues identified by staff who had been subjected to racially motivated discrimination in the

form of bullying and harassment and through unfair processes in awarding fixed term promotions. It was extremely disappointing to see this emerge as an issue within some of our clinical services. This matter was fully investigated and reported to the Board and actions were put in place to ensure that these issues were addressed. The BAME committee provided a forum in which to discuss these issues, however, it was recognised by the Board that it was essential that this behaviour was not tolerated by the Trust.

Extending access to speaking up support has been initiated through the Trust's Strategy and Vision policy, approved in 2019/20, and to be reviewed in 2022/23. Sixteen Freedom To Speak Up Champions continue to support the FTSU Guardian and this is now an established and effective provision. Our FTSU Champions have supported the FTSU Guardian role by extending support throughout the period of the COVID19 pandemic ensuring that staff were encouraged and know how to raise concerns. We have also continued to provide feedback to managers and staff about the themes emerging from the concerns raised to ensure that we learn from them. This is undertaken through the Trust wide briefing communication platform. The FTSU Guardian is also networked into several committees to ensure representation of the role as well as helping staff to speak up.

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 £77,500 (2019/20: £64,900 figure restated to include £10,000 agreed overrun) excluding VAT. This is the fee for an audit in accordance with the National Audit Office Code of Audit Practice 2020.

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 Trust forward plans (including operational and strategic plans submitted to NHS Improvement) as well as partnership working; the STP and Integrated Care System and the Heart and Lung Research Institute 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 2021:

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.

Gillian Francis
After bringing up her family Gillian started nursing in her early 40's, retiring as the 'Modern Matron' in Neuroscience at Addenbrooke's' 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.

Abigail Halstead
I have been under the care of the Royal Papworth Adult Cystic Fibrosis unit since 2011. During this time I have received regular care from all areas of both the inpatient and outpatient departments. I feel well placed to empathise and help offer ideas for improvement based on my own positive and negative experiences of patient life and challenges. As my care at Royal Papworth will be lifelong I will also be able to feedback on changes as they occur. I have experience working in branding and marketing and I want to use these skills to help improve patient experience, especially in the new world of virtual healthcare.

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.

Norfolk

Doug Burns
Doug is married with 5 sons and 10 grandchildren. He is chairman of a medium size family business in the software industry which he started 40 years ago and he is the proud owner of a Morgan classic car. Whilst having worked and lived in the Home Counties, London and the North of England, Doug has resided in Norfolk for some 45 years.

His career started in the accountancy profession at 16 and having qualified, he moved into the commercial world of service, leisure and construction industries before deciding to start his own business.

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.

John Fitchew
I joined the Governors as a long standing and grateful patient, having had a Mitral Valve repaired in 2004, and a Heart Transplant in 2013. I was in the building trade all my working life and I am married and between us we have 5 children and 12 grandchildren.

After receiving my new heart in 2013 I felt that I needed to give something back, as I had a new zest for life. I joined The Norfolk Zipper Club in July 2013, and was elected as Co Chairman in 2016. The Norfolk Zipper Club raises money that goes towards buying much needed equipment. It has been in existence for approximately 30 years and has raised in excess of £1.5 million. Whilst being involved with NZC I have on occasions spoken one to one with patients who have been awaiting cardiac procedures to help with any worries that they may have. I hope to continue with this work in the future.

Bob Spinks
Bob is a businessman who runs his own 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.

Trevor Colins
Trevor was diagnosed with Dilated Cardio Myopathy in 2001. The condition was managed with medication and frequent monitoring with the care and attention of the NHS. He maintained an active life until it was necessary for him to have further treatment.

Trevor has been a service-user at the Royal Papworth Hospital since 2016, having had a Heart Transplant in 2017 at the old site. Previously he worked in local government in Social Services and retired in 2016.

As a Hospital Volunteer since 2019, Trevor has a keen interest in supporting the patients journey to their recovery. Trevor is on the NHS Blood & Transplant Patient & Public Advisory Group, offering advice and knowledge as to the perspective of a service user.

Trevor also won two medals when he represented Royal Papworth Hospital at the 2019 Transplant Games in Newport, Wales.

David Gibbs
David is vice chairman of an Investment Management Company based in London. He is a Fellow of the Chartered Institute for Securities & Investment and has over 40 years' experience in the financial services industry looking after charities, pension funds and family portfolios. David lives in Rutland and has been associated with Royal Papworth as a patient for over ten years.

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.

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

Michelle Barfoot, Nurses
I have been part of the Royal Papworth family since March 2002 and I am passionate about Royal Papworth Hospital and the patients that we care for. I will use my role as Governor to influence the Royal Papworth of the future for both staff and patients.

I am currently a Ward Sister in Respiratory Medicine and previously worked in Critical Care for 17 years. I joined Royal Papworth because I had a sense that it truly cared for both its patients and staff and this has been true throughout my time here.

Aman Coonar, Doctors
As a RPH consultant since 2007, I have undertaken various roles including service lead. I became a governor to help RPH in our mission: great care, innovation, excellent patient experience, staff welfare and development.

Sound clinical input to governance is important. The value of this was shown during the COVID response when our policies informed by rapid clinically based decision making were well ahead and RPH was also strongly supportive to its staff. As an established doctor I will bring my professional and personal experiences to positively fulfil the governor role. I have also been a Papworth patient so I have a perspective of "both sides".

Having lived with my family from the age of 2 in East Anglia and London this is also "my constituency". As a governor I will add to the diversity of local representation and views.

Lorena Andreu Faz, Nurses
I started working as a Health Care Assistant in the Critical Care Area just over four years ago after completing Nursing Assistant studies in Spain, and I am currently completing a Nursing Degree. Being a health professional has taught me infinite values; it has made me more empathetic, compassionate, and understanding. Most importantly, working at RPH has taught me to strive to improve and to fight for my dreams. It has been 4 years since then and being part of the RPH family has been an amazing journey. I am a member of the CCA Teaching Team as well as a Student Nurse.

Lorena joined the Council of Governors in November 2020 and is eager to develop in her role as Governor.

Caroline Gerrard, Administrative, Clerical & Managers
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.

Rhys Hurst, Allied Health Professionals
Rhys is Staff Governor for Royal Papworth Hospital representing the Allied Health Professionals (AHP). He is a qualified and HCPC registered Physiotherapist and Clinical Physiotherapy Lead for the Cambridge Centre for Lung Infection and has worked at Royal Papworth in two stints first in 2007 and now since 2018. Rhys has over 20 years of experience in the NHS and has lived and worked in the East of England for the last 12 years in a variety of positions. Part of his role has been to shape the AHP strategy for Royal Papworth Hospital, enhancing his insight into the AHP services moving forwards and he is looking forward to representing this at Governor level. He is currently undertaking his MSc in Advanced Clinical Practice at Anglia Ruskin University.

Christopher McCorquodale, Scientific & Technical
Chris joined Royal Papworth Hospital in June 2012 as a Rotational Pharmacist and has undertaken a range of pharmacy roles over the last nine years. He has developed a clinical interest in transplant medicine and played a major role in the implementation of the Lorenzo electronic prescribing system across the Trust. As Deputy Chief Pharmacist, Chris now holds a leadership role within the pharmacy team, and also spends some time seconded to the Digital department, where he focuses on digital medicines and the clinical safety of IT systems.

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 (to 06 May 2021)
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 2021

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]	Gill Francis	Sept 2014	Sept 2017 Sept 2020	Sept 2021
	Richard Hodder	Sept 2014	Sept 2017 Sept 2020	Sept 2023
	Stephen Brown	Sept 2017	Sept 2020	Sept 2021
	Susan Bullivant	Sept 2019	n/a	Sept 2022
	Abigail Halstead	Sept 2020	Sept 2023	Sept 2023
Suffolk	Trevor McLeese	Sept 2017	Sept 2020	Sept 2021
	Julia Dunnicliffe	Sept 2019	n/a	Sept 2022
	Rodney Scott	Sept 2019	n/a	Sept 2022
	Vacancy	-	-	-
Rest of England and Wales	Harvey Perkins	Sept 2016	Sept 2019	Sept 2022
	Janet Atkins	Sept 2017	Sept 2020	Sep 2023
	Pippa Kent	Sept 2019	n/a	Sept 2022
	Trevor Colins	Sept 2020	-	Sept 2023
	David Gibbs	Sept 2020	-	Sept 2021
Norfolk	John Fiddy MBE	Sept 2014	Sept 2017 Sept 2020	Sept 2021
	Bob Spinks	Sept 2013	Sept 2016 Sept 2019	Sept 2022
	John Fitchew	Sept 2020	-	Sept 2023
	Doug John Burns	Sept 2020	-	Sept 2021
Elected Staff Constituency	**Name**	**First Elected**	**Re-Elected**	**End of Current Term of office**
Doctors	Aman Coonar	Sept 2020	-	Sept 2023
Nurses	Michelle Barfoot	Sept 2020	-	Sept 2023
	Lorena Andreu Faz	Sept 2020	-	Sept 2023
Allied Health Professionals	Rhys Hurst	Sept 2020	-	Sept 2023
Scientific & Technical	Christopher McCorquodale	Sept 2020	-	Sept 2023
Administrative, Clerical & Management	Caroline Gerrard	Sept 2019	-	Sept 2022
Ancillary, Estates and Others	Martin Ward	Sept 2019	-	Sept 2022
Appointed Governor	**Name**	**Start of Term of Office (*Notified)**	**Re-appointed**	**End of Current Term of office**
University of Cambridge	Caroline Edmonds	Oct 2016	Sept 2019	As agreed between organisations
Cambridge University Hospitals NHS FT	Lorraine Szeremeta	Oct 2018	n/a	As agreed between organisations
Cambridgeshire County Council	Councillor Linda Jones	May 2018 (Sept 2018)	-	May 2021
South Cambridgeshire District Council	Cllr Alex Malyon	May 2018 (June 2018)	-	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

CIVCA acted as the returning officer and independent scrutineer for the election process during 2020. There were vacancies for Governors in four of our public constituencies and four staff constituencies. The results of the elections are set out below:

Information on election results:

Cambridgeshire - four vacancies: fifteen nominations - election held
Norfolk - three vacancies: three nominations – uncontested election
Suffolk - two vacancies: two nominations* - uncontested election; one vacancy carried
Rest of England and Wales - three vacancies: four nominations – election held
Administrative, Clerical & Management: no election in 2020/21
Allied Health Professionals - one vacancy: two nominations – election held;
Ancillary, Estates and Others - no election in 2020/21
Doctors - one vacancy: two nominations – election held
Nurses - two vacancies: three nominations – election held
Scientific and Technical - one vacancy: four nominations – election held

* One nominee withdrew from the Council following their re-election as a Governor to West Suffolk Hospital NHS Foundation Trust

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, Performance 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	17-Jun-20	16-Sep-20	18-Nov-20	17-Mar-21
John Wallwork (Chairman)	✓	✓	✓	✓
Jag Ahluwalia	✓	×	×	✓
Michael Blastland	✓	✓	✓	✓
Cynthia Conquest	✓	✓	✓	✓
Amanda Fadero[1]				×
Diane Leacock[1]				✓
Gavin Robert	×	✓	✓	×
Ian Wilkinson	×	×	×	×
Stephen Posey	✓	✓	✓	✓
Tim Glenn	✓	✓	✓	✓
Roger Hall	✓	×	×	✓
Eilish Midlane	✓	✓	✓	×
Oonagh Monkhouse	✓	×	✓	✓
Josie Rudman[1]	✓	✓		
Andy Raynes	✓	✓	✓	×
Ivan Graham[1]			✓	✓

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

Royal Papworth Hospital is a Trust with a small management team. Whilst Executive and Non-executive Directors are keen to understand the views of Governors they rationalise attendance at all Trust meetings based on the content of the agenda. Council of Governor Meetings have been held virtually throughout 2020/21 and this has allowed for increased interaction between Governors and Non-Executive Directors. Governors also attend our public Board meetings as observers and are invited to attend other Governors briefings and Trust Committee meetings, where they contribute to discussions.

Table of Governor Attendance at Council of Governors' Meetings 2020/21

Council of Governors	17-Jun-20	16-Sep-20	18-Nov-20	17-Mar-21
Atkins, Janet	✓	✓	✓	✓
Brown, Stephen	✓	✓	✓	✓
Bullivant, Susan	✓	✓	✓	✓
Burns, Doug			✓	✓
Collins Trevor			✓	✓
Dunnicliffe, Julia	×	✓	✓	✓
Edge, Glenn	✓	✓	×	
Fiddy, John	×	✓	✓	✓
Fitchew, John				✓
Francis, Gill	✓	✓	✓	✓
Gibbs, David			✓	✓
Halstead, Abi			✓	✓
Hodder, Richard (Lead)	✓	✓	✓	✓
Jackson, Keith	✓	✓	×	
Kent, Pippa (Erskine)	✓	×	×	✓
Marner, Simon	✓	×		
McLeese, Trevor	✓	✓	✓	×
Munday, Peter	×	×		
Perkins, Harvey	✓	✓	✓	✓
Scott, Rodney	×	✓	✓	✓
Spinks, Bob	×	×	×	×
Andreu Faz, Lorena			✓	✓
Barfoot, Michelle			✓	✓
Coonar, Aman			✓	×
Gerrard, Caroline	✓	✓	✓	×
Martin, Penny	×	×	×	
McCorquodale, Christopher			✓	✓
Oats, Katrina	✓	×	×	
Riotto, Cheryl	×	×	×	
Ruggiero, Alessandro	×	×	×	
Ward Martin	✓	✓	✓	✓
Hurst, Rhys			✓	✓
Edmonds, Caroline	×	✓	✓	×
Jones, Linda	✓	✓	✓	✓
Malyon, Alex	×	✓	×	×
Szeremeta, Lorraine	×	×	×	×

Not a Governor* **✓ In attendance** **x Apologies received**

*All newly elected Governors are invited to join the November CoG meeting but they do not formally take on the role until after the Annual Members meeting has taken place.

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 30 March 2021:

Membership by constituency as at 30 April 2021		
Public Membership Profile	Number of Members*	% of total
Cambridgeshire	2654	51.4%
Norfolk	556	10.8%
Suffolk	765	14.8%
Rest of England & Wales	1193	23.1%
Sub-total	5168	100.0%
Constituencies – Staff*	Number of Members	% of total
Nurses	1083	45.7%
Doctors	273	11.5%
Allied Health Professionals	125	5.3%
Scientific & Technical	251	10.6%
Ancillary, Estates & Others	132	5.6%
Administrative, Clerical & Management	507	21.4%
Sub-total	2,371	100.00%
Total Membership	7,539	100.00%
*Note: Numbers are individual members of staff, not whole time equivalent		

* The Trust has moved to a new database for the collection of this information and the initial dataset was provided at the 30 April 2021.

Membership Plans

The revised membership strategy was approved by the Council of Governors in September 2020. This sets out the strategic objectives for membership development and the key priorities and actions for 2020/21. The implementation of actions has been reviewed with some further phasing of work across the year. We have launched our Community Hub which will host our membership data and provide opportunities for regular communications with members. The 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. As a result of COVID19 restrictions membership recruitment has continued principally through our website and social media presence.

Annual Members' Meeting

The Trust held its Annual Members' Meeting (AMM) on Wednesday 18 November 2020. This was a virtual event and our Foundation Trust Members heard updates on the hospital's performance over the past year and the impact of COVID19 on our patients and our staff.

Presentations included the Lead Governor speaking on the role of Governors, the Chief Nurse and Chief Finance Officer on the hospital's clinical and financial performance over the last 12 months and our clinicians sharing information on the response to COVID-19.

There was significant interest in 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 have maintained a presence on site providing tremendous support for staff and patients. Although the COVID19 pandemic has had a significant impact on the scope of support that can be provided we have continued to see our volunteers working at the Trust across the year supporting the Pharmacy team; the Family Liaison Team and the Trust's Vaccination programme.

The PALS Team have maintained contact with all volunteers via email throughout the pandemic and will continue to do so. We have 54 active hospital volunteers who are looking forward to returning to their work supporting clinics, wards, patient/carer meetings, Pharmacy, IT, Charity, proof reading and administration.

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. The PALS team is also researching how the hospital can implement volunteering opportunities for the under 18s and hope to trial a small cohort as a pilot project in 2021/22.

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.

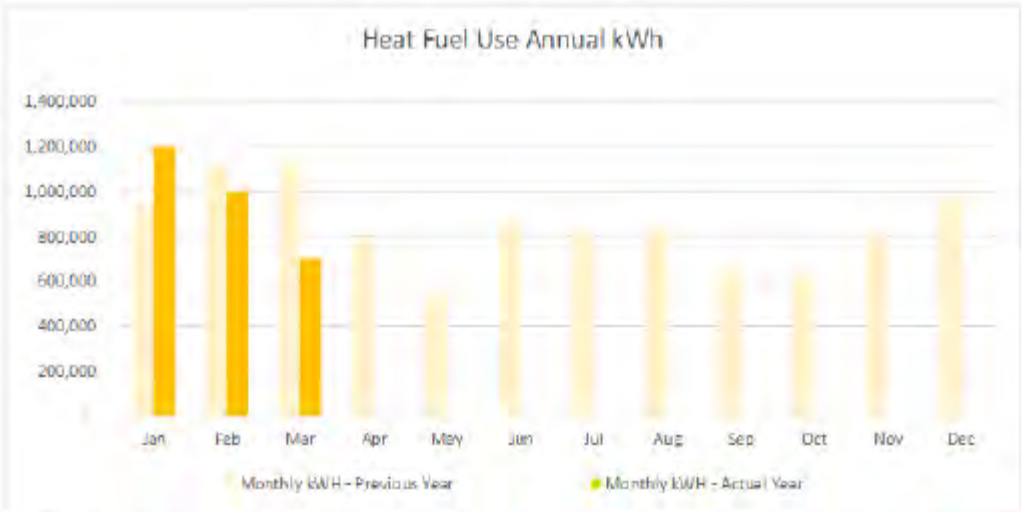
A commitment to sustainability and carbon reduction targets is now included within the NHS Long Term Plan to highlight the impact that working towards sustainable targets contributes to a “service fit for the future”. In 2020, the NHS becomes the world’s first national health system to commit to become ‘carbon net zero and the Trust is working towards developing a Green Plan to ensure significant contribution to the wider Greener NHS initiative. 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 alongside neighbouring partners to investigate where there were shared interests, and to review energy efficient opportunities in line with the PFI provider for the site, Skanska.

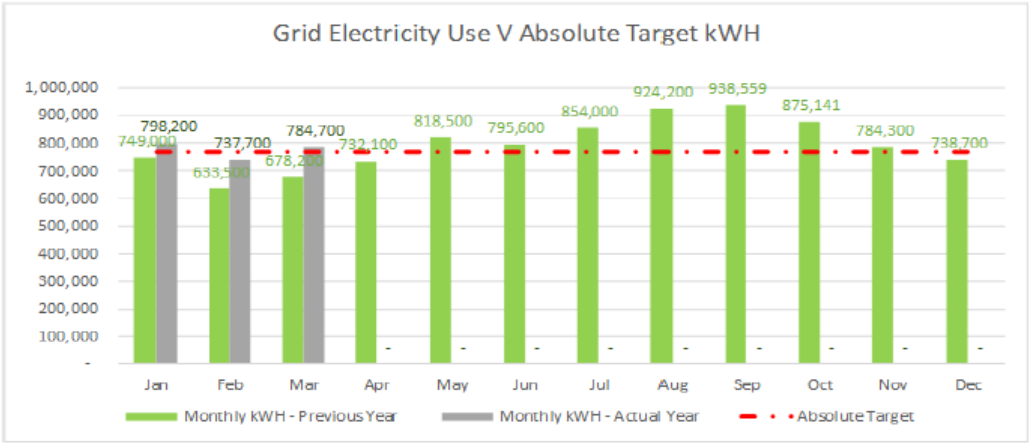
Across the last year, the Trust, along with all NHS organisations and society as a whole, has experienced the challenges posed as part of the COVID19 pandemic. The changes to ways of working has been unprecedented in recent history, and presented the Trust with options to review ways in which work is undertaken both from a clinical and administrative perspective. The Trust has been supported by the Digital Team in continuing to provide access to alternative ways of working for staff and online appointments for patients which will contribute to the reduction of travel and transport emissions in relation to Trust activity.

A Sustainability Board has been established to gather input into the development of sustainability plans from multiple departments from across the Trust. The board will meet regularly to discuss current and future plans for sustainability at Royal Papworth Hospital.

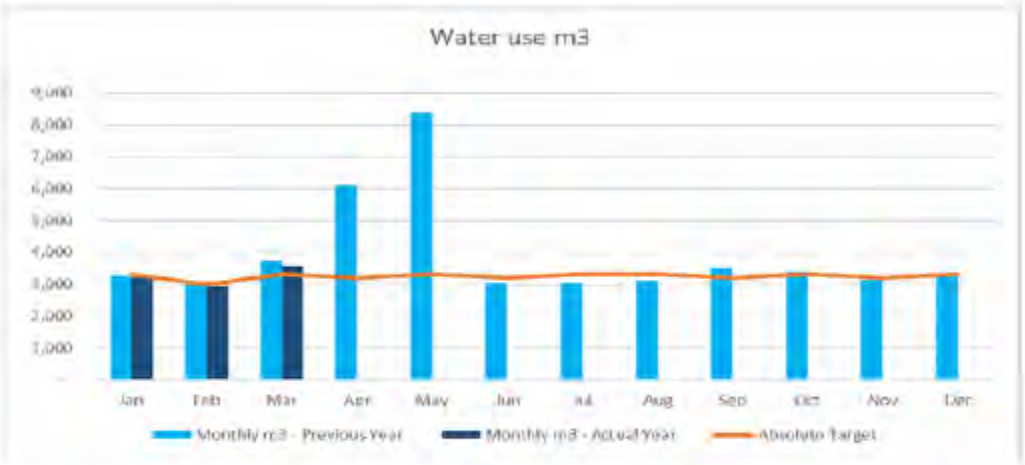
The Trust works alongside Project Co. and Skanska with regards to the monitoring of energy consumption, including water. Data is submitted to the Trust on a monthly basis with an emphasis on better understanding and smarter usage. Below are graphs for Gas, Electricity and Water usage as well as the CHP use. The increase in the figures for water usage in March and April 2020 reflected additional flushing requirements once we emptied wards and departments in preparation for COVID19.



The above chart shows the combined monthly gas and biodiesel (CHP) use. March use was -30% Below the previous month. When comparing to the previous year consumption is -38% Below 2020.



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. March use was 2% Above the straight-line target figure. When comparing to the previous year consumption is 16% Above 2020. This is, in part, due to low utilisation of the of CHP during March.



The above chart shows monthly water use plotted against the design target on a linear scale. March use was around 8% Above the target figure. When comparing to the previous year consumption is 4% below 2020.

Future Projects

Development of a five-year Green Plan 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 Greener NHS will be sought to support activity within these work streams, both on a regional and national level, and the Trust will encompass this activity within the development of the Green Plan to enable planning for future targets. The Trust is a member of the Sustainability National Performance Advisory Group to share ideas and discuss best practice with other key sustainability leads.

The Trust 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 continue to be reviewed 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 for future options and planning.

2.11 Equality and Diversity Report

The business and moral case for having a culture that has equality, diversity and inclusion (EDI) at its centre is comprehensive and clearly aligned to our corporate strategic objectives as a Trust. Our Trust is known for its medical excellence; it is important that the Trust also focuses on going above and beyond the minimal requirements set out by law or our regulators and achieving excellence in our leadership. The Trust's EDI work seeks to create a culture of continuous improvement with regards reducing health inequalities and tackling discrimination.

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.

The NHS People Plan published in July 2020 has EDI at its heart. In October 2020 the Trust appointed a dedicated EDI Manager to provide expertise and capacity to progress this strategic priority. The emergency situation has impacted on the work plan in this area and during 20/21 we have focused on those issues that have particularly come to the fore at this time. We are developing an overarching plan for

21/22 so that progress can be monitored. We have actively contributed to the development East of England Regional Anti-Racism Programme and will work with partner organisations in our Integrated Care System on how we implement the commitments set out in this important programme.

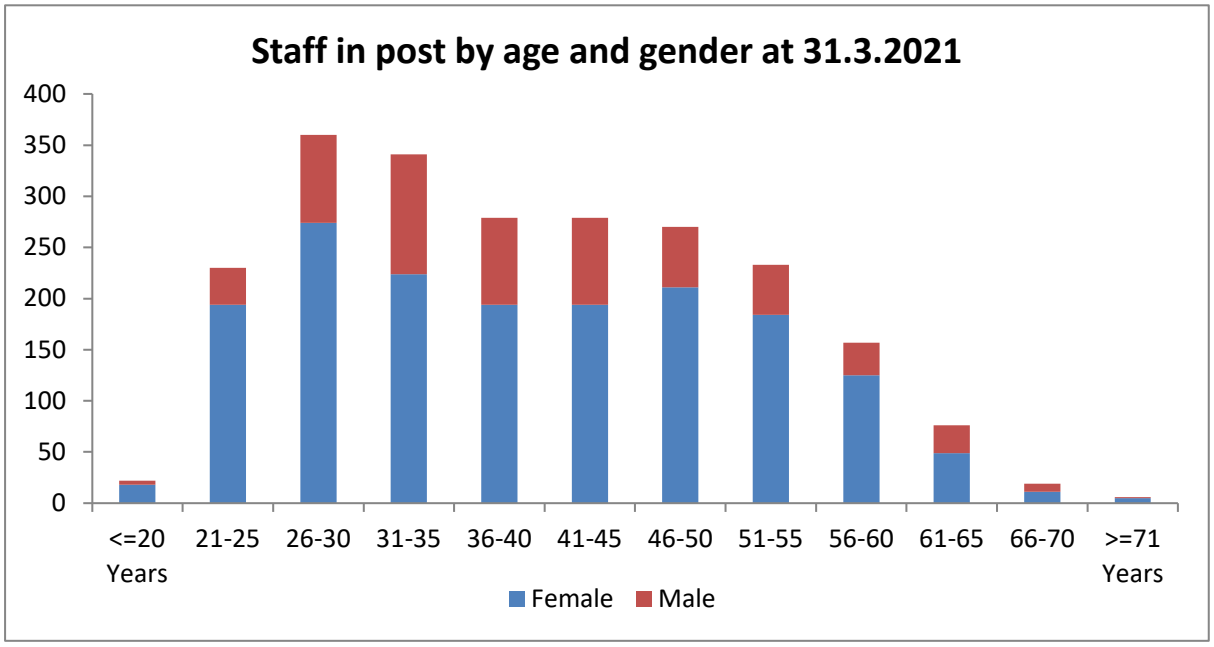
Workforce Profile – 31 March 2021

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 2272 employees at 31 March 2021, excluding hosted services, of which, 1687 were full time employees and 585 were part time.

Gender

Gender	Full Time		Part Time		Grand Total	
	Workforce	% of full time	Workforce	% of part time	Workforce	% of workforce
Female	1151	68.23%	532	90.94%	1683	74.08%
Male	536	31.77%	53	9.06%	589	25.92%
Grand Total	**1687**	100.00%	**585**	100.00%	**2272**	100.00%



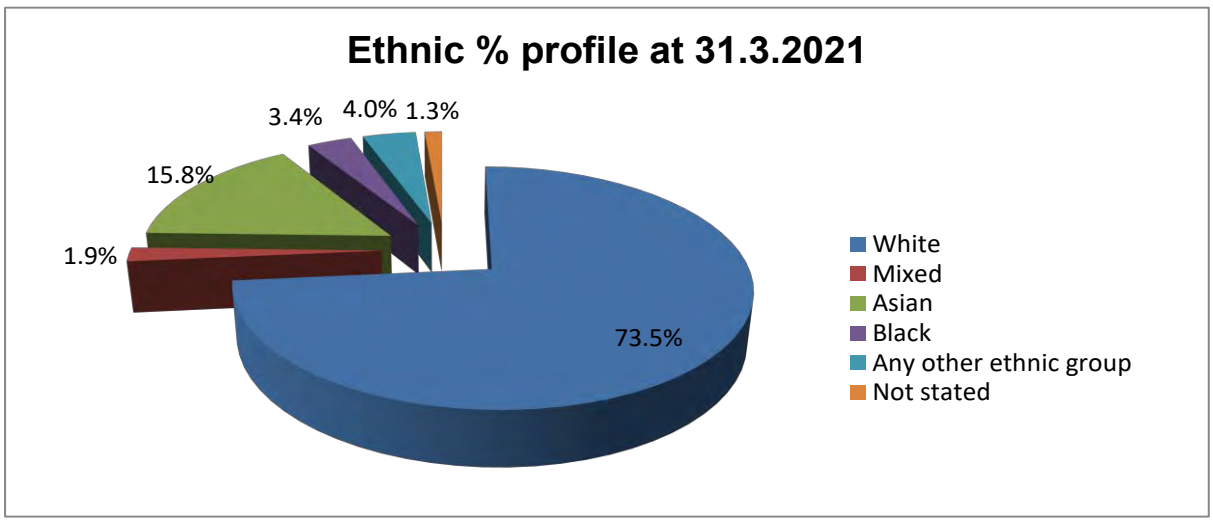
Age Band	Female	% of female workforce	Male	% of male workforce	Total	% of workforce
<=20 Years	18	1.07%	4	0.68%	22	0.97%
21-25	194	11.53%	36	6.11%	230	10.12%
26-30	274	16.28%	86	14.60%	360	15.85%
31-35	224	13.31%	117	19.86%	341	15.01%
36-40	194	11.53%	85	14.43%	279	12.28%
41-45	194	11.53%	85	14.43%	279	12.28%
46-50	211	12.54%	59	10.02%	270	11.88%
51-55	184	10.93%	49	8.32%	233	10.26%
56-60	125	7.43%	32	5.43%	157	6.91%
61-65	49	2.91%	27	4.58%	76	3.35%
66-70	11	0.65%	8	1.36%	19	0.84%
>=71 Years	5	0.30%	1	0.17%	6	0.26%
Grand Total	**1683**	**100.00%**	**589**	**100.00%**	**2272**	**100.00%**

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	
Year ending			Men	Women	Men	Women	Men	Women	Men	Women			Men	Women
2020	25.03%	7.42%	37.74%	62.26%	21.36%	78.64%	22.35%	77.65%	22.85%	77.15%	47.77%	72.73%	7.41%	0.76%

Ethnicity



Disability

Disability status	Female Workforce	% female workforce	Male Workforce	% male workforce	Total Workforce	% total workforce
No	1182	70.23%	406	68.93%	1588	69.89%
Not Declared	424	25.19%	170	28.86%	594	26.14%
Yes	72	4.28%	12	2.04%	84	3.70%
Prefer Not To Answer	4	0.24%	0	0.00%	4	0.18%
Unspecified	1	0.06%	1	0.17%	2	0.09%
Grand Total	**1683**	**100.00%**	**589**	**100.00%**	**2272**	**100.00%**

Sexual Orientation

Sexual Orientation	Total	% workforce
Heterosexual or Straight	1679	73.90%
Not stated (person asked but declined to provide a response)	529	23.28%
Bisexual	28	1.23%
Gay or Lesbian	25	1.10%
Other sexual orientation not listed	5	0.22%
Undecided	3	0.13%
Unspecified	3	0.13%
Grand Total	**2272**	**100.00%**

Religious Belief

Religious Belief	Total	% workforce
Christianity	1094	48.15%
I do not wish to disclose my religion/belief	609	26.80%
Atheism	313	13.78%
Other	154	6.78%
Hinduism	44	1.94%
Islam	32	1.41%
Buddhism	17	0.75%
Sikhism	4	0.18%
Unspecified	3	0.13%
Judaism	2	0.09%
Grand Total	**2272**	**100.00%**

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.

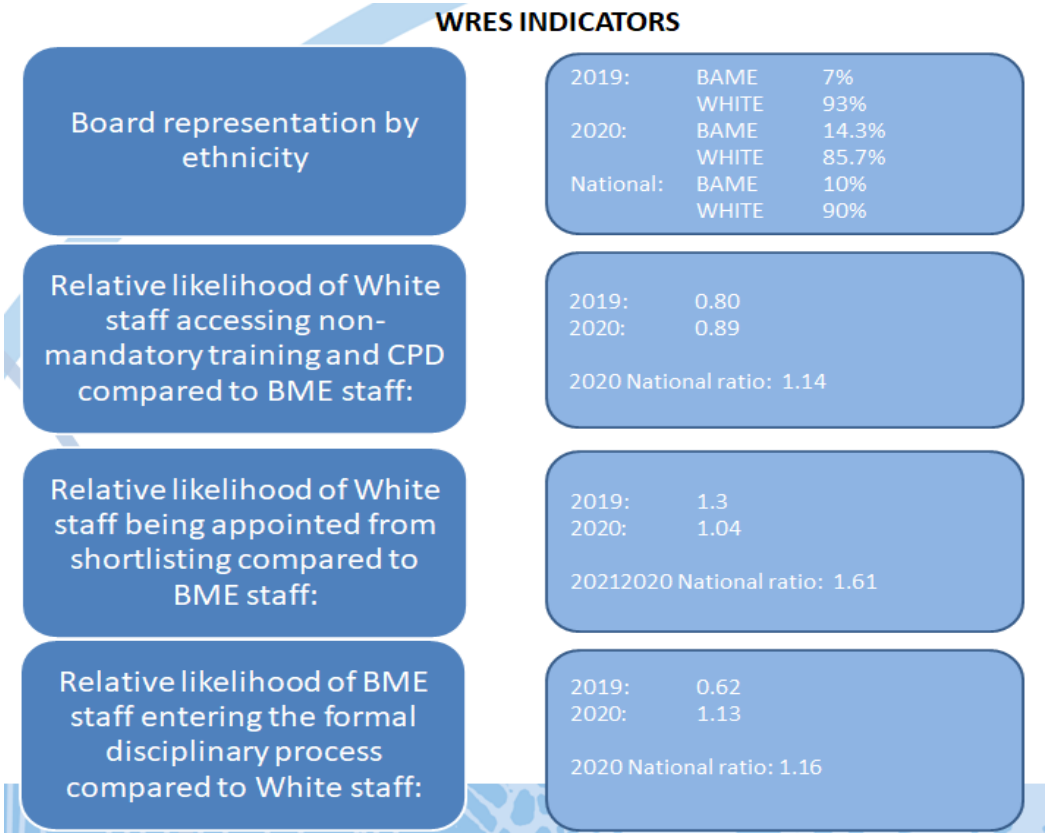
The planned work on using a system wide approach to the 2020/2021 Equality Delivery System audit and the release of EDS3, which will provide a more structured process for patient pathways and a greater emphasis on leadership of the EDI

agenda were postponed due to the pandemic. We anticipate that this work will be resumed in 2021/22.

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)



Indicator	2019	2020	2020 National Average
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White staff: 21%	White staff: 16.6%	White staff: 25.9%
	BAME Staff: 21.1%	BAME staff: 18.3%	BAME staff: 28.9%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White staff: 28.2%	White staff: 27.2%	White staff: 23.2%
	BAME Staff: 35.1%	BAME Staff: 32.6%	BAME staff: 28.8%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White staff: 82.1%	White staff: 81.7%	White staff: 87.3%
	BAME Staff: 55.8%	BAME Staff: 60.7%	BAME staff: 69.2%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	White staff: 8.6%	White staff: 7.6%	White staff: 6.2%
	BAME Staff: 20.5%	BAME Staff: 23.5%	BAME staff: 16.7%

Our WRES indicators clearly indicate that the priority areas of focus for the Trust are the experiences of BAME staff members of discrimination and bullying from their colleagues and line managers and that our BAME colleagues are less likely to believe we provide equal opportunity for career progression compared to their white colleagues. Only 60% of staff from a BAME background believe that there is equality of opportunity. Our overall BAME workforce is broadly representative (25.2%) of our communities, however, this representation is not present in our senior posts nor at a board level

The WRES action plan sets out how we will be addressing these specific areas and this plan is regularly reviewed and updated by the BAME Network which meets bi-monthly. The Equality and Diversity Steering Group oversees the delivery of the WRES action plan and there is a quarterly report to the Quality and Risk Committee.

Workforce Disability Equality Standard

Indicator	2019	2020	2020 National average
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Staff with LSE/Illness: 19.1%	Staff with LSE/Illness: 20.2	Staff with LSE/Illness: 31.6%
	Staff without LSE/Illness: 19.4%	Staff without LSE/Illness: 18.2%	Staff without LSE/Illness: 25.2%
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	Staff with LSE/Illness: 19.9%	Staff with LSE/Illness: 20.8	Staff with LSE/Illness: 18.6%
	Staff without LSE/Illness: 15.1%	Staff without LSE/Illness: 14.9%	Staff without LSE/Illness: 10.7%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with LSE/Illness: 29.2%	Staff with LSE/Illness: 26.2%	Staff with LSE/Illness: 25.7%
	Staff without LSE/Illness: 21.8%	Staff without LSE/Illness: 20.7%	Staff without LSE/Illness: 16.8%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with LSE/Illness: 53.7%	Staff with LSE/Illness: 44.4%	Staff with LSE/Illness: 49.6%
	Staff without LSE/Illness: 44.6%	Staff without LSE/Illness: 41.5%	Staff without LSE/Illness: 48%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with LSE/Illness: 75.5%	Staff with LSE/Illness: 77.4%	Staff with LSE/Illness: 78.5%
	Staff without LSE/Illness: 78.0%	Staff without LSE/Illness: 77.9%	Staff without LSE/Illness: 85.1%
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with LSE/Illness: 27.2%	Staff with LSE/Illness: 29.7%	Staff with LSE/Illness: 31.3%
	Staff without LSE/Illness: 25.1%	Staff without LSE/Illness: 21.7%	Staff without LSE/Illness: 23%
Percentage of staff satisfied with the extent to which their organisation values their work	Staff with LSE/Illness: 47.0%	Staff with LSE/Illness: 43.6%	Staff with LSE/Illness: 39.2%
	Staff without LSE/Illness: 47.8%	Staff without LSE/Illness: 51.2%	Staff without LSE/Illness: 50.5%

Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	Staff without LSE/Illness: 75%	Staff without LSE/Illness: 82.9%	Staff without LSE/Illness: 76.6%
Staff engagement score (0-10)	Staff with LSE/Illness: 7.1	Staff with LSE/Illness: 7.0	Staff with LSE/Illness: 6.67
	Staff without LSE/Illness: 7.1	Staff without LSE/Illness: 7.4	Staff without LSE/Illness: 7.14

The WDES action plan is published on our Trust website. This plan is developed and progress reviewed by the Disability and Difference Network. Delivery is overseen by the EDI Steering Group which reports to the Quality and Risk Committee. The focus of our plan is to improve self-declaration of disability status in order to improve our knowledge of our workforce and where we need to focus our attention. The plan also seeks to address bullying and harassment, line manager development to support staff with health conditions and career development.

Staff Networks

The Trust has three staff networks:

- BAME Network
- LGBT+ Network
- Disability and Difference Network

These Networks are an essential part of the Trust's EDI infrastructure and are instrumental in driving the equality agenda. During the 20/21 the BAME Network has played an important role in supporting staff during the pandemic in particular by advising on the development of the Trust's Risk Assessment process, encouraging and informing staff about the vaccination programme and communicating concerns and information about Personal Protective Equipment.

The Network Chairs and Deputies meet regularly with the EDI Manager and a programme of training for the Network Chairs and Deputies has been developed and will be implemented during 2021/22.

Equality, Diversity and Inclusion Steering Group.

The Equality, Diversity and Inclusivity Steering Group meets bi-monthly and reports to Quality and Risk Committee. It is chaired by the Chief Operating Officer and Director of Workforce and OD and all staff networks report into this committee.

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 did not comply with submission of Disclosure of Trade Union Facility Time set out in Schedule 2 to The Trade Union (Facility Time Publication Requirements) Regulations 2017 in 2020/21.

The Trade Union Facility Time data is set out below:

Ten employees were Relevant Union Officials during the relevant period (2019/20) and this equated to 9.3 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	£25,136.14
b	Total pay bill	£10,566,800
c	Total pay bill spent on facility time	0.24%
d	Time spent on paid trade union activities as a percentage of total paid facility time hours	11%

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: 03 June 2021

2.13 Annual Governance Statement

Executive summary

My annual governance review of 2020/21 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 2021/22. 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 2021 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 and one has attended the Performance 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 2020/21 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): 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. 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.

  Throughout 2020/21 the COVID 19 Pandemic has challenged and tested us as we respond to the huge demands on our specialist services. This has necessarily impacted on our ability to develop and meet some of the ambitions set out in the Quality Strategy. It is now more important than ever that we remain vigilant and agile to ensure continuous delivery of safe and effective care for our patients in these challenging times. Through our ongoing governance and performance monitoring structures and the fantastic commitment and hard work of our staff at all levels of the organisation, we have maintained a high quality and safe service throughout this difficult time.
- 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. The Audit Committee reviews the establishment and maintenance of the system of integrated governance, risk management and internal control, across the whole of the Royal Papworth Hospital's activities and gains Assurance from the Quality & Risk Committee for the Risk Assurance Framework. 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, business management, health safety and environmental) 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 with a rating of 12 and above are included in the Corporate Risk Register. Corporate risks are managed at a Division and Department level with oversight through the Quality & Risk Management structure supported by quarterly review through the Performance Committee. 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.

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
PR1: COVID19 pandemic: The need to sustain operational effort and resources to the COVID19 readiness and response.	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 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. These risks have been mitigated by the following measures: • Formal Command and Control structure in place to provide a single point of contact and decision making structure for the Trust. • Clinical Decision Cell formed to advise Command and Control on capacity utilisation and clinical prioritises. • Rapid review and adoption of the evolving guidance through the Infection Prevention

	Control team. • Footfall and visiting within the hospital limited and reviewed at regular intervals to ensure that social distancing is optimised and reduce the potential for hospital acquired infection. • Triage and testing put in place for all elective cases and rapid access to testing through point of care devices deployed for emergency pathway patients. • Infection control pathways put in place to ensure segregation of potential, confirmed positive and confirmed negative admissions to the hospital to again reduce the potential for hospital acquired infection. • Substantial efforts made to secure supply of personal protective equipment and to switch to sustainable, reusable items where ever possible. • Supply chain for medicines, consumables and medical devices maintained under continuous monitoring and escalation routes utilised where necessary. • Additional staff support and well-being initiatives deployed and embedded and staff have been encouraged to take restorative breaks through out. • Remote working facilities enabled for all staff where on-site attendance was not essential.
PR2: Workforce: The need to focus on recruitment and retention to support flow and our ability to deliver activity	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 have: • Implemented a rapidly developed streamlined recruitment and induction process. Vacancy rates and turnover are at the lowest levels for years. We expect these to rise again however as we reassess our staffing establishments in light of 2021/22 activity requirements and as staff who have delayed career plans choose to move to roles/opportunities in other organisations. • Introduced 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 and to support the return of staff to work who have been

	shielding. We have had excellent engagement with the COVID vaccination programme and 93% of our staff have been vaccinated. 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 with the areas of EDI, Health and Wellbeing and Line Manager training being priorities. 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. .
PR3: Hospital Optimisation: Failure to optimise the new facility to deliver activity plans and meet patient demand.	The overarching requirement to protect staff and patients in response to COVID19 will have an ongoing consequence on the flow of work through the hospital. Operational plans will need to reflect the changes to the services that we provide and the continued Infection Prevention and Control and Non Pharmaceutical Interventions requirements 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. Our model of using a Clinical Decision Cell has enabled rapid evaluation and decision making in response to COVID19 and the Trust is committed to bringing this approach into its ongoing process of review taking a balanced approach that also considers the needs of our patients and staff. 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.

PR4: 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 impact of changes in the NHS Planning framework and the structural system change brought about through the White Paper reforms will have an impact on the delivery of a sustainable financial plan for RPH. These changes will see the establishment of the Integrated Care Systems and these will have a direct impact on: • RPH Funding Flows • Escalations with Regulators • Revisions to oversight arrangements Our mitigation is: To engage actively in system leadership. The Trust is working with the ICS through their Distributed Leadership model and has taken lead roles for the System Delivery and Transformation and Digital workstreams. To work with specialised commissioners on future funding frameworks and strategy for NHSE and to be closely involved in the ICS/STP Finance forum through FPPG.
PR5: 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 many staff now 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 to ensure our teams and staff have access to the right technologies to work safely and securely. As an example: • 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 developed a Cyber Security communications plan to ensure current themes are regularly and consistently shared across our organisation through our top leaders. • We have employed a full time dedicated Cyber Security role are working towards achieving the Cyber Essentials Plus standard. • We have implemented a new backup solution for our system and have migrated off legacy servers. • We are a Digital Aspirant Trust with a plan to roll out new technologies throughout the year ahead. 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. • Improved our surveillance measures. • Implemented 'user' friendly reporting to highlight awareness, show progress and improve grip. • Introduced Windows 10 with Advanced Threat Protection across our estate.

Safe staffing and skill mix

Throughout the year, we have continued to utilise HealthRoster and SafeCare-Live. This has continued to inform appropriate deployment of our staff and it has also allowed us to identify and respond to staffing pressures in real time. SafeCare-Live 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 ten 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 is an integral part of the way we use the SafeCare module. Each month the Matrons undertake a peer audit of each other's areas (introduced in Q4 2019/20), 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 Clinical Professional Advisory Committee 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.

To help ongoing triangulation for safe staffing and skill mix, we also look at patient and public experience and adverse events. Patient feedback is gathered through the Friends and Family questionnaire and is reviewed on a real time basis by the Matrons 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'. Moderate grade adverse events and above are

discussed at the weekly Serious Incident Executive Review Panel (SIERP) and where required logged on PIPR Safe. Both allow for triangulation with safe staffing and skill mix.

We have also engaged with staff, through a feedback and debrief process, post first and second surge. During periods of surge response, we have also met regularly with clinically based leadership teams so that we remained pro-active in response to any feedback. Where there have been links to safe staffing and skill mix, we have been responsive to that feedback (for example, length of time deployed to a surge area and/or end dates (where they have been known), when a particular deployment will end).

Our staffing models and skill mix have been kept under constant review throughout the year in response to changing demands through periods of the COVID-19 surge response. These reviews have also taken into account national guidelines as required for surge planning and continued benchmarking against our established Royal Papworth metrics. A quality impact assessment was also completed in line with best practice recommendations for staffing as part of our regional response.

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'. The Trust undertook a CQC mock inspection for the whole organisation in February 2020 which assessed against the CQC key lines of enquiry (KLOE). The Trust had planned to undertake a further mock inspection in October 2020, however due to the Coronavirus pandemic, it was necessary to reduce the size of the inspection. Acknowledging that the 2019 CQC inspection did not independently rate End of Life Care, the trust therefore decided to focus the October 2020 mock inspection on End of Life Care. The Trust has also continued with its schedule of CQC Fundamental Standards reviews. The twelve standards are each planned to be reviewed over the course of a year, and whilst this programme has been interrupted in 2020/21 it is planned to use these to inform and support improvements in our standards in 2021/22.

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 national operating planning process for 2020/21 was suspended in March 2020 to

allow the sector to focus on responding to COVID-19.

In its place, a two-part framework was put in place covering a) April 2020 to September 2020 (H1) and b) October 2020 to March 2021 (H2 or Phase 3). All NHS providers were provided with a guaranteed minimum level of income and Integrated Care Systems were required to deliver breakeven financial positions within these funding envelopes. National plans were set for each organisation for H1; organisations were then given the opportunity to develop their own plans for H2.

The Trust undertook a planning exercise to support the submission of its H2 plan. This plan was approved by the Board of Directors and submitted as part of the wide Integrated Care System Plan to NHS England & Improvement (NHSE&I). The H2 plan reflected finance, workforce and activity requirements and progress against delivery of these variables has been 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 Trust continued to report and monitor its performance against these domains despite the additional COVID-19 surge over the Winter months. The process to ensure that resources are used economically, efficiently, and effectively across clinical services includes directorate and divisional reviews, and the regular monitoring of clinical indicators covering quality and safety. The Trust achieved its financial plan at the end of the year and supported colleagues across the Integrated Care System to achieve the same result.

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, a Data Protection 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 policies establish an information governance framework which includes up to date policies, procedures and accountabilities. Managers within the Trust are responsible for ensuring that the policies and 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 Data 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 September 2020, which included requirements relating to the Statement of Compliance and all assurances were declared as met. (Due to the impact on NHS organisations caused by COVID19 the 2021 DS&P toolkit submission deadline has been postponed until 30 June 2021.

In 2020/2021 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 Trust has a 'live' (updated every 24 hours) Access and Data Quality Dashboard which reflects the data held in Lorenzo. Access to this system is available for all members of staff and trend information is shared with business units weekly, showing error rates for a number of key issues.

The Trust assures the quality of its RTT waiting time data through the validation of the patient tracking list (PTL) which is available daily through Patient Pathway Plus (PP+) and is the validation and reporting system employed by the Trust. Patients are checked on both Lorenzo and other clinical systems to ensure that their waiting time is valid. Corrections to Lorenzo are made where required, which feed into the following day's PTL. 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 number of RTT data quality errors remains an issue at the Trust, due to the lack of formalised RTT training and limited resources available for RTT training. For these reasons a bespoke 18 week learning package was purchased and the following RTT training was approved for use by the Executive team and is in the process of being implemented by the Trust:

1. RTT to be discussed at local induction
2. Basic RTT e-learning training provided by NHSI to be completed by new staff members within the first week of joining the trust if applicable to their role.
3. Bespoke RTT eLearning package with compulsory modules needing to be completed by new staff members within 1-3 months of joining the trust. All existing staff members will also be required to complete the training where it forms part of their job role

Whilst the bespoke training package is in the creation stage, the central RTT and Data Quality team continue to support the operational teams in providing RTT error data and identifying areas for improvement, which are the discussed at a monthly Patient Pathway

Improvement meeting. A summary of this data is also provided at the weekly Trust Access meeting. The team also provide group and 1:1 training when required.

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 9 patient safety incidents reported as serious incidents in 2020/21. There were 0 never events in 2020/21. However in May 2021 the Trust reported a Never Event where a misplaced nasogastric tube was not checked prior to administering medication (there was no harm to the patient). Immediate actions were taken and the investigation is ongoing. The Care Quality Commission (CQC) and NHS Improvement (NHSI) were informed immediately.

The Trust's Quality Report is to be published by the 30 June 2021 and will contain further information on performance against the 2020/21 priorities and our 2021/22 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 draft Quality Report 2020/21; 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 2020/21 is that:
"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

During the year, seven internal audits were conducted: all except two 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 2020/21 are given below.

Substantial Assurance:
CQC
Key Financial Controls
Financial Governance during COVID-19

Reasonable assurance:
Contract Management – PFI
Risk Management and Assurance Framework

Partial Assurance (negative) opinions:
IT Back Up – Procurement of Service
Pharmacy – High Cost Drugs

No formal opinion provided
Financial Governance Part 1 and Part 2 were undertaken as advisory reviews but did not identify any significant issues.

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

Factors and findings which informed the HOIA opinion were they had not issued any 'no assurance' (red) opinions to the Trust during the year, although had issued two reports with 'partial assurance' (negative) opinions (as set out above). During the year and they had issued two reports where a substantial assurance (positive) opinion was provided (see above). They had also issued two audits where a reasonable assurance (positive) opinion was provided (see above).

Internal audit work for 2020/21 has been undertaken through the substantial operational disruptions caused by the COVID-19 pandemic. In undertaking this work, it was recognised that there had been a significant impact on both the operations of the organisation and its risk profile, and the annual opinion should be read in this context.

The internal audit follow up work had 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 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 CIP;
- Maintaining cash flow and liquidity;
- Information governance assurance framework including the NHS Digital Data Security and Protection Toolkit;
- Investigation reports and action plans following serious incidents.

Conclusion

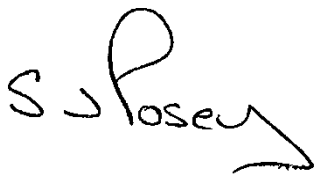
The overall opinion is that no significant control issues (i.e. issues where the risk could not be effectively controlled) have been identified that would impact on the delivery of the Trust’s strategic and annual objectives.

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
03 June 2021

Royal Papworth Hospital
NHS Foundation Trust

Group accounts for the year ended 31 March 2021

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

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Royal Papworth Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2021 and of the Group's and Trust's income and expenditure for the year then ended; and
- 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 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Group 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.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and 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").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Group and Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Group's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated target, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that additional funding was claimed inappropriately through the extra resources made available as a result of Covid-19 and the risk that Group management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals and provisions.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of Group and Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included:
    - Unexpected postings to cash, revenue and expenses codes.
    - Journals containing certain words in the description.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the existence of income recognised with specific emphasis placed on cut-off. This included:
    - Sample testing of year end income accruals;
    - Review and sample testing of income recognised either side of year-end

Assessing the appropriateness of expenditure recognised with specific emphasis placed on cut-off. This included:

- Sample testing of year-end accruals and provisions including consideration of year on year movements;
- Review of year-end journals posted to increase expenditure accounts;
- Sample testing of invoices and bank payments post year-end;

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), [and from inspection of the Group's and Trust's regulatory and legal correspondence] and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 96 of the Annual Report the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its 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 paragraph 1(d) of Schedule 10 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

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

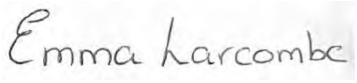
We have nothing to report in these respects.

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 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Emma Larcombe
for and on behalf of KPMG LLP
Chartered Accountants
Botanic House
100, Hills Road
Cambridge
CB2 1AR

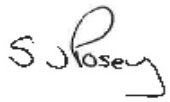
16 June 2021

FOREWORD TO THE ACCOUNTS

ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST

These accounts for the year ended 31st March 2021 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: 03 June 2021

CONSOLIDATED AND TRUST STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 MARCH 2021

	NOTE	Group 2020/21 £000	Trust 2020/21 £000	Group 2019/20 £000	Trust 2019/20 £000
OPERATING INCOME					
Operating income from patient care activities	2	**176,037**	**176,037**	149,774	149,774
Other operating income	3	**71,279**	**69,308**	37,728	35,917
TOTAL OPERATING INCOME FROM CONTINUING OPERATIONS		**247,316**	**245,345**	187,502	185,691
Operating expenses	4-6	**(239,116)**	**(237,495)**	(182,107)	(178,329)
OPERATING SURPLUS FROM CONTINUING OPERATIONS		**8,200**	**7,850**	5,395	7,362
Finance income	7	**113**	**-**	298	134
Finance expenses	8	**(5,236)**	**(5,236)**	(5,350)	(5,350)
Public Dividend Capital dividends payable	25	**(1,489)**	**(1,489)**	(2,005)	(2,005)
NET FINANCE COSTS		**(6,612)**	**(6,725)**	(7,057)	(7,221)
Gains on disposal of non-current assets	9	**2,385**	**1,675**	2,275	2,185
Movement in fair value of investments	12	**484**	**-**	(336)	-
SURPLUS FOR THE YEAR		**4,457**	**2,800**	277	2,326
OTHER COMPREHENSIVE INCOME					
Impairments	11	**-**	**-**	(4,150)	(4,150)
Gain on revaluations	11	**24,140**	**24,140**	-	-
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		**28,597**	**26,940**	(3,873)	(1,824)

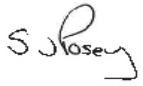
The notes on pages 11 to 57 form part of these accounts.

CONSOLIDATED AND TRUST STATEMENT OF FINANCIAL POSITION

AS AT 31 MARCH 2021

	NOTE	Group 31 March 2021 £000	Trust 31 March 2021 £000	Group 31 March 2020 £000	Trust 31 March 2020 £000
NON-CURRENT ASSETS					
Intangible assets	10	**2,522**	**2,522**	3,392	3,392
Property, plant and equipment	11	**179,029**	**179,029**	159,296	159,296
Investments	12	**5,679**	**-**	4,536	-
Trade and other receivables	14	**754**	**754**	415	415
Total non-current assets		**187,984**	**182,305**	167,639	163,103
CURRENT ASSETS					
Inventories	13	**5,517**	**5,483**	5,327	5,312
Trade and other receivables	14	**8,408**	**8,330**	21,455	20,804
Non-current assets for sale	16	**104**	**104**	2,847	2,629
Cash and cash equivalents	15	**58,647**	**56,086**	17,924	16,650
Total current assets		**72,676**	**70,003**	47,553	45,395
TOTAL ASSETS		**260,660**	**252,308**	215,192	208,498
CURRENT LIABILITIES					
Trade and other payables	17	**(47,221)**	**(47,201)**	(27,465)	(27,446)
Other liabilities	18	**(834)**	**(834)**	(78)	(78)
Borrowings	19	**(2,474)**	**(2,474)**	(2,113)	(2,113)
Provisions	20	**(1,499)**	**(1,499)**	(1,723)	(1,723)
Total current liabilities		**(52,028)**	**(52,008)**	(31,379)	(31,360)
TOTAL ASSETS LESS CURRENT LIABILITIES		**208,632**	**200,300**	183,813	177,138
NON-CURRENT LIABILITIES					
Other liabilities	18	**(696)**	**(696)**	-	-
Borrowings	19	**(90,370)**	**(90,370)**	(97,224)	(97,224)
Provisions	20	**(769)**	**(769)**	(768)	(768)
Total non-current liabilities		**(91,835)**	**(91,835)**	(97,992)	(97,992)
TOTAL ASSETS EMPLOYED		**116,797**	**108,465**	85,821	79,146
FINANCED BY:					
TAXPAYERS' EQUITY					
Public dividend capital	25	**125,017**	**125,017**	122,638	122,638
Revaluation reserve		**24,257**	**24,257**	1,100	1,100
Income and expenditure reserve		**(40,809)**	**(40,809)**	(44,592)	(44,592)
OTHERS' EQUITY					
Charitable fund reserves	33	**8,332**	**-**	6,675	-
TOTAL TAX PAYERS' AND OTHER'S EQUITY		**116,797**	**108,465**	85,821	79,146

The financial accounts on pages 6 to 57 were approved by the Board on the 03 June 2021 and signed on its behalf by:



Stephen Posey, Chief Executive
Date: 03 June 2021

CONSOLIDATED AND TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2021

	Trust				Charitable Fund	Group
	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total Reserves	Reserves	Total Reserves
	£000	£000	£000	£000	£000	£000
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 Expense 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**
Taxpayers' and others' equity at 1 April 2020	**122,638**	**(44,592)**	**1,100**	**79,146**	**6,675**	**85,821**
Changes in taxpayers' equity for 2020/21						
Total Comprehensive Income for the year	**-**	**2,800**	**-**	**2,800**	**1,657**	**4,457**
Revaluations - Property, Plant and Equipment	**-**	**-**	**24,140**	**24,140**	**-**	**24,140**
Public dividend capital received	**2,379**	**-**	**-**	**2,379**	**-**	**2,379**
Transfer to retained earnings on disposal of assets	**-**	**983**	**(983)**	**-**	**-**	**-**
Taxpayers' and others' equity at 31 March 2021	**125,017**	**(40,809)**	**24,257**	**108,465**	**8,332**	**116,797**

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 2021

	NOTE	**Group 2020/21**	Group 2019/20	**Trust 2020/21**	Trust 2019/20
		£000	£000	**£000**	£000
CASH FLOWS FROM OPERATING ACTIVITIES					
Operating surplus		**8,200**	5,395	**7,850**	7,362
NON CASH INCOME AND EXPENSE:					
Depreciation and amortisation	10/11	**9,249**	7,088	**9,249**	7,086
Net Impairments	5	**-**	(25)	**-**	(25)
Income recognised in respect of capital donations		**(579)**	-	**(662)**	(80)
(Increase) in inventories		**(171)**	(807)	**(171)**	(807)
(Increase)/decrease in receivables and other assets		**12,010**	(11,979)	**11,980**	(11,892)
Increase/(decrease) in trade and other payables		**19,902**	(3,023)	**19,902**	(3,023)
Increase/(decrease) and other liabilities		**1,452**	(170)	**1,452**	(170)
Increase in provisions		**(223)**	88	**(223)**	88
NHS Charitable fund – net movements in working capital, non-cash transactions, non operating cash flows		**824**	2,644	**-**	-
Net cash generated from / (used in) operating activities		**50,664**	(789)	**49,377**	(1,461)
Cash flows from investing activities					
Interest received		**5**	144	**5**	144
Payments for land, property, plant and equipment		**(3,711)**	(7,235)	**(3,711)**	(7,235)
Proceeds from disposal of property, plant and equipment		**4,312**	7,383	**4,312**	7,383
Payments for intangible assets		**(398)**	(1,090)	**(398)**	(1,090)
Net cash used in investing activities		**208**	(798)	**208**	(798)
Net cash outflow before financing		**50,872**	(1,587)	**49,585**	(2,259)
Cash flows from financing activities					
Public dividend capital received		**2,379**	585	**2,379**	585
Other loans (paid)/received		**(4,400)**	5,000	**(4,400)**	5,000
Capital element of PFI payments		**(2,110)**	(2,110)	**(2,110)**	(2,110)
Interest paid		**(61)**	(81)	**(61)**	(81)
Interest paid on PFI obligations		**(5,158)**	(5,268)	**(5,158)**	(5,268)
PDC dividends paid		**(799)**	(1,936)	**(799)**	(1,936)
Net cash generated from financing activities		**(10,149)**	(3,810)	**(10,149)**	(3,810)
Increase / (decrease) in cash and cash equivalents		**40,723**	(5,397)	**39,436**	(6,069)
Cash and cash equivalents at 1 April		**17,924**	23,321	**16,650**	22,719
Cash and cash equivalents at 31 March	15	**58,647**	17,924	**56,086**	16,650

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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 £2.1m pre impairment and donated assets, with a bottom line surplus of £2.8m for the 2020/21 financial year;
- The Trust reported a closing cash position for the 2020/21 financial year of £56.1m.

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 would 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 introduced revised funding arrangements as from 1 April 2020 designed to support NHS organisations throughout the coronavirus period. The operational plan framework for 2020/21 was paused; however, the NHS England and Improvement has confirmed that the current financial framework put in place

in 2020/21 to support the NHS in response to this crisis will be rolled forward into the first half of 2021/22. The financial framework beyond this period is unclear at this point.

Further national guidance is being developed for the 2021/22 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 accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

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

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

Comparative period 2019/20

In the comparative period (2019/20), the NHS Foundation Trust's contracts with NHS commissioners included those where the NHS Foundation Trust's entitlement to income varied

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

The NHS Foundation Trust received income from NHS commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The NHS Foundation Trust agreed schemes with its NHS 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.

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

Revenue from research contracts

Where research contracts fall under IFRS15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the NHS Foundation 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.

Grants and donations

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

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income as the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

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 schemes 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 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:

- It is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to or service potential be provided to the 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.

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.

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

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 Institution 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 specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated

replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided.

Non-specialist operational assets fair value is based on an assumption of a continuation of the existing use, derived from relevant market evidence. For the main part, these comprise the NHS Foundation Trust's operational land.

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

A valuation of the Royal Papworth Hospital site on the Cambridge Biomedical Campus was carried out in 2020/21 by the NHS Foundation Trust's externally appointed independent valuer, Gerald Eve LLP, Chartered Surveyors. The effective date of valuation was the 31st March 2021 and is accounted for in the 2020/21 accounts. See Note 11.

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

Assets in the Course of Construction

Assets in the course of construction for service or administration purposes are valued at cost, less any impairment loss and are valued by professional valuers 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.

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. A revaluation gain due to an increase in general market price does not represent a reversal of a previous economic benefit/service potential impairment and is therefore accounted for as a revaluation gain rather than a reversal of a past economic benefit impairment.

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 the criteria in IFRS 5 below 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 current value in existing use, if they will be held for their service potential, or otherwise 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 purchased items of property, plant and equipment.

In 2020/21 this includes assets donated to the NHS Foundation Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the NHS Foundation Trust applies the principle of donated asset accounting to assets that the NHS Foundation Trust controls and is obtaining economic benefits from at the year end.

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 they are 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 and measured at current value in existing use.

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

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

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	27	87

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	54	180
Soft Furnishings	54	84
Office and Information Technology Equipment	36	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	36	120

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.

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

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 expands 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 contractual 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. The NHS Foundation Trust does not recognise loss allowances for stage 1 or stage 2 impairments against other government bodies.

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 recognised initially in other liabilities on the statement of financial position and charged to operating expenses on a straight line basis 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 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
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 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% 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 with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts,.

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 disapply 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 2021 or prior periods.

1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.20 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.

1.21 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.

1.22 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.

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.

1.23 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.

1.24 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.

1.25 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.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.27 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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The 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 2022, 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 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the NHS Foundation 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 implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

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

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

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.

1.28 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 2020, or the amounts charged through the Statement of Comprehensive Income.

2. OPERATING INCOME FROM PATIENT CARE ACTIVITIES

2.1 Income from patient care activities (by nature)

	2020/21	2019/20
	£000	£000
Block contract / system envelope income*	**152,905**	130,564
High cost drugs income from commissioners**	**11,115**	5,551
Other NHS clinical income***	**2,743**	2,775
Private patient income	**4,203**	6,676
Additional pension contribution central funding ****	**4,335**	3,782
Other clinical income*****	**85**	426
Annual Leave accrual	**562**	-
Central funding for overtime payments (Flowers)	**89**	-
Total income from patient care activities	**176,037**	149,774

* As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

** Additional income received for cost and volume drugs and visible cost model devices

*** Other WGA bodies.

**** 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.

***** Non-NHS overseas patients including non reciprocal agreements.

2.2 Patient income by source

	2020/21	2019/20
	£000	£000
NHS Foundation Trusts	**-**	1
NHS England*	**136,816**	107,160
Clinical Commissioning Groups	**32,190**	32,732
Department of Health and Social Care	**-**	4
NHS Other	**2,743**	2,775
Non NHS:		
- Private patients	**4,203**	6,676
- Overseas chargeable patients	**84**	426
- Other	**1**	-
Total revenue from patient care activities	**176,037**	149,774

A change in the 2020/21 NHS financial framework has meant that the NHS Foundation Trust has received fixed payments for patient related activity with no additional variability for the number of patients treated. Under this framework the NHS Foundation Trust has not included partially completed patient treatment in its patient activity income 2020/21(£374k – 31 March 2020).
*NHS England income includes reimbursement for homecare drugs which has been reported on a gross basis, a change from the previous year net basis reporting. This is as a result of the change in the national financial framework for 2020/21 in response to the Coronavirus pandemic which moved reimbursement of homecare drugs to a mixed model of block and cost and volume.

2.3 Operating segments

IFRS 8 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.

For 2020/21 the Trust considers that it only has one operating segment, healthcare. The Board of Directors receives financial reports that analyse financial performance across the Trust as one operating segment and this has been reinforced by the revised financial framework that came into place at the start of 2020/21.

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

	2020/21	2019/20
	£000	£000
NHS England	**136,816**	107,160
Cambridgeshire and Peterborough CCG*	**15,037**	13,674
Norfolk & Waveney CCG	**4,397**	4,290
West Suffolk CCG	**4,016**	4,093
Bedfordshire CCG	**2,284**	2,155
Lincolnshire CCG	**1,706**	1,622
Ipswich & East Suffolk CCG	**1,348**	1,347
West Essex CCG	**1,327**	1,349
East and North Hertfordshire CCG	**1,308**	1,313
North East Essex CCG	**206**	379
Department of Health and Social Care	**-**	4
Other CCGs	**561**	2,510
Other NHS	**1,807**	1,846
Subtotal	**170,813**	141,742
Welsh Health Boards	**837**	854
Scottish Health Board	**73**	35
Northern Ireland Health Boards	**25**	41
Private patients	**4,203**	6,676
Other non-NHS	**86**	426
Total revenue from patient care activities per note 2.1	**176,037**	149,774

* Includes funding for treatment of overseas patients 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:

	2020/21	2019/20
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	**176,037**	149,774

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

	2020/21	2019/20
	£000	£000
Income recognised this year	**84**	426
Cash payments received in-year	**327**	88
Amounts added to provision for impairment of receivables	**38**	43
Amounts written off in-year	**9**	-

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 principal 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	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
Research and development NHS Levy	**1,598**	1,332	**1,598**	1,332
Education and training	**4,667**	4,173	**4,667**	4,173
Provider sustainability fund/Financial recovery fund *	**-**	15,453	**-**	15,453
Charitable and other contributions to expenditure	**-**	-	**701**	980
Merit award funding	**1,723**	1,530	**1,723**	1,530
Staff lodging	**622**	576	**622**	576
Staff recharges **	**1,517**	1,846	**1,517**	1,846
Research and development gross up ***	**1,773**	2,191	**1,773**	2,191
NHS Charitable income:				
Incoming resource excluding investment income	**2,672**	2,791		-
Transitional funding ****	**-**	4,050	**-**	4,050
Covid Response funding:				
Reimbursement and top up funding	**29,425**	-	**29,425**	-
Donated Equipment from DHSC	**579**	-	**579**	-
Contributions to expenditure from DHSC group bodies	**2,302**	-	**2,302**	-
System top-up and COVID funding	**23,272**	-	**23,272**	-
Other income	**1,129**	3,786	**1,129**	3,786
	71,279	37,728	**69,308**	35,917

* 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 £nil (2019/20 - £4.05m).

4. OPERATING EXPENSES

4.1 Operating expenses comprise:

	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Executive Directors' costs	**1,218**	1,137	**1,218**	1,137
Non-Executive Directors' costs	**121**	128	**121**	128
Staff costs	**114,797**	104,531	**114,797**	104,531
Drug costs *	**44,452**	5,903	**44,452**	5,903
Supplies and services - clinical	**34,259**	33,309	**34,259**	33,309
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**1,651**	-	**1,651**	-
Supplies and services - general	**2,868**	1,676	**2,868**	1,676
Inventories written down (consumables donated from DHSC bodies for COVID response)	**150**	-	**150**	-
Establishment	**1,875**	1,542	**1,875**	1,543
Research & Development	**1,129**	804	**1,129**	804
Transport	**1,350**	958	**1,350**	958
Premises	**11,359**	9,145	**11,359**	9,145
Increase/(decrease) in provisions for impairments of receivables	**(218)**	51	**(218)**	51
Depreciation of property, plant and equipment	**8,489**	6,549	**8,489**	6,547
Amortisation of intangible assets	**760**	539	**760**	539
Impairments of property, plant and equipment	**-**	(25)	**-**	(25)
Audit services - statutory audit	**78**	55	**78**	55
NHS Charitable Funds - statutory audit services	**12**	4	**-**	-
Consultancy	**1,558**	953	**1,558**	953
Internal audit and counter fraud services	**60**	59	**60**	59
Clinical negligence	**1,488**	1,079	**1,488**	1,079
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes on IFRS basis	**6,837**	6,315	**6,837**	6,315
Other	**3,214**	3,622	**3,214**	3,622
NHS Charitable Funds - other resources expended	**1,609**	3,773	**-**	-
	239,116	182,107	**237,495**	178,329

***** Homecare drug costs, which are included in drug costs have been reported on a gross basis which is a change from the previous year net basis reporting. This is due to the change in the NHS England and Improvement financial framework for 2020/21.

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 £77,500 (2019/20: £54,900), 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 (2019/20: £nil 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 (2019/20: £1 million) in the aggregate in respect of all such services.

External auditors will also receive remuneration of £12,000 (2019/20: £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

	2020/21	2019/20
	£000	£000
Minimum lease payments	**990**	1,196

Total future minimum lease payments

	2020/21	2019/20
	£000	£000
Payable:		
Not later than one year	**1,146**	1,059
Between one and five years	**3,373**	3,358
After five years	**14,919**	15,673
	19,438	20,090

The NHS Foundation Trust leases one (2019/20:1) 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

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus/(deficit) resulting from:		
Impairment reversal of New Papworth Hospital	**-**	(25)
	-	(25)

There was a part reversal in 2019/20 of £25k relating to 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	
		2020/21	2019/20	**2020/21**	2019/20
		£000	£000	**£000**	£000
Salaries and wages	*	**87,848**	77,948	**87,848**	77,948
Social security costs	*	**8,326**	7,751	**8,326**	7,751
Apprenticeship levy		**416**	372	**416**	372
Employer contributions to NHS Pensions Agency		**9,998**	8,666	**9,998**	8,666
Pension cost - employer contribution paid by NHSE on provider's behalf (6.3%)	**	**4,335**	3,782	**4,335**	3,782
Pension cost - other		**11**	-	**11**	-
Temporary staff (including agency/bank)		**5,081**	7,149	**5,081**	7,149
Employee benefit expenses	*	**116,015**	105,668	**116,015**	105,668

* Excludes Non-Executive Directors' salary costs. These salary costs are included in note 4.1. The total value of annual leave accrual for the year is £1,052k (2019/20: £490k).

** 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 £9,998k (2019/20: £8,666k).

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

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

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 2020/21 was £11k (2019/20 £7k).

6.2 Staff Exit Packages

	2020/21		2019/20	
	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**	
	2020/21 Total Number	2019/20 Total Number	**2020/21 Total Number**	2019/20 Total Number
Permanently Employed				
Medical and dental	**234**	215	**234**	215
Administration and estates	**419**	383	**419**	383
Healthcare assistants and other support staff	**414**	355	**414**	355
Nursing, midwifery and health visiting staff	**682**	608	**682**	608
Scientific, therapeutic and technical staff	**166**	149	**166**	149
Health care science staff	**76**	68	**76**	68
Other	**1**	2	**1**	2
Other				
Bank staff	**70**	63	**70**	63
Agency/contract staff	**41**	58	**41**	58
Other	**23**	9	**23**	9
Total	**2,126**	1,910	**2,126**	1,910

6.4 Retirements due to ill-health

In the year to 31 March 2021, there were 2 early retirement agreed on the grounds of ill-health (31 March 2020: 2). The estimated additional pension liability in respect of early retirements agreed on the grounds of ill-health is £69k (31 March 2020: £33k); 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	
	2020/21 Total	2019/20 Total	**2020/21 Total**	2019/20 Total
	£000	£000	**£000**	£000
Salary	**1,082**	1,022	**1,082**	1,022
Taxable benefits	**-**	9	**-**	9
Employer's pension contributions	**120**	109	**120**	109
Total	**1,202**	1,140	**1,202**	1,140

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

7 FINANCE INCOME

	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Interest revenue:				
Investments in listed equities	**113**	159	**-**	-
Short term investments and deposits	**-**	5	**-**	-
Bank accounts	**-**	134	**-**	134
	113	298	-	134

8 FINANCE EXPENSES

	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Loans from the Department of Health and Social Care	**77**	82	**77**	82
Main finance costs on PFI scheme obligations	**4,690**	4,808	**4,690**	4,808
Contingent finance costs on PFI scheme obligations	**469**	460	**469**	460
	5,236	5,350	**5,236**	5,350

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

	Group		Trust	
	2020/21	2019/20	**2020/21**	2019/20
	£000	£000	**£000**	£000
Gain/(loss) on disposal of property, plant and equipment	(76)	124	(76)	124
Gain on disposal of assets held for sale	1,784	2,067	1,784	2,067
Loss on disposal of intangibles	(33)	(6)	(33)	(6)
Gain on disposal of charitable funds investments	657	90	-	-
Gain on disposal of charitable funds PPE	53	-	-	-
	2,385	2,275	**1,675**	2,185

10 INTANGIBLE ASSETS

2020/21	Computer Software Purchased £000	Intangible Assets Under Construction £000	Total Intangible Assets £000
Gross cost at 1 April 2020	6,949	212	**7,161**
Additions purchased - Trust	(77)	-	**(77)**
Reclassifications	212	(212)	**-**
Disposals	(912)	-	**(912)**
Gross cost at 31 March 2021	**6,172**	**-**	**6,172**
Accumulated amortisation at 1 April 2020	3,769	-	**3,769**
Provided during the year	760	-	**760**
Disposals	(879)	-	**(879)**
Accumulated amortisation at 31 March 2021	**3,650**	**-**	**3,650**
Net book value			
- Purchased at 31 March 2021	2,490	-	**2,490**
- Donated at 31 March 2021	32	-	**32**
Total at 31 March 2021	**2,522**	**-**	**2,522**

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)	-	
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**

11 PROPERTY, PLANT AND EQUIPMENT

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

2020/21	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 2020	12,600	119,445	-	14	38,605	36	7,761	3,829	182,290
Additions purchased - Trust	-	16	-	-	3,011	-	473	(1)	3,499
Additions purchased - cash donations	-	-	-	-	83	-	-	-	83
Additions - equipment donated from DHSC for COVID	-	-	-	-	579	-	-	-	579
Revaluations*	3,360	15,741	-	-	-	-	-	-	19,101
Reclassifications	-	(9)	-	(11)	20	-	-	-	-
Disposals	-	-	-	-	(6,875)	(22)	(2,776)	(149)	(9,822)
At 31 March 2021	**15,960**	**135,193**	**-**	**3**	**35,423**	**14**	**5,458**	**3,679**	**195,730**
Accumulated depreciation at 1 April 2020	-	2,158	-	-	15,435	32	4,736	633	22,994
Provided during the year	-	2,881	-	-	4,270	2	807	529	8,489
Revaluations *	-	(5,039)	-	-	-	-	-	-	(5,039)
Disposals	-	-	-	-	(6,800)	(22)	(2,772)	(149)	(9,743)
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**12,905**	**12**	**2,771**	**1,013**	**16,701**
Net book value									
- Purchased at 31 March 2021 - Trust	15,960	206	-	3	19,943	-	2,556	2,592	41,260
- On-SoFP PFI contract at 31 March 2021	-	134,987	-	-	-	-	-	-	134,987
- Donated at 31 March 2021	-	-	-	-	2,012	2	131	74	2,219
- Donated from DHSC for COVID response at 31 March 202	-	-	-	-	563	-	-	-	563
Total at 31 March 2021	**15,960**	**135,193**	**-**	**3**	**22,518**	**2**	**2,687**	**2,666**	**179,029**

The revaluation gain relates to the revalutaion of the PFI asset and land. The gain of £24,140k is made up of an increase in the cost value of £19,101k and the reversal of the cumultaive depreciation of £5,039k.

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**

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

In line with the Trusts accounting policies (see note 1.7) an interim valuation of the new Royal Papworth Hospital site was carried out during the financial year ended 31 March 2021. The valuation was carried out by the NHS Foundation Trust's externally appointed valuers Gerald Eve LLP, Chartered Surveyors in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The effective date of valuation was the 31 March 2021.

The interim valuation has resulted in an increase in the land value of the new hospital site by £3.4m and the site buildings by £20.8m. The increase in the site valuation reflects general market changes and as such is accounted for as a revaluation gain.

The valuer has stated in the valuation report that the 'valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS valuation – Global Standard'.

Papworth Everard site
The land at the Papworth Everard site was impaired in 2019/20 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 for the site 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 Institution of Chartered Surveyors (RICS) Valuation Global Standards ('Red Book'), the valuer declared a 'material valuation uncertainty' in the valuation report. This was 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 from this report have been used to inform the measurement of property asset valuation in these financial statements.

The NHS Foundation Trust continued to keep the valuation of the Papworth Everard site under review right up until the site was sold on 26 November 2020, see note 16.

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 2021 £000	31 March 2020 £000
Investment Managers		
Market value at 1 April	**3,773**	6,614
Add: Additions of shares	**5,194**	1,337
Less: Disposals at carrying value	**(3,773)**	(3,842)
Net gain/(loss) on revaluation	**484**	(336)
Market value at 31 March (shares only)	**5,678**	3,773
Cash held with Investment Managers at 31 March	**1**	763
Total value of investments	**5,679**	4,536
Historic cost at 31 March (shares only)	**5,194**	3,711

The valuation of the investments is at 31 March 2021 and may not be realised at the date the investments are disposed of.

During the year the NHS Foundation Trust changed its investment managers. The shares held at the 31 March 2020 were sold during the year by the NHS Foundation Trust's investment managers. Proceeds from these sales have been used to purchase shares in SUTL Cazenove Charity Responsible, Multi-Asset Fund, Units -S- GBP Distribution, BF78454. At 31 March 2021 10,523,316 shares were held in this fund, with a market value at 31 March 2021 of £5,678,381 (31 March 2020 - £nil).

The historic cost represents the value of shares after purchases and sales at 31 March 2021 before the shares were revalued.

Cash held with the NHS Foundation Trust's investment managers at 31 March 2020 has been used to purchase shares during the year. The NHS Foundation Trust's investment managers are holding £1k of cash within the investment portfolio.

13 INVENTORIES

	Group		**Trust**	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Drugs	**642**	533	**642**	533
Consumables	**4,841**	4,779	**4,841**	4,779
NHS Charity - gift shop	**34**	15	**-**	-
TOTAL	**5,517**	5,327	**5,483**	5,312

The cost of inventories recognised as an expense and included in 'operating expenses' amounted to £60,288k (2019/20: £23,184k).

The value of inventories recognised as a write-down expense during the year was £150k (2019/20: £nil).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to the NHS providers free of charge. During 2020/21 the NHS Foundation Trust received £2,302k of items purchased by the DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

14 TRADE AND OTHER RECEIVABLES

Current	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Contract receivables: invoiced NHS	**2,118**	4,989	**2,118**	4,989
Contract receivables: invoiced other	**1,722**	2,758	**1,644**	2,874
VAT receivables	**883**	1,155	**883**	1,155
Contract receivables: not yet invoiced *	**1,010**	10,342	**1,010**	9,586
Allowance for the impaired contract receivables	**(236)**	(729)	**(236)**	(729)
PDC dividend receivable	**-**	471	**-**	471
Prepayments other	**2,701**	2,307	**2,701**	2,296
Clinician pension tax provisions reimbursement funding from NHSE	**199**	152	**199**	152
Other receivables	**11**	10	**11**	10
TOTAL	**8,408**	21,455	**8,330**	20,804
Non-current				
Clinician pension tax provisions reimbursement funding from NHSE	**241**	223	**241**	223
PFI lifecycle prepayments	**513**	192	**513**	192
TOTAL	**754**	**415**	**754**	**415**

* Included within contract receivables not yet invoiced is accrued income for Provider sustainability fund/Financial recovery fund £nil (2019/20 £5.41m) and funding related to specific COVID 19 expenditure £nil (2019/20 £1.5m).

14.1 Allowances for credit losses

	Total trade receivables £000	**Other trade receivables £000**
At 1 April 2020	**729**	**729**
New allowance arising	**166**	**166**
Changes in the calculation of existing allowances	**23**	**23**
Receivables written off during the year as uncollectable	**(275)**	**(275)**
Reversals of allowances	**(407)**	**(407)**
At 31 March 2021	**236**	**236**

	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

14.2 Analysis of impaired receivables

	31 March 2021 £000	31 March 2020 £000
Ageing of impaired receivables		
Current	**108**	40
0 - 30 days	**22**	47
30 - 60 days	**5**	82
60 - 90 days	**7**	9
90 - 180 days	**13**	18
Over 180 days	**81**	533
TOTAL	**236**	729

14.3 Analysis of non-impaired receivables

	31 March 2021 £000	31 March 2020 £000
Ageing of non-impaired receivables		
Current	**2,004**	5,047
0 - 30 days	**87**	635
30 - 60 days	**45**	642
60 - 90 days	**40**	288
90 - 180 days	**164**	243
Over 180 days	**950**	21
TOTAL	**3,290**	6,876

15 CASH AND CASH EQUIVALENTS

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
At 1 April	**17,924**	23,321	**16,650**	22,719
Net change in year	**40,723**	(5,397)	**39,436**	(6,069)
Balance at 31 March	**58,647**	17,924	**56,086**	16,650
Made up of:				
Government Banking Services	**55,563**	16,222	**55,563**	16,222
Cash at commercial banks and in hand	**3,084**	1,702	**523**	428
Cash and cash equivalents as in statement of cash flows	**58,647**	17,924	**56,086**	16,650

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 2021 £nil was held on short term deposit (31 March 2020: £nil) by the NHS Foundation Trust and £nil (31 March 2020: £nil) was held on short term deposit by the NHS Charity.

16 NON-CURRENT ASSETS FOR SALE

	Group		Trust	
	31 March 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
NBV of non-current assets held for sale at 1 April	**2,847**	-	**2,629**	-
Assets classified as held for sale in the year	**-**	7,939	**-**	7,721
Assets sold in the year	**(2,743)**	(5,092)	**(2,525)**	(5,092)
NBV of non-current assets held for sale at 31 March	**104**	2,847	**104**	2,629

In 2019/20 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 Biomedical 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.

During the year, with the exception of one of the residential properties, all property and land held for sale at 31 March 2020 has been sold. The NHS Foundation Trust is actively marketing the remaining residential property.

17 TRADE AND OTHER PAYABLES

Current	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
NHS Payables - revenue*	**10,598**	1,654	**10,598**	1,654
Other trade payables - revenue	**6,490**	6,221	**6,490**	6,221
Other trade payables - capital	**892**	1,258	**892**	1,258
Receipts in advance	**3,884**	3,176	**3,884**	3,176
Other taxes payable	**2,650**	2,117	**2,650**	2,117
Accruals**	**20,973**	11,734	**20,953**	11,715
PDC dividend payable	**219**	-	**219**	-
Other payables	**1,515**	1,305	**1,515**	1,305
TOTAL	**47,221**	27,465	**47,201**	27,446

*Includes invoices for the recharge of services provided by other NHS providers and contribution to system partners.

**Includes accruals for homecare drugs (see note 4), an accrual for the calculation of holiday pay for staff who received regular pay supplements and services received but not yet invoiced.

Outstanding pension contributions of £1,470k falling within one year are included within 'Other payables' for the year to 31 March 2021 (31 March 2020: £1,272k).

Non-current

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

18 OTHER LIABILITIES

Current	**31 March 2021**	31 March 2020
	£000	£000
Deferred Income	**834**	78

Includes income paid on account for private patient activity, funding received to cover the cost of staff posts and expenditure to be incurred in 2021/22 and the current element of deferred income from the PFI contractor following a Deed of Amendment.

Non-current	**31 March 2021**	31 March 2020
	£000	£000
Deferred Income	**696**	-

Includes the non-current element of the deferral of income received from the PFI contractor following a Deed of Amendment which has been allocated over the remaining term of the contract.

19 BORROWINGS

	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Loans from Department of Health	443	3	10,176	15,000
Obligations under PFI contract	2,031	2,110	80,194	82,224
	2,474	2,113	**90,370**	97,224

19.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£000**
Carrying value at 1 April 2020	15,003	84,334	**99,337**
Cash movements:			
Financing cash flows - payments and receipts of principal	(4,400)	(2,110)	**(6,510)**
Financing cash flows - payments of interest	(61)	(4,689)	**(4,750)**
Non-cash movements:			
Application of effective interest rate	77	4,690	**4,767**
Carrying value at 31 March 2021	**10,619**	**82,225**	**92,844**

	Loans from DHSC	**PFI and LIFT schemes**	**Total**
	£000	**£000**	**£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:			
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. During the year NHS Foundation Trust negotiated revised repayment terms for the loan which permitted the NHS Foundation Trust to make a pre-payment against the loan from the disposal proceeds of the Papworth Everard site, £4,400k and repay the remaining outstanding loan balance, £10,600k over a 25 year period commencing after the sale completion date. The final payment is due on 27 November 2045. Interest on the loan is charged at 0.57%.

20 PROVISIONS

	Pensions relating to other staff £000	Clinician pension tax reimbursement £000	Land and buildings £000	Other £000	Total £000
					31 March 2021
At 1 April 2020	**591**	**375**	**870**	**655**	**2,491**
Change in the discount rate	14	-	-	-	**14**
Arising during the year	-	65	-	514	**579**
Utilised during the year	(35)	-	(47)	(23)	**(105)**
Reversed unused	-	-	(179)	(532)	**(711)**
At 31 March 2021	**570**	**440**	**644**	**614**	**2,268**
Expected timing of cash flows:					
- not later than one year;	42	199	644	614	**1,499**
- later than one year and not later than five	138	49	-	-	**187**
- later than five years.	390	192	-	-	**582**
Total	**570**	**440**	**644**	**614**	**2,268**

	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

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.

Other provisions also include a provision for an employment tribunal claim that is ongoing.

The amount included in the provision of NHS Resolution at 31 March 2021 in respect of clinical negligence liabilities of the NHS Foundation Trust is £18,327k (31 March 2020: £13,509k).

21 CONTINGENT ASSETS AND LIABILITIES

The value of contingent liabilities in respect of NHS Resolution legal claims at 31 March 2021 is £10k (31 March 2020: £6k).

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 £0.11m (31 March 2020: £0.77). There were no commitments under finance leases at the end of the financial year (31 March 2020: £nil).

These commitments relate to orders for IT equipment and software which is part of the NHS Foundation Trust's capital programme.

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 £6.84m (2019/20 £6.32m). 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 £163.6m, but was subsequently re-valued to £135.19m at 31 March 2021 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 2021 £000	31 March 2020 £000	**31 March 2021 £000**	31 March 2020 £000
Gross PFI finance lease liabilities	**82,225**	84,334	**82,225**	84,334
Of which liabilities are due				
- not later than one year;	**2,030**	2,110	**2,030**	2,110
- later than one year and not later than five years;	**9,346**	8,864	**9,346**	8,864
- later than five years.	**70,849**	73,360	**70,849**	73,360
Net PFI liabilities	**82,225**	84,334	**82,225**	84,334
- not later than one year;	**2,031**	2,110	**2,031**	2,110
- later than one year and not later than five years;	**9,346**	8,864	**9,346**	8,864
- later than five years.	**70,848**	73,360	**70,848**	73,360

23.2 PFI total unitary payments obligations

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Total future payments committed in respect of the PFI arrangement	**535,620**	516,545	**535,620**	516,545
Of which liabilities are due				
- not later than one year;	**15,340**	14,373	**15,340**	14,373
- later than one year and not later than five years;	**65,656**	60,958	**65,656**	60,958
- later than five years.	**454,624**	441,214	**454,624**	441,214

23.3 Analysis of amounts payable to service concession operator

	Group		Trust	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Unitary payment payable to service concession operator	**14,427**	13,771	**14,427**	13,771
Consisting of:				
- Interest charge	**4,690**	4,808	**4,690**	4,808
- Repayment of finance lease liability	**2,110**	2,110	**2,110**	2,110
- Service element and other charges to operating expenditure	**6,837**	6,315	**6,837**	6,315
- Contingent rent	**469**	460	**469**	460
- Addition to lifecycle prepayment	**321**	78	**321**	78
	14,427	13,771	**14,427**	13,771

24 EVENTS AFTER THE REPORTING YEAR

There are no events after the reporting year.

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 total dividend payable for 2020/21 was £1,489k (2019/20 - £2,005k). The net dividend paid as at 31 March 2021 (net of the 2019/20 receivable of £471k) was £799k (2019/20 £1,936k). The outstanding dividend payable at 31 March 2021 was £219k (2019/20 – receivable £471k).

In 2020/21 the NHS Foundation Trust received £2,379k of PDC funding (2019/20 - £585k) which included the funding of medical equipment to enable the COVID 19 response, IT expenditure under the digital aspirants agenda and to support adapt and adopt endoscopy recovery and CT/MRI home reporting.

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 8 (2019/20: 7). Included in this number for 2020/21 is a staff member who held the post of Executive Director on an interim basis.

	2020/21	2019/20
	£000	£000
Remuneration payment	**1,082**	1,029
Employer contribution to the NHS Pension Scheme	**120**	109
	1,202	1,138

The remuneration payment relating to the highest paid director is £187k (2019/20: £161k). 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. He is also a Director and shareholder in Ahluwalia Education and Consulting Limited. During the year the NHS Foundation Trust made payments to Ahluwalia Education and Consulting Limited of £nil (2019/20: £25k) and had £nil (2019/20: £nil) owing to Ahluwalia Education and Consulting Limited at 31 March 2021.

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.

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 £106k (2019/20: £103k) to the CUHP for its share of the CUHP running costs. At 31 March 2021 there was £55k owing by the NHS Foundation Trust to CUHP (31 March 2020: £26k). There were no amounts written off during the year and there are no provisions for doubtful debts at 31 March 2021 in respect of CUHP (31 March 2020: £nil). The Chief Executive and Chairman 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 £2,780k (2019/20: £6,027k) and had £4,130k (2019/20: £2,244k) owing to CUH at 31 March 2021. 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 £2k (2019/20: £14k) and had £nil (2019/20: £nil) owing to the Moller Centre at 31 March 2021.

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 until 8 January 2021. During the year the NHS Foundation Trust made payments to the Norfolk Community Health & Care NHS Trust of £7k (2019/20 £6k) and had £5k owing to the Norfolk Community Health & Care NHS Trust at 31 March 2021 (2019/20 £nil).

Mrs A Fadero joined the Board on 1 December 2020 as a Non-Executive Director and held the post of Associate Non-Executive Director at East Sussex Healthcare NHS Trust. The NHS Foundation Trust has made no payments to East Sussex Healthcare NHS Trust during the year.

Mr D Dean joined the Board on the 1 November 2018 as a Non-Executive Director and served until 31 May 2020. He held 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 £nil (2019/20 £3k) and had £nil owing to the Guy's and St Thomas' NHS Foundation Trust at 31 March 2020 (2019/20 £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
	2020/21	2019/20	**2021**	2020
	£000	£000	**£000**	£000
NHS England	**163,826**	126,343	**1,184**	10,434
NHS Cambridgeshire and Peterborough CCG	**38,763**	13,718	**509**	85
NHS Norfolk and Waveney CCG	**4,397**	4,290	**-**	-
Health Education England	**4,324**	4,052	**-**	-
NHS West Suffolk CCG	**4,016**	4,093	**-**	55
NHS Bedfordshire CCG	**2,284**	2,155	**-**	-
NHS Blood and Transplant	**2,056**	1,995	**141**	728
NHS Lincolnshire CCG	**1,706**	1,622	**-**	-
NHS Ipswich and East Suffolk CCG	**1,348**	1,350	**-**	-
NHS West Essex CCG	**1,327**	1,349	**-**	-
NHS East and North Hertfordshire CCG	**1,308**	1,313	**1**	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 2021 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).

Patient activity related income for first half of 2021/22 (April 2021 to Sept 2021) is based on the financial framework for month 7 to month 12 of 2020/21 as defined by NHS England/Improvement Guidance in relation to the financial framework for the second half of 2021/22 (October 2021 to March 2022) has not yet been issued by NHS England/Improvement. The value of the patient related income for the first half of 2021/22 is anticipated to be £97.58m.

	Expenditure		Current Payables	
			At 31 March	At 31 March
	2020/21	2019/20	**2021**	2020
	£000	£000	**£000**	£000
NHS Pension Scheme	**14,333**	12,448	**1,470**	1,272
HM Revenue & Customs - NI Contributions	**8,742**	8,123	**2,650**	2,117
Cambridge University Hospitals NHS Foundation Trust - medical, staffing, pathology and other services	**5,703**	6,027	**4,349**	2,244
NHS Resolution (formerly NHS Litigation Authority)	**1,491**	1,079	**-**	-
Public Health England (was Health Protection Agency)	**642**	716	**168**	-

The related party organisations listed above are those where expenditure for the year to 31 March 2021 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 equity investments are held in a responsible multi-asset fund, designed specifically for charities which targets a stable and sustainable total return distribution of 4% per annum. With the COVID 19 pandemic there is a potential for higher exposure to market risk. This is mitigated by the fact that the fund is monitored by an Independent Advisory Committee.

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 three months of 2021/22. Private patient activity has been reduced 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	**2,278**	2,278	**2,054**	2,054
Receivables not yet invoiced	**1,450**	1,450	**1,450**	1,450
Other receivables (net provision for impaired debts)	**1,337**	1,337	**1,337**	1,337
Other investments	**5,679**	5,679	**-**	-
Cash at bank and in hand	**58,647**	58,647	**56,086**	56,086
Total at 31 March 2021	**69,391**	69,391	**60,927**	60,927
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	**22,719**	16,650
Total at 31 March 2020	**40,005**	40,005	**39,508**	33,439

Financial liabilities

	Group		Trust	
	Total	Other financial liabilities	**Total**	Other financial liabilities
	£000	£000	**£000**	£000
Payables with DHSC group bodies	**10,697**	10,697	**10,697**	10,697
Other payables	**8,518**	8,518	**8,498**	8,498
Accruals	**21,253**	21,253	**21,253**	21,253
Provisions under contract	**2,268**	2,268	**2,268**	2,268
DHSC loans	**10,619**	10,619	**10,619**	10,619
Finance leases and PFI liabilities	**82,225**	82,225	**82,225**	82,225
Total at 31 March 2021	**135,580**	135,580	**135,560**	135,560
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

Notes:
In accordance with IFRS 9, the fair value of the financial assets and liabilities (held at amortised cost) is not considered significantly different to book value.

29 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	At 31 March 2021	*At 31 March 2020	**At 31 March 2021**	*At 31 March 2020
	£000	£000	**£000**	£000
Less than one year	**44,480**	26,091	**44,460**	26,072
In more than one year but not more than five years	**11,440**	24,184	**11,440**	24,184
Greater than five years	**80,362**	73,910	**80,362**	73,910
	136,282	124,185	**136,262**	124,166

*March 2020 values have been restated in line with IFRS 7 which requires values to be based on undiscounted future contractual cashflow (gross liabilities including finance charges).

30 THIRD PARTY ASSETS

The NHS Foundation Trust held £1,179k cash at bank at 31 March 2021 (31 March 2020: £968k) 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 2021 (31 March 2020: £nil) was held by the NHS Foundation Trust on behalf of patients.

31 LOSSES AND SPECIAL PAYMENTS

	2020/21		2019/20	
	No. of cases	**Value of cases £000**	No. of cases	Value of cases £000
Losses:				
Overpayment of salaries	**8**	**12**	5	2
Private patients	**151**	**256**	2	-
Overseas visitors	**2**	**9**	-	-
Other	**11**	**11**	24	64
Total losses	**172**	**288**	31	66
Special payments:				
Loss of personal effects	**2**	**4**	9	5
Other employment payments	**2**	**11**	2	66
Special severance payments	**-**	**-**	3	70
Other	**-**	**-**	9	2
Total special payments	**4**	**15**	23	143
Total	**176**	**303**	54	209

These payments are calculated on an accruals basis but exclude provisions for future losses. There were no individual cases in 2020/21 (2019/20: nil) where a debt write off exceeded £100k.

32 FOREIGN CURRENCY

During the year income with a value of £14k was received in foreign currency (2019/20: £nil) and expenditure with a value of £35k was paid to suppliers in foreign currency (2019/20: £141k).

33 CHARITABLE FUND RESERVE

	Balance 1 April 2020 £000	**Incoming Resources £000**	**Resources Expenses £000**	**Other movements £000**	**Balance 31 March 2021 £000**
Restricted Fund Balance	1,061	1,647	(1,297)	(109)	**1,302**
Unrestricted Fund Balance	5,614	2,317	(1,010)	109	**7,030**
Total	**6,675**	**3,964**	**(2,307)**	**-**	**8,332**

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.

A member of

CAMBRIDGE UNIVERSITY
Health Partners

Knowledge-based healthcare

Royal Papworth Hospital NHS Foundation Trust
Papworth Road | Cambridge Biomedical Campus | Cambridge | CB2 0AY

Tel: 01223 638000 | www.royalpapworth.nhs.uk