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Annual report and accounts 2022/23

Annual Report and Accounts
2022/23

Cambridge University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust Annual Report and Accounts 2022/23

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

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1. Chair's statement

The last year has been unexpectedly tough. In so many ways, we have faced an onslaught of challenges, from high inflation rates and sky-rocketing costs of living to the worsening climate crisis, from an unstable UK political landscape to horrifying conflicts and emergencies in Ukraine, Afghanistan, Turkey, Sub-Saharan Africa and so many other parts of the world.

While these events are far beyond our control, they almost always directly impact us as individuals, as a Trust and as the NHS.

At CUH we are a family of many nationalities, and the devastating international emergencies unfolding around the world will be very real for many of our staff. I am incredibly proud that we have so many staff who, despite so much pressure within our own system, still give what time and expertise they can to improve the health of communities further away from home.

Two admirable examples spring to mind: Syrian British CUH emergency doctor Tirej Brimo spent seven weeks treating people at a Ukraine border crossing last year, and is now raising funds with Cambridge Global Health Partnerships for hospitals in Syria following the huge earthquake there; and CUH specialist Emergency Department nurse Deborah Swann was deployed with UK International Search and Rescue in Turkey, working in the hardest hit earthquake zones to rescue and treat those trapped in collapsed buildings.

There are so many other brave individuals whose contributions go unnoticed. We are surrounded at CUH by remarkable and unceasingly dedicated people. As I write, we are in one of the several periods of unprecedented industrial action within the NHS.

Our focus during the strikes has been twofold: on the rights of staff wishing to take legitimate industrial action, while maintaining safe patient care for our urgent, emergency and inpatient services. Staff working in our hospitals and the wider NHS must be properly valued, recognised and rewarded for the incredible work that they do. That's why we have continued to call for urgent resolution to the national pay disputes, as well as a long-term plan for the NHS workforce. We have been working through all possible channels – and will continue to do so – to help bring about a resolution, as we know that the cumulative impact of ongoing industrial action has had a significant detrimental impact on our patients and our staff.

Even without strike action, this winter was a hard one in the NHS. CUH, along with the entire health and care system, was under extreme pressure. Throughout winter, the Trust experienced significant challenges, particularly in relation to Emergency Department waiting times and staffing levels, exacerbated by high levels of Covid-19 and flu. However, alongside these challenges, we performed relatively strongly in terms of clinical outcomes, access to cancer care, elective recovery, financial delivery, and service improvement and transformation.

Knowing that many members of staff and their families have been struggling with the rising cost of living, particularly with Cambridge being such an expensive place to live, we have prioritised staff health and wellbeing within our workforce strategy. This includes providing financial support for transport costs, car parking and food, as well as a one-off payment to all staff in December 2022. We will continue to look for more ways of extending meaningful help to staff.

Other significant changes within the health system include the introduction of Integrated Care Boards (ICBs) which took legal effect in July 2022. The Trust leadership and Board have long taken the view that a hospital simply cannot provide safe, kind and excellent health care in isolation from other parts of the health and social care system. We are pleased to work in very close collaboration with our partners in primary care, community care, social care, the local authority and other acute and specialist providers across the region. We are in daily touch with our ICB partners, and I am pleased to say we are driving forward new ways of delivering patient care closer to home, through GP surgeries, through the enhanced use of technology, through better communication and through listening to our patients who have lived experience of this care.

In March last year, the Care Quality Commission (CQC) undertook an unannounced inspection of the Trust's urgent and emergency care (UEC) pathway, as part of a Cambridgeshire and Peterborough system-wide UEC inspection. The overall rating was 'good', with 'excellent' in the caring and well-led categories, though with a number of 'must do's' and 'should do's' identified. These were all areas that CUH had self-assessed as needing additional work, and action plans are in place to address these.

Yet despite our best efforts to improve care and recover elective activity post-Covid, we remain painfully aware that many patients are not getting the treatment they need soon enough. Waiting lists are too long; anxieties and concerns are rising as a result of delays and deferred treatment experienced by patients in the last three years. We are experiencing pressure points across the whole hospital, particularly in emergency care and maternity services. These are not unique to CUH, nor always entirely

within our control. But we need to be strong in our plans and strong on their delivery.

This is why it is so important to remain focused on our priorities. During 2022 we launched a refreshed Trust strategy, with input from a wide range of stakeholders, including staff, patients, partners, Board members and governors. With three overriding priorities – to improve patient care, to support our staff and to build for the future – this strategy will help each one of us keep our eyes on the goal ahead: a healthier life for everyone through care, learning and research.

Despite the sobering year, there is much to celebrate. We held the first annual CUH staff awards last year, for which approximately 1,200 members of staff were nominated – an incredible testimony to the immense effort put in by so many teams in the workplace. This culminated in an awards ceremony which took place in King's College, Cambridge and was hugely enjoyed by those who attended. I would like to express our thanks and gratitude to the Addenbrooke's Charitable Trust (ACT) and the Alborada Trust for sponsoring these awards so generously, enabling us to recognise so many of our Trust colleagues.

In other good news, the Cambridge Biomedical Research Centre (BRC) was awarded £86.2 million by the National Institute for Health and Care Research to help discover new treatments for patients The Cambridge BRC is a partnership between CUH and the University of Cambridge, creating an ideal environment for cutting-edge 'translational' research – where scientific discoveries from the laboratory are turned into experimental and clinical trials to demonstrate benefit, and ultimately improve care.

Over the next five years, Cambridge will continue research in areas such as cancer, dementia and cardiovascular and respiratory diseases, as well as focusing on developing areas of technology that will likely revolutionise NHS care, such as artificial intelligence (AI), genomic medicine and new state-of-the-art imaging techniques.

Our position on the Cambridge Biomedical Campus, the largest life sciences campus in Europe, continues to offer new opportunities for collaboration in the interest of patients locally, regionally, nationally and internationally. The third strand of our strategy – building for the future – aims to capitalise on the strength of this co-location with other leaders in the life science sector.

We were delighted that the vision for the Cambridge Cancer Research Hospital, due to be built on land opposite the entrance to the

Addenbrooke's Treatment Centre, has been endorsed by the Secretary of State for Health. In May 2023 it was confirmed that the hospital will be funded as part of the New Hospital Programme, and our plans can proceed subject to approval from HM Treasury on the Outline Business Case. The ambition of beginning construction in 2024/25 remains.

The Cambridge Children's Hospital, which will be the first hospital to bring mental and physical health together in one place with dual-trained staff, continues to excite and inspire patients, clinicians, scientists and the public alike. We are well on course to meet our philanthropic fundraising target of £100m, thanks to the excellent work of the fundraising teams. We are expecting a final decision from national bodies on the Outline Business Case in autumn 2023.

As both these new hospitals are speciality facilities that will benefit patients across the whole of the East of England, we engaged with all of our regional Members of Parliament through offers of briefings and visits. 31 MPs signed an open letter in support of these two new research hospitals in a strong reflection of widespread regional support. We plan to build on this further in the year ahead.

Back in September 2022, we heard the sad news of the death of Her Majesty Queen Elizabeth II. Whatever one's views on the monarchy, the late Queen had been a constant presence and touched the lives of so many of us. News of her death resounded across the world in another example of tumultuous change. And we remembered the links that the Queen had with our hospitals during her reign.

So as we acknowledge the difficult times and the way world events impact on us, we need to face into these problems together, taking strength and inspiration from the ongoing kindness and compassion of the CUH family and all our partners.

May I thank you all for your tireless hard work and dedication during this very challenging time. Without you, we are nothing. I know that we have some of the best people in the NHS in this hospital and we are all united in our determination to do all we can to deliver safe, kind and excellent patient care.

Mike More
Chair
27 June 2023

2. Performance report

2.1 Overview

This section of the report provides a summary of the organisation, its purpose, the key risks to the achievement of its objectives and performance during the past year.

2.2 Statement from the Chief Executive

It is three years since Covid first gripped CUH, with its trauma and disruption, triggering an extraordinary response from everyone across the Trust.

Now we are facing its legacy and, in many ways, it is tougher than ever.

There has been no let up in the pressure on our emergency services and the knock-on impact across the Trust. We have experienced industrial action on a scale never seen before and thousands of patients are still on long waiting lists for planned treatment.

But despite all this, we have seen incredible progress, innovation and teamwork from all corners of the Trust. We have continued our excellent collaboration with the wider health community and our colleagues in the UK life science sector. This focused and sustained effort by our staff and partners has helped us meet many of the challenges – while also providing safe, kind and excellent care for our patients.

Looking longer term, this year also marked the next phase in our CUH strategy to deliver key priorities for the future with an ambitious agenda for improving quality of care, tackling inequalities, working more closely with our partners – from GPs to academia, industry and life sciences – and ensuring we have a sufficient workforce that feels valued.

One of the toughest periods was in the weeks leading up to Christmas when pressure on our emergency services peaked. This was driven by a combination of rising seasonal demand, industrial action and our highest ever recorded surge in Covid and flu cases. This led to an increase in control measures to avoid staff and other patients being infected, adding another layer of complexity. What resulted was too many patients, waiting too long for the level of care they needed, with extreme pressure on bed space and staffing felt across the Trust. However, with careful planning and collaboration we were able to recover quickly and we were in a far better, sustainable position by January.

New initiatives helped to create vital extra emergency capacity, with clinical areas repurposed to support the early release of ambulances from our A&E back into the community. This had a significant impact on ambulance handover times with a 44% improvement between December and January. This was sustained through February and March, with CUH achieving the best handover performance in the region. In a pioneering partnership, we also eased the shortage of beds at CUH by transferring medically-fit patients to a temporary new ward in Royal Papworth Hospital staffed and run by CUH.

Meanwhile the Trust has continued to hit key NHS priorities for planned care and reduce waiting lists. Across the year the number of people waiting more than 18 months for elective care dropped by 80%, to below 100. For cancer, CUH patients are getting a definitive diagnosis or the all clear within 28 days and the proportion waiting longer than 62 days for treatment continues to be the lowest in the East of England.

At the same time, 30% fewer patients are now waiting more than six weeks for a diagnostic test and we are progressing well with plans to open Community Diagnostic Centres in Ely and Wisbech later this year, enabling patients to access the testing and care they need closer to home. In Outpatients, we are increasingly delivering more personalised follow-up care, tailored to a patient's individual needs and circumstances, and avoiding unnecessary trips to hospital clinics.

Innovation and technology are also playing a vital role in tackling the backlog and improving quality of care. Robotic surgery at CUH is steadily increasing with more major operations now performed in our day surgery unit, with patients able to go home within 23 hours instead of spending days on a ward. And our second Da Vinci robot, funded by Addenbrooke's Charitable Trust, will give us even greater capability. CUH is also breaking new ground in artificial intelligence, trialling how it can help scan patient images and samples and speed up diagnosis. All this has been reflected in two high profile media stories in the Financial Times and a 6 page colour feature in the Saturday Times Magazine which included the quote "Even amid the stresses and strains of winter, the hospital is pioneering innovations that show a way forward for the rest of the health service."

As for building work, our three new orthopaedic theatres are on track to open in autumn 2023. These will initially focus on cutting long waits for knee and hip operations, carrying out around 2,700 procedures a year while also creating an orthopaedic centre of excellence for years to come. Refurbishment work to our three neurosurgery theatres is also finishing soon – giving further capacity to our surgical teams.

Meanwhile virtual appointments and our new virtual ward go from strength to strength. We now see one in five of our patients via a virtual clinic compared to one in 50 before the pandemic, reducing travel time for patients and freeing up capacity. Wearable technology also means selected inpatients can have safe, fully monitored care in their own home. To date more than 286 patients, from 26 different specialities, have been looked after by our virtual ward team with both patients and families giving excellent feedback.

Financially, we are in a good position. Despite an increase in challenges on all fronts, this year we have achieved a small financial surplus of £0.1m (after technical adjustments related to donated assets). This is the third year in a row that we achieved a breakeven or better financial performance, demonstrating the extraordinary efforts of staff across the organisation to manage within the budget, despite the pressures we have faced.

Alongside our continued good performance on our income and expenditure position, we have also continued to invest in our physical estate, equipment and systems as part of a £70.1m capital programme delivered during the year. These investments align with our strategic priority of 'Building for the Future' and position us well for the challenges we face.

A strong financial position is vital in building confidence in the Trust so that we can continue to deliver on our strategic priorities. Looking ahead, next year is going to be even more challenging financially with external factors such as inflation impacting on funds. More than ever, the Trust will need to combine efficiencies with investment while continuing to recruit and retain staff. It's a fine balance, but it is key to improving patient care.

All these achievements, however, are only possible thanks to the extraordinary dedication and commitment of CUH staff, many of whom also found themselves in the centre of industrial action this year. For the first time in our history, hundreds of nurses went on strike at CUH, followed by physiotherapists and junior doctors. This action has had an impact on us all, from those taking part in strikes, to other staff working hard to maintain safe services and the thousands of patients who have had their operations and appointments postponed, delaying care for many who have already waited months. It is in all our interest to reach resolution as soon as possible.

Core to CUH is our commitment to investing and supporting staff and improving the workplace. As our services expand and capacity increases, demand for staff continues to grow. In recent months we've been recruiting an additional 120 new nursing and healthcare support workers to staff our

new orthopaedic theatres and in March 2023 we reached our 12,000th employee, another milestone for CUH. As for vacancy rates, they have continued to fall this year, with a sustainable supply of staff coming from a number of areas including traditional undergraduates joining our healthcare professions, apprenticeship schemes and international recruitment.

All this, and CUH remains at the forefront of ground-breaking research and improvements in care. We continue to be a national leader in patient DNA testing and whole genome sequencing, pushing the boundaries of diagnosis and treatment. This is now routine for all our paediatric oncology patients with many now offered more bespoke and kinder treatment, tailored to their specific type of cancer. For eight-week-old Oliver, testing by the NHS East Genomic Lab at CUH proved the tumour he was born with was benign, spared him chemotherapy and surgery.

This sort of world-class research is underpinning the new Cambridge Cancer Research Hospital. Excellent progress has been made here, with the Outline Business Case (OBC) having been reviewed and awaiting final approval from government. Work on developing the Full Business Case is progressing in advance of building work starting next year. Meanwhile we have continued to work hard on our plans for Cambridge Children's Hospital, hosting a number of visits and discussions to look at all the options for funding with support from national colleagues, with a view to OBC review and approval in September 2023.

There is a lot to look forward to in the coming months, and much of it has been driven by the extraordinary effort of teams across the Trust this year, alongside our friends and colleagues across health and care, local government, the Cambridge Biomedical Campus and beyond.

In the next three years we have also set ambitious targets to provide specialised care for more patients closer to home in an environment which is kinder and more sustainable. We want to forge ahead with world-leading research and harness the latest in technology, data and life sciences to help drive economic growth and improve care.

Thanks to all of you, and for everything you continue to do. Above all, I want to thank every member of staff for your dedication to CUH and your commitment to our patients. You are the heart of CUH and the reason we continue to strive and inspire.

Roland Sinker
Chief Executive
27 June 2023

2.3 About CUH

Cambridge University Hospitals NHS Foundation Trust (CUH), including both Addenbrooke's and the Rosie Hospitals, was one of the first NHS foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003, and came into being in July 2004.

The Trust has its foundation in Addenbrooke's Hospital, which opened in October 1766 in Trumpington Street, Cambridge, as one of the first provincial teaching hospitals in the country. By the 1950s, the hospital was experiencing difficulty accommodating the expansion generated by the introduction of the NHS, and moved to the site on Hills Road. It was officially opened by Her Majesty Queen Elizabeth II in 1962.

CUH employs over 12,000 people and has an annual budget of over £1.3 billion. We provide services as a local hospital for people in Cambridge, South and East Cambridgeshire, and as a specialist hospital for a much wider population. As an academic medical centre, we work across 75 medical and surgical specialties, with corporate and support teams – and health, care, academic and industry partners – to deliver care, learning and research.

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

CUH is an internationally-renowned healthcare organisation. As part of the NHS, we deliver expert care for patients, train the workforce of tomorrow and shape healthcare for the future. Our vision is 'a healthier life for everyone through care, learning and research'.

Each of these three strands is equally important and mutually beneficial: conducting research attracts staff wanting to broaden their skills and enables our patients to benefit from better care sooner; and providing care enables innovative clinical treatments to get into practice sooner.

Our location in Cambridge, as part of an innovation ecosystem, unlocks huge opportunity to go further. As the largest centre of health science and medical research in Europe, we aspire to continue developing the cross-industry partnerships that further improve outcomes for patients while powering economic growth.

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

We are part of the Cambridgeshire and Peterborough Integrated Care Board
(ICB) and we host the Cambridgeshire South Care Partnership (CSCP) which brings together primary, community, acute and social care providers in the south of the county to deliver integrated care at place and neighbourhood level.

2.4 Key risks

Key risks are identified by the Board of Directors through the Board Assurance Framework (BAF). At the end of 2022/23, the most significant risks to achieving the organisation's strategic objectives as identified by the Board are outlined in Table 1.

Table 1: Board Assurance Framework (BAF)

The top ten 'risks' identified in the 2022/23 BAF as reviewed by the Board of Directors on 8 March 2023 were as set out in the table below. Risks are scored using a risk matrix with 1 to 5 scores for both the consequence (1 being negligible and 5 being catastrophic) and likelihood (1 being rare and 5 being almost certain). The highest risk score is therefore 25.

Risk ref.	Current risk score	Risk description	Lead Executive	Board monitoring committee(s)
001	**20**	Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably restore services to pre-Covid levels and reduce waiting lists, while at the same time managing future Covid surges and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.	Chief Operating Officer	Performance and Quality
005	**20**	A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	Director of Capital, Estates and Facilities Management	Performance
006	**20**	As a result of a failure to address fire safety statutory compliance priorities due to insufficient capital funding and decant capacity, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.	Director of Capital, Estates and Facilities Management	Board of Directors
007	**20**	There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.	Director of Workforce	Workforce and Education
002	**16**	Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.	Chief Nurse and Medical Director	Quality
011	**16**	There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.	Chief Finance Officer	Performance
008	**16**	There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and	Director of Workforce and Chief Nurse	Board of Directors, Workforce and Education, and Quality

		implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.		
013	**16**	There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.	Director of Workforce	Workforce and Education
003	**16**	The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.	Director of Improvement and Transformation	Audit
009	**16**	New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.	Interim Director of Strategy and Major Projects	Addenbrooke's 3 and Board of Directors

The BAF is used by the Board of Directors and its sub-committees to track progress in seeking assurance that appropriate controls are in place and actions are being taken to mitigate the key risks to the achievement of the Trust's strategic objectives. Further details of how the Board gains assurance that there are effective arrangements in place for internal control and risk management to safeguard public investment, the Trust's assets, patient safety and service quality are included in the Annual Governance Statement (AGS) at Section 3.28.

The processes outlined in the AGS ensure that the BAF is a living document, representing the risks of greatest concern to the Board of Directors.

2.5 Going concern statement

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

2.6 Performance management approach

Our approach to performance management is based on our Operational Plan with clear priorities, objectives and metrics aligned to the NHS England Operational Planning Guidance. A process is in place to ensure staff are clear about the priorities and that these are linked to individual objectives. Arrangements are in place for reporting to our commissioners and regulators, and there is a clear and simple quality message to our patients and the wider public through our Quality Account. The Quality Account for 2022/23 will be published on the Trust's website.

Performance is monitored by the Board of Directors through a monthly Integrated Performance Report, with detailed scrutiny and assurance sought by the Performance, Quality and Workforce and Education Committees of the Board. There is a focus across a broad range of metrics covering quality, operational performance, workforce and finance. Clinical divisions review performance through their divisional boards and associated governance arrangements and monthly performance review meetings are held between the executive team and each clinical division, with issues escalated as required to the Management Executive. In addition, there is a weekly taskforce focused on reducing the numbers of patients waiting over 65 weeks from referral to treatment and achieving the cancer waiting time standards.

2.7 Financial performance

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

2.8 Environmental matters, social, community and human rights issues

The activities and policies of CUH in the areas of social, environmental, community and human rights are outlined in Chapter 3, specifically within the equality, diversity and inclusion report and the sustainability and climate change report.

2.9 Emergency Planning, Resilience and Response

Under the Civil Contingencies Act (2004), the Trust is classified as a Category One responder alongside other agencies at the core of an emergency response. As such, the Trust has a statutory duty to:

- Assess the risk of emergencies occurring and use this to inform contingency planning.

- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance coordination
- Cooperate with other local responders to enhance coordination and efficiency.

The roles and responsibilities are clearly outlined to ensure that the Trust has arrangements in place to respond appropriately to incidents or events affecting the health of the community and minimise any further disruption.

The Trust has a Major Incident Plan, which sets out the process by which the organisation will respond to, manage and recover from an incident. The Chief Operating Officer, who has the role of the Accountable Emergency Officer for the Trust, sponsors this plan. The Trust's Lead Resilience Manager, who has the responsibility for ensuring it is reviewed in line with organisational policy, owns this plan. The Trust's Major Incident Plan and the Emergency Department's Major Incident plan are being reviewed to ensure they reflect recent changes in guidance and process.

The Trust has completed the annual self-assessment against the NHS England Emergency Planning, Resilience and Response (EPRR) core standards in conjunction with a peer review conducted by the Cambridgeshire and Peterborough Integrated Care Board (ICB). The Trust was declared as 'fully compliant' against the core standards in October 2022, and remained so at the six-month review point.

The Trust has been involved in a number of live incidents which have tested local, regional and national plans. These have included the responses to high consequence infectious diseases (HCIDs) and several rounds of industrial action. Learning from these incidents is being collated and captured to ensure it is embedded into current plans and documented to enhance our future response arrangements.

The Trust continues to participate in emergency planning exercises and training and is an active member of the Local Resilience Forum working group. We continue to attend local and regional planning sessions and exercises focusing on the reinforced autoclaved aerated concrete (RAAC) panel failure risk. The Trust has been asked to participate in a number of system-wide events testing the capability to receive a large number of patients in a partial or whole site evacuation scenario. Due to the regional

risk of a RAAC related incident, the Trust has been mandated to adopt a new hospital evacuation system which, once live, will become mandatory training for clinical staff. The Trust also supported the Local Resilience Forum during an NHS England led exercise on a National Power Outage incident.

Emergency planning priorities for 2023/24 include:

- Support the incident response for industrial action and ensure lessons learnt are implemented across the Trust.
- Continue to capture and embed learning from incidents to inform future planning arrangements.
- Support any further contingency work related to RAAC panels while working alongside the local and regional system to ensure evacuation plans are aligned.
- Develop the Trust's contingency plans for a National Power Outage incident.
- Review and update Business Continuity Plans and Business Impact Analysis.
- Ensure the Trust's EPRR policies and procedures are current and fit for purpose.
- Continue to prepare and deliver a range of training and exercises across the Trust and with multi-agency partners.

2.10 Freedom to Speak Up

The Trust's Freedom to Speak Up Guardian reports to the Director of Corporate Affairs and is supported by a network of local listeners across the organisation. There is a link Non-Executive Director for Freedom to Speak Up.

The Freedom to Speak Up service offers a confidential service to all employees and workers to ensure their concerns are heard and acted upon. The Freedom to Speak Up Guardian works with staff and leaders across the Trust to ensure continued promotion and embedding of an open and listening organisational culture.
In the financial year 2022/23, 111 colleagues raised concerns with the Freedom to Speak Up service compared to a figure of 88 in 2021/22.

The main themes of concerns raised in 2022/23 related to inappropriate attitudes and behaviours and worker safety and wellbeing. The staff groups accounting for the greatest proportion of concerns raised were Nursing & Midwifery and Administrative & Clerical staff. Themes and trends in

concerns raised continue to be monitored through the bi-annual reports to the Board of Directors.

The 2022 National Staff Survey shows that the Trust remains at or above the national average in respect of the questions relating to raising concerns. Nevertheless, further work is required to address differences in the results across staff groups and protected characteristics.

The Freedom to Speak Up Guardian continues to engage with national, regional and local networks in order to promote learning and development.

2.11 Significant events after the balance sheet date

The Government announced a formal pay offer to Agenda for Change unions for staff subject to Agenda for Change pay, terms and conditions. Subject to the offer being agreed, staff would receive two one-off non-consolidated pay awards on top of their existing 2022/23 pay award, which includes:

- A non-consolidated award worth 2.0% applied equally across all Agenda for Change bands
- A one off "backlog bonus" with tiered payments worth between £1,250 and £1,600

The Trust has followed the guidance to account for the costs of an additional pay award for 2022/23. The NHS staff council subsequently agreed the 2022/23 pay award plan which will be paid out in June 2023.

2.12 Joint forward plans and capital resource plans

The Trust has worked alongside the Cambridgeshire and Peterborough Integrated Care System and system partners in the development of the Joint Forward Plan (JFP). This has included Trust representation and participation in the System Strategic Planning Group (SSPG) which has oversight responsibility for production of the Plan, and the Strategy and Planning Engagement Group which ensures co-ordination, alignment and a collaborative approach across strategies and operational plans.

Direct contribution to the content of the JFP has been provided by a number of system operational groups, which include Trust representatives, as well as existing strategies and plans from across the system. Additionally, the Trust's Management Executive held a forum with ICS representatives to discuss the draft JFP and provide feedback to help

inform the final version which is due to be submitted to NHS England by 30 June 2023.

A joint capital resource use plan has been developed in collaboration with the Cambridgeshire and Peterborough ICB and partner trusts. The capital needs of the ICB partner trusts were consolidated and shared in Q4 2022/23 to facilitate greater understanding and awareness of each member's requirements. Then, following iterations to align with the ICB funding envelope, the Trust's capital budget was agreed as part of this broader plan. The plan will support a number of key strategic priorities across the system, particularly those outlined in the JFP.

The joint capital resource use plan will enable the Trust to undertake backlog building maintenance works and make key investments in our infrastructure, IT and medical equipment with the aim of improving operational delivery.

This coincides with the development of a series of strategic multi-year programmes aimed at increasing our physical inpatient and operating capacity alongside revenue investments in virtual ward capacity to support growing patient demand.

2.13 Health inequalities

In 2022/23 the Trust has, as a member of the Cambridge and Peterborough ICS, been working with partners across the public and voluntary sector to help address the underlying causes of healthcare inequalities.

Our Medical Director is a member of the Integrated Care Health Inequality Board established in 2022, and our Corporate Head of Nursing with responsibility for Patient Equity and Inclusion is a member of the associated operational group to support delivery of the published Cambridgeshire and Peterborough ICS Healthcare Inequality Strategy which includes:

- A system-wide approach to addressing health inequalities, underpinned by population health management methodology.
- Addressing inequalities through needs-based commissioning through the allocation of NHS funding proportionate to need.
- Tackling inequalities in cardiovascular disease through targeted action on hypertension and diabetes.

Work has been undertaken and continues to be taken forward to address the opportunities to improve healthcare in these areas, including case finding of patients with raised blood pressure, atrial fibrillation and elevated cholesterol levels; smoking cessation programmes targeted at pregnant patients and inpatients; improved access to mental health care; and increasing the uptake of screening programmes (particularly abdominal aortic aneurysm, breast cancer and cervical cancer).

At a Trust level, a wide range of work has been undertaken including:

- Steps to better understand the demographics of our patient population, including improving data collection.
- Clearing the Covid-19 backlog of breast cancer screening referrals and work to increase the uptake in Ethnic, Gypsy, Roma and Traveller communities.
- Development of an outline Patient Equality, Diversity and Service User Inclusion work plan for 2023-2025. Specific projects progressed to date include the development of a Sensory Impairment working group, reviewing the AccessAble website standards and improving facilities for those with sensory impairment.
- Appointing a Learning Disability lead for children in autumn 2022 and refreshing the Trust's Learning Disability Improvement Plan.
- Improving support for patients with visual impairments, in particular through the support of the Eye Clinic Liaison Officer role.
- Publishing more than 1,000 digitised patient information leaflets on our website in an accessible and inclusive format, including enabling patients to listen to the content, translate the content, and modify its appearance.
- Working with digitally excluded patients, including implementing PC tablets to support translation services.

3. Accountability report

3.1 Board of Directors

The Board of Directors comprises full-time Executive and part-time Non-Executive Directors, the latter selected for their knowledge, areas of relevant expertise and experience. All directors meet the Fit and Proper Persons Requirements.

The role of the Board of Directors is to provide effective and proactive leadership of the NHS foundation trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided; and to ensure that the Trust is well-governed in all aspects of its activities.

The section below demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors bring to the foundation trust.
The Board of Directors met 17 times during the year under review, six times in public and 11 times in confidential session.

3.2 Board and committee effectiveness

The performance of the Board of Directors is reviewed collectively as part of a board evaluation process; and individually, with each Board director undertaking performance appraisal with either the Chief Executive for the Executive Directors or the Chair for the Chief Executive and Non-Executive Directors. The Chair is appraised by the Senior Independent Director in consultation with the Lead Governor. Board committees undertake an annual review of their effectiveness against their terms of reference and work programmes and report to the Board of Directors on this.

3.3 Trust Chair

Dr Michael More, CBE – Chair

Mike became Chair of CUH on 11 April 2017, having served as a Non-Executive Director since September 2013. In December 2019 Mike was re-appointed for a further term of three years starting in April 2020, and in May 2022 he was re-appointed for a final term from April 2023 to September 2025.

He was Chair of the Cambridgeshire and Peterborough STP (the forerunner of the Integrated Care System or ICS) from 2018 until 2022, guiding it to successful transition to an ICS. Previously, he had an executive career in central and local government, starting with Cambridgeshire County Council and from 2002 until 2014 was Chief Executive of Suffolk County Council and the City of Westminster respectively.

3.4 Non-Executive Directors

Daniel Abrams – Non-Executive Director

Daniel was first appointed to the Board of Directors in September 2017. In March 2020 he was re-appointed for a further three-year term starting on 1 September 2020 and in March 2023 he was re-appointed for a final three-year term starting on 1 September 2023.

Daniel is a non-executive director of Genome Research Ltd (Wellcome Sanger Institute) where he is also the Audit Committee Chair, and a consultant to private equity firm GHO where he is also Audit committee Chair of a portfolio company. Daniel has previously held executive director positions including as Chief Financial Officer at Volex plc, Fiberweb plc, CDT inc and Xenova plc and senior executive roles at PepsiCo inc and Diageo plc.

He is also a former non-executive director of the Biotech Industry Association and Panel member of the FRRP in the FRC.

Daniel has an MA (Hons) Law from Cambridge University and is a qualified chartered accountant, FCA, and barrister-at-law.

Adrian Chamberlain – Non-Executive Director

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

Adrian began his career working with Bank of America before joining Boston Consulting Group after receiving and MBA from London Business School. In 1986 he joined British Telecom plc as a Business Strategy Manager before becoming Marketing and Commercial Director for Sears Sports and Leisurewear.

Subsequently he undertook a number of senior roles with Cable and Wireless plc including Chief Executive of the Consumer Markets Division

(now Virgin Media), Managing Director of the Consumer and Multimedia Division in Australia and Group Director of Strategy and Corporate Development.

He then became Chief Executive Officer of Global Services for Europe and Asia and a member of the Cable and Wireless Board. In 2003 he was appointed Main Board Director and CEO Europe of Bovis Lend Lease Corporation, a leading construction, property development and property management company. Between 2006 and 2015 he was CEO of private equity backed MessageLabs and Achilles, high tech companies specialising in Software as a Service cyber security and supply chain management.

He is a Non-Executive Director and Chair of the Remunerations Committee for Alfa Financial Software Holdings plc.

Dr Annette Doherty OBE FRSC – Non-Executive Director

Annette was first appointed to the Board of Directors in September 2017. In March 2020 she was re-appointed for a further three-year term starting on 1 September 2020 and in March 2023 she was re-appointed for a final three-year term starting on 1 September 2023.

Annette has 35 years of international experience working within the pharmaceutical sector, including at Warner-Lambert, Pfizer and most recently GSK where she was Senior Vice President, Global Head of Product Development and Clinical Supply. She has been directly involved in the research, development and launch of over 30 new medicines in respiratory, infectious diseases, cancer and inflammatory conditions.

She is currently Senior Adviser at Frazier Life Sciences, a team investing in and building companies developing and commercializing novel therapeutics. She has served on the Boards of various research, educational and charitable organizations including the Association for British Pharmaceutical industry (ABPI) and the Medical Research Council. In addition to her NED role at CUH, she currently holds Trustee positions at several charities including Addenbrookes Hospital Charitable Trust (ACT), The Royal Society of Chemistry (RSC), St John Ambulance and Tonbridge Grammar School Academy Trust.

She has a BSc in Chemistry and a PhD in Organic Synthesis from Imperial College London and conducted postdoctoral research with a NATO fellowship at Ohio State University.

She was recently elected as the next President of the Royal Society of Chemistry, a charity focusing on education and research to advance the chemical sciences.

In 2009, Annette was awarded an OBE in recognition of her services to the pharmaceutical sector.

Professor Ian Jacobs – Non-Executive Director

Ian was appointed to the Board of Directors for a three-year term commencing on 5 April 2022.

Ian is a surgeon, academic and university leader and previously worked as president and vice chancellor of the University of New South Wales (UNSW), Sydney, where he led an ambitious strategy to establish UNSW as one of the top 50 universities in the world. Prior to this Ian was dean of medicine and vice president of the University of Manchester (2011-2015) and dean of medicine at University College London (2004-2011).

Ian qualified in medicine at the University of Cambridge and the University of London and trained as an obstetrician and gynaecologist, before specialising as a women's cancer surgeon at St Bartholomew's Hospital and University College London Hospital. For the last 35 years Ian has led a research team working on screening for ovarian cancer which included the UK Collaborative Trial of Ovarian Cancer Screening.

In 1985, Ian founded the Eve Appeal charity, which funds research and raises awareness into gynaecological cancers, and in 2005 the Uganda Women's Health Initiative.

Ali Layne-Smith – Non-Executive Director

Ali was appointed to the Board of Directors for a three-year term commencing on 13 January 2022.

Ali Layne-Smith is an experienced Human Resources (HR) Director who has worked in demanding and complex organisations in both the private and public sectors.

This has included roles at GE Healthcare and Johnson & Johnson. She was previously the Director of People and Organisational Development at West Midlands Police and the Director of People and Culture at the London Ambulance Service NHS Trust.

Ali is currently an HR Director at HMRC leading a team of HR professionals who provide support to the 28,000 colleagues in the customer tax compliance business group (CCG).

Ali is a Trustee of Oasis Community Learning (OCL), which is one of the UK's largest Multi-Academy Trusts, where she chairs their newly formed People Committee which incorporates the Remuneration Committee. OCL's focus is on transforming education for children, their families and their communities.

Professor Patrick Maxwell – Non-Executive Director

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

Patrick Maxwell is Regius Professor of Physic and Head of the School of Clinical Medicine at the University of Cambridge.

As a clinician scientist he has been centrally involved in a series of discoveries that have revealed how changes in oxygenation are sensed, and how genetic alterations cause kidney disease.

Patrick is a Fellow of the Royal College of Physicians and the Academy of Medical Sciences, Director of Cambridge University Health Partners and a Non-Executive Director of Cambridge University Hospitals, Cambridge Enterprise, Scottish Mortgage Investment Trust and the International Biotechnology Trust.

Professor Sharon Peacock, CBE FMedSci – Non-Executive Director

Sharon was first appointed to the Board of Directors in October 2015. She was subsequently re-appointed for a second term of three years commencing on 1 October 2018, and for a third three-year term which commenced on 1 October 2021.

Sharon Peacock is Professor of Public Health and Microbiology in the Department of Medicine at the University of Cambridge, a Fellow of St John's College Cambridge, and a Trustee of the Sir Jules Thorn Charitable Trust.

Sharon has built her scientific expertise around pathogen genomics, antimicrobial resistance, and a range of tropical diseases. She was the founding director of COG-UK (the COVID-19 Genomics UK Consortium), formed in April 2020 to provide SARS-CoV-2 genomes to UK public health agencies, the NHS and researchers. Prior to this, she dedicated more than a decade to the translation of pathogen sequencing into clinical and public

health microbiology, as well as using sequencing to examine the transmission of antibiotic-resistant bacteria between humans, livestock, and the environment. Sharon has served and continues to serve the wider science ecosystem through appointments to numerous scientific funding Boards.

Sharon was made a Fellow of the Royal College of Physicians, London (2002), and a Fellow of the Royal College of Pathologists (2005). She was elected Fellow of the Academy of Medical Sciences (2013); Fellow of the American Academy of Microbiology (2014), Member of the European Molecular Biology Organization (EMBO); and elected to the Academia Europaea (2022). She was awarded a DSc (Honoris causa), Royal Veterinary College, London (2022), and a DSc (University of Southampton) in 2023. She was made an Honorary Fellow of the Royal College of Physicians in 2023.

In 2015, Sharon was appointed by Her Majesty The Queen to a Commander of the Order of the British Empire (CBE) for services to Medical Microbiology. She was awarded the Microbiology Society Unilever Colworth Prize for outstanding contribution to translational microbiology (2018); the Microbiology Society Marjorie Stephenson Prize for exceptional contributions to the discipline of microbiology (2023); and received the Medical Research Council Millennium Medal (2021).

Rohan Sivanandan – Non-Executive Director

Rohan was appointed to the Board of Directors for a three-year term commencing on 1 August 2021.

Rohan has held a number of executive, board and non-executive director positions across the public, private and voluntary sectors and have a particular interest in addressing social inequalities and injustice.
Rohan worked as an economist and senior executive in the private sector before moving into the education field. Rohan has worked across all phases of education, latterly as an education chief officer, before setting up a consultancy specialising in organisational design and transformation, and leadership coaching.

Currently, Rohan is a non-executive director for the Children and Family Court Advisory and Support Service (Cafcass). Rohan is a lay member of the Independent Reconfiguration Panel (an advisory non-departmental public body sponsored by the Department of Health and Social Care), and Vice-Chair of the Bar Standards Board's Independent Decision-Making Body.

Rohan chairs NHS Mental Health Act hearings and also chair fitness to practice hearings for Social Work England. Rohan is an independent member for the Greater London Authority and the Boundary Commission for England.

3.5 Executive Directors

Roland Sinker – Chief Executive

Areas of responsibility include: *accounting officer, overall responsibility for management of the Trust, ensuring its obligations and targets are met within a framework of prudent and effective systems of internal control*

Roland has served as Chief Executive of Cambridge University Hospitals NHS Foundation Trust (CUH) since 2015. From 2018 to 2021, he assumed the accountable officer role for the integrated care system partners in Cambridgeshire and Peterborough, who between them serve a population of 1 million people with a health and social care spend of £1.5 billion. The integrated care system and the hospital trust are heavily focused on innovation and improvement, linking with universities and industry to deliver this. He was Chair of the Shelford Group of ten teaching hospitals from 2020 to 2023, and leads nationally on life sciences for NHS England.

CUH is one of the UK's foremost specialist referral centres and delivers world-leading teaching and research as well as providing local care for the people of Cambridgeshire. The Trust is a founding partner in the Cambridge Biomedical Campus, where its neighbours include the world-famous Laboratory of Molecular Biology, part of the University of Cambridge. With a turnover of £1.3 billion, the Trust is a high performing centre for clinical care and patient experience, rated as Good overall and Outstanding for well-led and Caring with the Care Quality Commission. The Trust runs the UK's most digitally developed hospitals and is a multi-award winning centre for the use of digital systems to improve patient care.

Before joining CUH, Roland was chief executive, chief operating officer and strategy director at King's College Hospital NHS Foundation Trust. He began his career in the field of corporate law at Linklaters, based in London and Hong Kong, and later moved to McKinsey to work in strategy consultancy.

Nicola Ayton – Chief Operating Officer

Areas of responsibility include: *clinical and operational services, performance management and emergency planning*

Nicola took up the role of Chief Operating Officer at the start of 2020 having joined Cambridge University Hospitals in 2018 as Director of Strategy and Major Projects. During this time she has also spent six months at 10 Downing Street as an adviser on Health and Social Care Integration. Previously she held the position of Deputy Director for the National System Transformation Group at NHS England, as well as Head of Strategy and Delivery for the New Care Models Programme. Before joining NHS England in 2015, Nicola worked as a civil servant in Central Government where she held a number of senior policy roles including health spending at HM Treasury. Prior to that, she worked at the Department for Education focusing on school funding reform having started her career at Deloitte.

Dr Ewen Cameron – Director of Improvement and Transformation (until 17 February 2023)

Areas of responsibility as Director of Improvement and Transformation include: *continuous improvement within the organisation as well as cost improvement, eHospital, information governance and innovation.*

Until February 2023 Ewen was the Director of Improvement and Transformation for CUH, a post he took up in February 2018. During most of 2021/22, he was the interim Chief Operating Officer for CUH.

Having originally trained in Cambridge, he returned to the Trust as a Consultant Gastroenterologist with an interest in Endoscopy in 2007. He was the Clinical Lead for Endoscopy and the Clinical Director of the Cambridge Bowel Cancer Screening Centre from 2007 until 2013 when he was appointed Divisional Director for Medicine. He was subsequently the Divisional Director for Division C from 2014.

Ewen was responsible for the development of a programme of continuous improvement within the organisation as well as cost improvement, eHospital and innovation. During his time as an executive director, Ewen continued to practice as a Gastroenterologist.

Nick Kirby – Interim Director of Strategy and Major Projects (from 27 August 2022)

Nick joined CUH from the leadership community in North Central London where, as Managing Director of the UCL Health Alliance, he worked across 14 member organisations to establish the Alliance as the provider collaborative for the system.

Since joining as a graduate trainee in 2004, Nick has worked across a range of geographies and organisations in the NHS.

Highlights from recent years include being part of the cancer community which set up the national cancer vanguard and delivered the reconfiguration of complex care in North Central and East London.

More recently, Nick was managing director of the Shelford Group, a national collaboration of providers with a collective turnover exceeding £12.5bn.

Mike Keech – Chief Finance Officer

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

Mike has been the Chief Finance Officer at CUH since November 2020, having previously worked as Director of Finance at Milton Keynes University Hospital NHS Foundation Trust. Prior to that, Mike held a number of roles at Monitor (now NHS Improvement) with a focus on supporting organisations and systems to develop long term plans to ensure financial sustainability. Mike originally trained with the accountancy firm Deloitte and is member of the Institute of Chartered Accountants in England and Wales (ICAEW).

In his role at CUH Mike leads on financial aspects of the Trust's work, including the development of the Trust's financial plans, financial reporting, the Trust's commercial strategy and procurement.

Dr Ashley Shaw – Medical Director

Areas of responsibility include: *professional medical governance; medical revalidation clinical outcomes; infection prevention and control; research and development; medicines management; clinical networks; GP liaison; undergraduate education; post-graduate education.*

Ashley took up the post of Medical Director for CUH in November 2017. He joined the Trust as a Consultant Radiologist with an interest in cancer imaging in 2004 and became Divisional Director for Investigative Sciences in 2012, subsequently for Division B from 2014.

Ashley leads and is responsible for the professional activities of the medical staff within CUH, medical research, postgraduate medical education,

infection prevention and control, medicines, medical equipment and information governance within the organisation. Ashley continues to practice as a radiologist.

Claire Stoneham – Director of Strategy and Major Projects (on maternity leave from 27 August 2022)

Areas of responsibility include: *establishing and agreeing strategic choices, business planning, working with partners across the Integrated Care System and East of England, and delivering major new hospital developments.*

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

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

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

Lorraine Szeremeta – Chief Nurse

Areas of responsibility include: *nursing and midwifery strategy and standards, executive lead for quality and safety and patient experience, safeguarding children and vulnerable adults, professional lead for allied health professionals, and executive lead for psychological medicine services.*

Lorraine joined CUH as Chief Nurse in July 2018, coming to the organisation from University College London Hospitals, where she had worked as Deputy Chief Nurse for the surgery and cancer board for 5 years. During her time in London she also worked on a part time seconded basis on the pan London Capital Nurse programme, leading on retention workstreams.

Lorraine has held a number of senior management and nursing roles throughout her career in a number of different organisations, and has a keen interest in staff development and organisational culture. She is co-chair of the Shelford Group's Safer Nursing Care Tool Steering Group and a member of the NHSI Safe Staffing Faculty Steering Group. She is also co-chair of the Shelford Chief Nurse group and the Chief Nurse for the East Genomic Medicine Service Alliance (GMSA).

Ian Walker – Director of Corporate Affairs

Areas of responsibility include: *corporate governance, communications, public engagement, medico-legal services, foundation trust membership and raising concerns.*

Ian joined the Trust in May 2017, having previously worked at Barts Health NHS Trust for 14 years as Director of Corporate Affairs and Trust Secretary. Prior to that, Ian worked at Her Majesty's Treasury where he undertook a wide range of roles, including on health policy and funding.

In his role Ian leads on corporate governance, public engagement, medico-legal services, communications and foundation trust membership. Ian is also executive lead for raising concerns.

David Wherrett – Director of Workforce

Areas of responsibility: *human resources, diversity and inclusion, staff health and wellbeing, medical staffing, education, learning and development, temporary staffing and volunteering.*

David Wherrett is the Trust's Director of Workforce, joining CUH in April 2014 and leading on all aspects of the Trust's workforce agenda.

David has a wide ranging experience of leading workforce and organisational development teams in various organisations. He has spent the majority of his career in the NHS, primarily in hospitals. His focus is to ensure that CUH staff have a positive experience of work, are able deliver excellent care for patients, outstanding research and great education opportunities.

3.6 Register of interests

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an ongoing basis.

The register is available online at https://cuh.mydeclarations.co.uk/. The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs

3.7 Appointment of Chair and Non-Executive Directors

The Council of Governors has the responsibility for appointing the Chair and the other Non-Executive Directors (except in the case of the Regius Professor of Physic) in accordance with the Constitution and in line with relevant legislation.

Candidates are nominated by the Council of Governors' Nomination and Remuneration Committee. This Committee comprises two public governors, two patient governors, one staff governor and one partnership governor. It is chaired by the Chair of the Trust for Non-Executive Director appointments only, and by a governor (currently Patient Governor Julia Loudon) for all its other functions including the appointment of the Trust Chair.
Non-Executive Directors are normally appointed for a term of three years. Following this term, and subject to satisfactory performance appraisal, a Non-Executive Director is eligible for consideration by the Council of Governors for re-appointment for subsequent terms of up to three years each up to a maximum cumulative total of nine years' service.

In May 2022 the Council of Governors amended the Trust Constitution to allow a Chair, in exceptional circumstances, to serve on the Board of Directors for a cumulative maximum period of 12 years.

When undertaking its nomination responsibilities, the Committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate.

The removal of a Non-Executive Director requires the approval of three quarters of members of the Council of Governors. Details of the criteria for disqualification from holding the office of a director can be found in the Constitution.

Disclosures of the remuneration paid to the Chair and Non-Executive Directors (and also to the Chief Executive and Executive Directors) are given in the remuneration report at section 3.22.

3.8 Non-Executive Directors' expenses

CUH is committed to reimbursing expenses incurred on Trust business to the Chair and Non-Executive Directors at rates set by the Council of Governors. A copy of the policy is available from the Director of Corporate Affairs.

3.9 Attendance at Board meetings in 2022/23

Meeting dates

2022: 13 April, 11 May, 15 June, 13 July, 14 September, 12 October, 9 November and 14 December.

2023: 18 January, 8 February and 8 March.

With the exception of the meeting on 8 February 2023, the Board met remotely via videoconference during the reporting period.

There were two separate meetings of the Board of Directors on the dates listed above in each of May, July, October and November 2022 and in January and March 2023. A total of 17 Board meetings were therefore held in 2022/23.

Table 2: Attendance at Board meetings in 2022/23

Name	Title	Attendance
Dr Michael More	Trust Chair	17/17
Daniel Abrams	Non-Executive Director	17/17
Nicola Ayton	Chief Operating Officer	17/17
Dr Ewen Cameron*	Director of Improvement and Transformation	15/15
Adrian Chamberlain	Non-Executive Director	14/17
Dr Annette Doherty	Non-Executive Director	13/17
Nick Kirby**	Interim Director of Strategy and Major Projects	11/11
Mike Keech	Chief Finance Officer	17/17
Professor Ian Jacobs	Non-Executive Director	16/17

Ali Layne-Smith	Non-Executive Director	16/17
Professor Patrick Maxwell	Non-Executive Director	17/17
Professor Sharon Peacock	Non-Executive Director	14/17
Dr Ashley Shaw	Medical Director	17/17
Roland Sinker	Chief Executive	17/17
Rohan Sivanandan	Non-Executive Director	11/17
Claire Stoneham***	Director of Strategy and Major Projects	7/7
Lorraine Szeremeta	Chief Nurse	14/17
Ian Walker	Director of Corporate Affairs	17/17
David Wherrett	Director of Workforce	16/17

* Dr Ewen Cameron left the Trust in February 2023
** Nick Kirby joined the Trust in August 2022
*** Claire Stoneham was on maternity leave from August 2022

3.10 Committees of the Board of Directors

The Board of Directors is required to establish and maintain an Audit Committee and a Remuneration Committee. Further details about the Audit Committee and the Remuneration Committee are contained in Sections 3.11 (Audit Committee) and 3.22 (Remuneration and Nomination Committee).

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

- Addenbrooke's 3 Committee
- Performance Committee
- Quality Committee
- Workforce and Education Committee

The membership of the committees is determined by the Chair of the Trust in consultation with the Board of Directors. Any changes to the membership of committees are reported to the next meeting of the Board of Directors.

Table 3 below shows Board committee membership as at 31 March 2023. A number of changes to committee membership were agreed by the Board of Directors in March 2022 and took effect from 1 April 2022.

Table 3: Committee membership as at 31 March 2023

Board Committee	Membership
Audit Committee	NEDs: Daniel Abrams (Chair), Dr Annette Doherty, Prof Sharon Peacock
Remuneration and Nomination Committee	NEDs: Ali Layne-Smith (Chair), all Non-Executive Directors including the Trust Chair are members
Quality Committee	NEDs: Prof Sharon Peacock (Chair), Adrian Chamberlain, Rohan Sivanandan Executive Directors: Chief Nurse and Medical Director
Performance Committee	NEDs: Adrian Chamberlain (Chair), Daniel Abrams, Prof Ian Jacobs Executive Directors: Chief Finance Officer, Chief Operating Officer and Medical Director
Workforce and Education Committee	NEDs: Rohan Sivanandan (Chair), Ali Layne-Smith, Prof Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director
Addenbrooke's 3 Committee	NEDs: Annette Doherty (Chair), Prof Patrick Maxwell, Prof Ian Jacobs Executive Directors: Director of Strategy and Major Projects, Chief Nurse, Medical Director

Table 4: Attendance of committee members at Board Committee meetings 2022/23

Addenbrooke's 3 Committee:

Name	Title	Attendance
Dr Annette Doherty	Committee Chair	6/6
Professor Ian Jacobs	Non-Executive Director	6/6
Nick Kirby	Interim Director of Strategy and Major Projects	4/4*
Professor Patrick Maxwell	Non-Executive Director	3/6
Dr Ashley Shaw	Medical Director	3/6
Claire Stoneham	Director of Strategy and Major Projects	2/2**
Lorraine Szeremeta	Chief Nurse	3/6

* Nick Kirby attended the meeting as a member from August 2022
**Claire Stoneham was on maternity leave from August 2022

Audit Committee:

Name	Title	Attendance
Daniel Abrams	Committee Chair	5/5
Dr Annette Doherty	Non-Executive Director	5/5
Professor Sharon Peacock	Non-Executive Director	4/5

Performance Committee:

Name	Title	Attendance
Adrian Chamberlain	Committee Chair	11/11
Daniel Abrams	Non-Executive Director	11/11
Nicola Ayton	Chief Operating Officer	11/11
Professor Ian Jacobs	Non-Executive Director	10/11
Mike Keech	Chief Finance Officer	10/11
Dr Ashley Shaw	Medical Director	11/11

Quality Committee:

Name	Title	Attendance
Professor Sharon Peacock	Committee Chair	6/6
Adrian Chamberlain	Non-Executive Director	5/6
Dr Ashley Shaw	Medical Director	6/6
Rohan Sivanandan	Non-Executive Director	3/6
Lorraine Szeremeta	Chief Nurse	5/6

Remuneration and Nomination Committee:

Name	Title	Attendance
Ali Layne-Smith	Committee Chair	3/3
Daniel Abrams	Non-Executive Director	2/3
Adrian Chamberlain	Non-Executive Director	2/3
Dr Annette Doherty	Non-Executive Director	2/3
Profession Ian Jacobs	Non-Executive Director	3/3
Professor Patrick Maxwell	Non-Executive Director	0/3
Dr Michael More	Trust Chair	3/3
Rohan Sivanandan	Non-Executive Director	2/3
Professor Sharon Peacock	Non-Executive Director	3/3

Workforce and Education Committee:

Name	Title	Attendance
Rohan Sivanandan	Committee Chair	4/4
Ali Layne-Smith	Non-Executive Director	4/4
Professor Patrick Maxwell	Non-Executive Director	2/4
Dr Ashley Shaw	Medical Director	3/4
Lorraine Szeremeta	Chief Nurse	1/4
David Wherrett	Director of Workforce	4/4

Other Directors and Senior Managers attend committees as required.

3.11 Audit Committee

Membership of this committee is made up of Non-Executive Directors and the committee was chaired by Daniel Abrams for the entire reporting period.

The committee's primary role is to oversee the governance and assurance process and the effectiveness of the risk management system and the control environment, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, and also the adequacy of the Trust's internal audit arrangements.

The committee's terms of reference are available on the Trust website.

Meeting dates

The Audit Committee met as follows:

2022: 6 April, 13 June, 20 July and 28 November
2023: 1 February

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

Significant issues – update following Audit Committee

The Audit Committee met in June 2023 to consider the financial statements for the period for the period 2022/23. The Audit Committee reviewed the financial statements and identified no significant issues with the statements.

External auditors

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

Mazars LLP reports to the Council of Governors through the Audit Committee. Mazars' accompanying report on the financial statements is based on its examination conducted in accordance with Code of Audit Practice as issued by the National Audit Office. Their work includes a review of the Trust's internal control structure for the purposes of designing their audit procedures.

The external audit process is subject to annual review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The Audit Committee meets with the auditors (Internal and External) without any of the Trust's Executive Directors present prior to each meeting to improve its knowledge of their contribution.

Non-audit work may be performed by the external auditors where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is

followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

Audit Fees

The statutory audit fee, including quality account and whole of government accounts and others is included in Note 3 to the accounts.

Internal auditors

During 2019/20, following a tender process, KPMG were re-appointed as the internal auditors for the Trust with effect from 1 April 2020.

The internal auditors are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit Committee on the audit activity undertaken.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. Further details are provided in the Annual Governance Statement at Section 3.28.

3.12 Remuneration and Nomination Committee of the Board of Directors

The work of the Remuneration and Nomination Committee is described in Section 3.22.

There is also a Governors' Nomination and Remuneration Committee which oversees the appointment and remuneration of Non-Executive Directors as described in Section 3.4.

3.13 Cost statement

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector information guidance during 2022/23.

3.14 Better payment practice code

The Trust's performance against the better payment practice code in 2022/23 was as follows:

Better payment practice code	Expected Sign	19ACTYTD01 Current YTD Actual 31/03/2023 YTD Number	19ACTYTD Current YTD Actual 31/03/2023 YTD £'000
Non NHS			
Total bills paid in the year	+	157,251	582,274
Total bills paid within target	+	137,168	504,679
Percentage of bills paid within target	%	**87.2%**	**86.7%**
NHS			
Total bills paid in the year	+	3,276	63,727
Total bills paid within target	+	2,106	47,749
Percentage of bills paid within target	%	**64.3%**	**74.9%**
Total			
Total bills paid in the year	+	**160,527**	**646,001**
Total bills paid within target	+	**139,274**	**552,428**
Percentage of bills paid within target	%	**86.8%**	**85.5%**

3.15 Quality strategy

With input from the Council of Governors, the Board of Directors agreed a five-year quality strategy (the Quality Plan) in 2018 which aims to ensure every patient receives safe care, provided to the highest clinical standards, while ensuring a positive patient experience.

The plan is aligned to the Trust's overarching strategy, with a clear focus on ensuring improvement work enhances patient care across all domains of quality while supporting improved performance.

The Quality Plan (2018-2023) builds on the work undertaken during the previous five years, outlining plans to increase in capability and capacity for improvement. The Trust has commenced working with the Institute for Healthcare Improvement as its improvement partner.

The Quality Plan outlines how success will be shared and learned from, in addition to reinforcing the framework for improvement, with a focus on supportive leadership, which will enable our workforce to drive improvement.

The Quality Plan is due to be updated in the year ahead and will incorporate requirements of the new National Patient Safety Strategy.

3.16 Income statement

CUH has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

3.17 Statement regarding disclosure to auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors to be aware of any relevant audit information and to establish that the auditors are aware of that information.

3.18 Patient care

Improvements in patient/carer information

It is important to the Trust that the information provided to patients, families and carers is of a high quality and appropriate for people from a variety of backgrounds.

The Trust Reader Panel is a voluntary group of 35 members that reviews new patient information leaflets from a non-clinical perspective. They provide feedback and recommendations to improve the readability of the leaflets, paying particular attention to:

- Will it be easy to understand by the intended audience?
- Is the main message clear?
- Is it jargon-free?
- Are medical terms clearly explained?
- Would images help support explanations?
- Is it free of typos, spelling mistakes and grammatical errors?

During 2022/23 the Panel reviewed 110 documents.

The compliance status of patient information leaflets is reported monthly to each division's governance forums and escalated to the Patient Experience Group where appropriate.

MyChart provides patients with electronic access (via a mobile app or website) to their clinical records held at the Trust. At the end of March 2023 there were 132,887 patients with an active MyChart account. Over the last year, 41.5% of patients who attended Outpatients used MyChart, a total of 2,345,958 test results were released to patients and the portal was accessed by 4,668,476 logins.

The Accessible Information Standard

The Accessible Information Standard (AIS) sets out the requirements for NHS organisations to identify, record, flag, share and meet patients' and carers' information and communication support needs – for example, providing printed information in a large typeface, or arranging for a British sign Language interpreter to attend a patient's appointment. Systems are in place across the Trust to meet our obligations, and over the year a steering group continued to work towards improving our performance against the Standard.

The Trust's website complies with accessibility standards and can be used by people with a range of needs.

Patients and carers are invited to tell us about their communication and information needs, and staff - supported by the CUH Accessibility Team - work to meet the needs. Improvements have been made to record patients' information and communication needs in our electronic patient record system: the recording system has been standardised and improved so that it is easier for staff to record and see patients' needs.

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

Information on complaints handling

The Trust welcomes patient feedback and aims to make the complaints process accessible and responsive. The information from complaints investigations is used to make improvements to treatment and patients' experience of care.

In 2022/23 CUH received 922 complaints, a 47% increase on the previous year's total of 627. This represents a significant increase in workload for the Complaints team, and reflects the operational pressures across the Trust.

The overall rate of complaints was 0.05% of activity, the same as the previous year ('activity' here means patient episodes, e.g. an inpatient stay or an outpatient attendance).

Of the total number of complaints received in 2022/23, investigated and closed at the date of reporting (427 as at 28 April 2023), 43 were fully upheld, 108 were partially upheld and 153 were not upheld after investigation. Where complaints are not upheld – where it is considered that there were no shortfalls in the care provided – an explanation is provided, and an apology is given for the patient's negative experience. 495 cases received in 2022/23 remain open as at 28 April 2023.

The complaints regulations require NHS organisations to acknowledge complaints within three working days. In 2022/23, we achieved this in 81% of cases.

Under current legislation, NHS organisations have six months to resolve a complaint: this allows for flexibility and agreement with the complainant as to an appropriate timescale for investigating and responding. CUH aims to provide a response in as timely a manner as possible, and works to internal standards of responding to 50% of complaints within the timeframe set after initial receipt and assessment of the complaint, and responding to 90% of complaints within the initial timeframe or within an extended timeframe agreed with the complainant.

Complaints are graded from 1 to 5 according to complexity/severity. Cases graded 1, 2 or 3 in the grading framework should be investigated and responded to within 30 working days (or fewer); cases graded 4 - response within 45 working days, cases graded 5 - response within 60 working days.

During investigation, factors can arise which mean that cases take longer to investigate and the time to respond exceeds the initial set timeframe. Factors affecting timeliness of responding are availability of Trust staff to investigate complaints, resource issues within the complaints team and unforeseen additional information being required as a result of initial investigations. In these cases the complaints team communicate with complainants in order to negotiate an extended set timeframe for response.

Of the total number of complaints received in 2022/23, investigated and closed at the date of reporting, we responded to 26% of complaints within the initial set timeframe. We agreed and met an extension to the responding timeframe in a further 40% of cases, meaning that we responded to 66% of complaints either within the initial set timeframe or by the later date agreed, which is below our internal target.

Complaints are recorded on a secure database and the information is categorised to help us identify themes and trends. We record the area where the issue occurred (division, directorate, specialty, ward/clinic), the staff group (e.g. consultant, physiotherapist, nurse) and the subject of the complaint (e.g. communication, cancelled appointment, delayed discharge), as well as the outcome of the investigation, the lessons learned and action taken, and whether the complaint was upheld. This information is available to staff across the Trust and presented to the Patient Experience Group.

We categorise complaints by their main subject (e.g. ‘clinical treatment’, ‘communications’), together with sub-subjects within that category (e.g. ‘delay or failure in treatment or procedure’, ‘post-treatment complications’, ‘communication with patient’). Most complaints are about several different subjects. The most common main subject of all complaints received is consistently clinical treatment. Within this category, delays or failures in diagnosis and treatment are the most common issues reported.

Emphasis is placed on identifying lessons learned and actions taken where shortfalls in care are identified. Over the past year, examples of actions implemented as a result of patient complaints include: review of gestational diabetes nutrition patient information by the dietetic team; changes to chemotherapy infusion scheduling together with additional instructions and equipment for infusion pumps and staff register of appropriately training chemotherapy staff; the practice development team have worked with staff to improve their knowledge of drug administration.

The Parliamentary and Health Service Ombudsman (PHSO) undertakes the second stage in the complaints procedure. Complainants may take their case to the PHSO if they consider that attempts at local resolution have failed, and the PHSO will review the case and decide whether to re-investigate. Two cases were accepted for investigation by the PHSO in 2022/23, the same number as in 2021/22, of the 11 compliant files requested for preliminary review. One PHSO investigation was partially upheld with action plan required and the second was partially upheld with no further action required. The Trust was required to make financial remedies in both cases.

In addition to complaints, the Trust receives and responds to a larger volume of feedback through the Patient Advice and Liaison Service (PALS), encompassing enquiries, comments, concerns, requests for advice and compliments. All cases are recorded on our database apart from straightforward queries such as wayfinding and car parking information. 5179 cases were managed and recorded on the database compared with 5929 in 2021/22.

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

More than 199 compliments were received by the PALS team in 2022/23, although this is just a small proportion of the greater number of compliments and expressions of gratitude received directly by ward and clinic staff. This is unlikely to be a true reflection of actual figures as not all compliments have been logged on the system.

The PALS team aim to resolve 80% of cases within ten working days. For 2022/23, 67% were resolved compared to 74% of cases in 2021/22. This performance is lower than target due to ongoing increase in the complexity of cases and staffing challenges experienced during the year by the PALS team.

3.19 Stakeholder engagement

Patient experience

The Patient Experience Group, chaired by the Chief Nurse, monitors activities relating to learning from and improving patient experience. The group meets bi-monthly and has governor representation to ensure that the views of members and the public are heard.

Information reviewed by the Group includes complaints, concerns and compliments, the 'Friends and Family Test' survey results, local and national patient survey results, the work of Trust patient participation groups, reports from Trust operational groups such as the Carers' Working Group and the Patient Communications Group, and other sources of feedback such as that received by Healthwatch. Patient experience data are also reviewed at specialty clinical governance meetings, divisional governance meetings and cross-divisional groups such as the Outpatients Board.

Results of the Friends and Family Test surveys show that the Trust continues to be rated very positively by patients.

The Trust participated in the relevant national survey programmes over the year and action plans were prepared after consideration of the findings. Local surveys are also carried out to supplement as required.

Patient participation groups are active in several services across the Trust, and the groups undertook a variety of projects over the year.

Cambridge University Health Partners (CUHP) and Academic Health Science Centre

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

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

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

For more information on CUHP please see www.cuhp.org.uk.

Consultation with local authorities covering the membership area

The Trust works with a range of local authorities across the region including as a member of the Cambridgeshire and Peterborough Integrated Care System and the Cambridgeshire and Peterborough Health and Well-Being Boards.

Education and training

CUH is a teaching hospital for medical undergraduates and postgraduates, Nurses, Midwives and Allied Health Professions. Patient-centred teaching is one of our core activities and is central to our vision. We are the teaching hospital for the University of Cambridge through the School of Clinical Medicine and the Postgraduate Medical Centre which provide the infrastructure and support to facilitate the education, training and continuing development of postgraduate professionals in hospital medicine, general practice and dentistry.

At CUH, we work in partnership with 12 higher education institutions to facilitate 900 clinical placements for pre-registration Nursing, Midwifery and Allied Health Professionals per year. The Non-Medical Clinical Education Team provide teaching, clinical supervision and facilitation of learning to these students and apprentices alongside the practice educators, supervisors and assessors within the clinical environment. In addition to the traditional university degree programmes, CUH also provides a 'grow your own' apprenticeship pathway with degree apprenticeships for Assistant Practitioner, Nursing, Nursing Associate, Health Care Science,

Physiotherapy, Occupational Therapy, Operating Department Practitioners as well as Diagnostic and Therapeutic Radiographers. CUH is currently supporting over 365 clinical apprenticeships within the trust.

Research and development

In partnership with the University of Cambridge, Cambridge University Hospitals hosts a NIHR Biomedical Research Centre, a NIHR Clinical Research Facility (CRF), a NIHR Experimental Cancer Medicine Centre, and a NIHR Brain Injury MedTech Co-operative and the NIHR Bioresource. The UK Clinical Research Collaboration registered Cambridge Clinical Trials Unit (CCTU) and Cambridge Epidemiology and Trials Unit deliver research in priority areas of health and social care and public health across all phases of clinical trials, involving NHS organisations, academia, and industry.

NIHR Cambridge Biomedical Research Centre (BRC)

The outcome of the NIHR Biomedical Research Centre competition was announced in October 2022. The NIHR Cambridge BRC was re-designated as a Biomedical Research Centre, and awarded £86.2m to translate scientific discoveries from the laboratory into the clinic.

NIHR BioResource

The NIHR BioResource, a national recallable resource involving over 120 NHS organisation and over 250,000 volunteers from the general population, and patients with rare and common diseases. It is one of four key infrastructures supporting population level genomic projects in the Life Science Industrial Strategy. The NIHR BioResource Rare Diseases led the Genomics England 100,000 Genomes pilot, providing evidence for the utility of whole genome sequencing in the NHS and changing healthcare policy. Following a successful regional launch at St Michael's High School, Rowley Regis, West Midlands the NIHR Young People's BioResource will be launched nationally in 2023.

In November 2022 DHSC confirmed that the NIHR BioResource has been awarded £16,998,161 funding for the period 1 December 2022 to 30 November 2024.

Cambridge Clinical Research Centre (CCRC)

The application for re-designation and funding of the NIHR Cambridge Clinical Research Facility (CRF) was successful, with funding of

£15,200,000 from 1 September 2022 to 31 August 2027, representing an uplift of 30% on current funding. The review committee considered the quality and breadth of early translational and experimental medicine research and strategic plan to be strong, and that the application demonstrated very strong partnerships with industry, UKRI, other NIHR Infrastructure, charity partners and the wider NHS.

Cambridge led COVID-19 clinical trials

PROTECT-V (PROphylaxis for vulnerable paTiEnts at risk of COVID-19 infecTion), CI Rona Smith, is evaluating the use of agents to prevent COVID-19 in vulnerable patients, including kidney patients on dialysis or receiving immunosuppression for a renal transplant. The study is a 'platform trial', which allows new drugs to be added.

The first drug to be evaluated is niclosamide, a drug used to treat intestinal worms, which has shown activity against SARS-CoV-2 in the laboratory and is being delivered as a nasal spray. Sotrovimab, a fully humanised neutralising monoclonal antibody directed against the spike protein of SARS-CoV-2 was added in 2022.

1653 patients were randomsied in the niclosamide arm of the study, and follow up has been completed and data analysis is underway. The results will be presented as a late breaking clinical trial presentation at the European Renal Association meeting in Milan in June. Recruitment to the sotrovimab arm is ongoing.

3.20 Trust membership

The membership

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

Public Membership

Any person who is 16 years of age or over and who lives within our membership area is eligible for public membership.

Table 5: The membership area

Braintree District Council	Bumpstead electoral ward
Cambridge City Council	All wards
East Cambridgeshire District Council	All wards
East Hertfordshire District Council	Buntingford; Braughing and Mundens & Cottered electoral wards
North Hertfordshire District Council	Ermine; Royston Palace; Royston Meridian and Royston Heath electoral wards
South Cambridgeshire District Council	All wards
Uttlesford District Council	Ashdon; Clavering; Debden and Wimbish; Littlebury, Chesterford and Wenden Lofts; Newport; Saffron Walden Audley; Saffron Walden Castle; Saffron Walden Shire; The Sampfords; Takeley and Thaxted and the Eastons electoral wards
West Suffolk Council	Clare, Hundon and Kedlington; Exning All Haverhill Wards (West, North, East, South, Central and South East); Newmarket East; Newmarket North; Newmarket West and Withersfield electoral wards

Patient membership

Any individual who has been a patient at any of the Trust's hospitals from 5 July 1948, or who has been a carer of a patient who meets that criterion, is eligible for patient membership, regardless of where they live, as long as they are aged 16 years or over.

Staff membership

All staff at CUH with contracts of employment of at least 12 months, or contracts with no fixed term, are automatically members unless they choose to opt out. Registered volunteers are also automatically members of the staff constituency. The Trust greatly values the contribution that employees of partner organisations on the Campus make to CUH and for this reason staff membership includes, on application, all employees of organisations based on the Campus who provide services to CUH.

Membership data

At 31 March 2023, there were 20,400 members (2022: 19,810). The breakdown is as follows: patients 3,676 (2022: 3,854); public 4,549 (2022: 4,721) and staff 12,175 (2022: 11,235).

Membership strategy

The current Membership Engagement Strategy sets out our vision for a representative, active and engaged membership, grouped around three priorities:

1. Making the offer clear.
2. Building an active membership and improving representation from under-represented groups.
3. Providing regular, engaging communications.

The Membership Engagement Strategy Implementation Group meets regularly to oversee the implementation of the Strategy and reports to the Council of Governors.

3.21 Council of Governors

The Council of Governors is composed of 19 elected governors (eight patient, seven public and four staff) and 8 partnership governors (two further positions identified in the Constitution are not currently appointed to). The Council is chaired by the Trust Chair.

Dr Neil Stutchbury was elected unopposed as the new Lead Governor with effect from 1 October 2021.

Dr Jane Biddle was elected unopposed as the new Deputy Lead Governor with effect from 1 December 2021.

Table 6: Patient governors

The table below shows patient governors during 2022/23, representing and elected by the patient members of Cambridge University Hospitals NHS Foundation Trust.

Mr Brian Arney (until 18 December 2022)	Elected in 2021 for a first term of two years. Stood down from the Council of Governors in December 2022.
Miss Ruth Greene	Re-elected in 2022 for a third three-year term.

Dr Julia Loudon	Re-elected in 2021 for a third term of three years.
Dr David Noble	Elected in 2021 for a first term of three years.
Dr Colin Roberts	Re-elected in 2021 for a second term of two years.
Dr Howard Sherriff	Re-elected in 2022 for a second term of three years.
Dr Neil Stutchbury	Re-elected in 2021 for a second term of two years.
Mrs Adele White	Re-elected in 2021 for a second term of three years.

Table 7: Public governors

The table below shows public governors during 2022/23, representing and elected by the public members of Cambridge University Hospitals NHS Foundation Trust.

Dr Samira Addo	Elected in 2021 for a first term of three years.
Dr John Lee Allen	Elected in 2021 for a first term of three years.
Dr Jane Biddle	Re-elected in 2021 for a second term of two years.
Mr David Dean	Re-elected in 2021 for a second term of two years.
Ms Gemma Downham	Elected in 2021 for a first term of three years.
Ms Melisa Lee	Re-elected in 2022 for a second terms of three years.
Dr Carina Tyrrell	Elected in 2021 for a first term of two years.

Table 8: Staff governors

The table below shows staff governors during 2022/23, representing and elected by the staff members of Cambridge University Hospitals NHS Foundation Trust.

Mr Mahad Nur	Elected in 2022 for a first term of three years.
Ms Polly Rushton-Ray	Elected in 2021 for a first term of two years.
Ms Gill Shelton	Elected in 2021 for a first term of three years.
Dr Will Watson	Elected in 2021 for a first term of three years.
Mr Bill Davidson	Elected in 2019 for a first term of three years. Term ended on 30 June 2022.

Governor elections 2022

Governor Election turnout by constituency 2019, 2020, 2021 and 2022

Table 9: Election turnout

<table>
<tr><th>Constituency</th><th>2019</th><th>2020</th><th>2021</th><th>2022</th></tr>
<tr><td>Patient constituency</td><td>25.7%</td><td rowspan="3">Elections deferred to impact of Covid-19 pandemic</td><td>Candidates elected unopposed</td><td>18.3%</td></tr>
<tr><td>Public constituency</td><td>22.9%</td><td>17.2%</td><td>17.5%</td></tr>
<tr><td>Staff constituency</td><td>21.9%</td><td>17.5%</td><td>15.0%</td></tr>
</table>

Partnership governors during 2022/23, representing and appointed by external organisations to the Council of Governors are shown in the table below.

Table 10: Partnership governors

Anglia Ruskin University	Dr Annette Thomas-Gregory	Stood down from the Council of Governors in June 2022.
Anglia Ruskin University	Dr Rachael Cubberley	Appointed in June 2022 for a three-year term.
Cambridge Biomedical Campus Research Organisations	Ms Karen Woodey	Appointed in January 2021 for a three-year term.

Cambridge City Council	Cllr Mairead Healy	Re-appointed in May 2022 for a 12-month term.
Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)	Ms Jessica Bawden	Stood down from the Council of Governors in June 2022 when the CCG ceased to exist.
Cambridgeshire and Peterborough NHS Foundation Trust	Mr Stephen Legood	Re-appointed in February 2021 for a three-year term.
Cambridgeshire County Council	Cllr Gerri Bird	Re-appointed in June 2022 for a 12-month term.
Royal Papworth Hospital NHS Foundation Trust	Dr Stephen Webb	Appointed in October 2020 for a three-year term.
University of Cambridge	Professor Peter St George-Hyslop	Re-appointed in July 2021 for a three-year term.
University of Cambridge	Professor John Clarkson	Stood down from the Council of Governors from September 2022 while on sabbatical from his University role.
University of Cambridge	Professor Dame Carol Black	Appointed in September 2022 for a 12-month term while Professor John Clarkson is on sabbatical from his University role.

Register of governors' interests

At the time of their appointment, all Governors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an ongoing basis.

The register is available online at https://cuh.mydeclarations.co.uk/. The register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs.

Governor expenses

Governors participating in events such as Council meetings whose expenses are not paid by another organisation are entitled to claim reasonable expenses. Expenses are reimbursed at rates agreed by the Council of Governors, which has adopted HMRC approved amounts. Expenses to be reimbursed include:

Travel by car, motor cycle or bicycle; public transport on a like for like basis on provision of a receipt; receipted costs for caring arrangements at previously agreed rates of up to £10 per hour; expenses for a companion required to enable the individual to participate and costs for interpretation. Governor expenses are reported in the remuneration report at Section 3.22. The full policy is available from the Director of Corporate Affairs.

Table 11: Attendance at Council of Governors' meetings in 2022/23

Name	Title	Attendance
Dr Michael More	Trust Chair	2/4*
Dr Samira Addo	Public Governor	7/7
Dr John Lee Allen	Patient Governor	7/7
Mr Brian Arney	Patient Governor	4/4*
Ms Jessica Bawden	Partnership Governor	3/3*
Dr Jane Biddle	Public Governor	5/7
Cllr Gerri Bird	Partnership Governor	0/7
Prof Dame Carol Black	Partnership Governor	1/3*
Prof John Clarkson	Partnership Governor	1/3*
Dr Rachael Cubberley	Partnership Governor	4/5*
Mr Bill Davidson	Staff Governor	3/3*
Mr David Dean	Public Governor	5/7
Ms Gemma Downham	Public Governor	7/7
Ms Ruth Greene	Patient Governor	7/7
Cllr Mairead Healy	Partnership Governor	1/7
Ms Melissa Lee	Public Governor	7/7
Mr Stephen Legood	Partnership Governor	2/7
Dr Julia Loudon	Patient Governor	7/7
Mr David Noble	Patient Governor	3/7
Mr Mahad Nur	Staff Governor	3/3*
Dr Colin Roberts	Patient Governor	5/7
Ms Polly Rushton-Ray	Staff Governor	5/7
Ms Gill Shelton	Staff Governor	5/7
Dr Howard Sherriff	Patient Governor	7/7

Professor Peter St George Hyslop	Partnership Governor	3/7
Dr Neil Stutchbury	Patient Governor	7/7
Dr Annette Thomas-Gregory	Partnership Governor	0/1*
Dr Carina Tyrrell	Patient Governor	5/7
Dr Will Watson	Staff Governor	5/7
Dr Stephen Webb	Partnership Governor	1/7
Mrs Adele White	Patient Governor	3/7
Ms Karen Woodey	Partnership Governor	0/7

* Please note that the above table takes into account the following:
- Mike More was not eligible to attend three meetings due to conflicts of interest in relation to the agendas
- Brian Arney resigned as a Governor in December 2022
- Bill Davidson's term as a Governor ended in June 2022
- Muhad Nur's first meeting during his term was in September 2022
- Annette Thomas-Gregory stood down from the Council in June 2022 and was replaced by Rachael Cubberley
- John Clarkson temporarily stood down from the Council in September 2022 and was replaced by Carol Black
- Jessica Bawden stood down from the Council in June 2022 when the Cambridgeshire and Peterborough CCG ceased to exist

There were seven meetings of the Council of Governors during 2022/23, four in public and three confidential. The Chief Executive, Non-Executive Directors and Executive Directors also attended where appropriate.

Governor activities

During 2022/23 the Council of Governors continued to focus on ensuring that:

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

Governors' access to papers is via a secure portal. Governors are provided regularly with Trust news, wider NHS news, relevant national policy initiatives and press coverage information.

As part of the code of conduct, all governors on appointment/election are expected to sign up to the fact that they have read and will abide by our policy for governor communication with members and the public. The emphasis is, as always, on encouraging interaction, listening and capturing views, speaking on behalf of members and thereby being able to influence opinions and decisions before feeding-back to members and the public.

The Trust's Annual Public Meeting took place on 28 September 2022 and provided attendees with a review of 2021/22 and an update on current and future developments.

Representatives of governors attended the annual NHS Providers' conference in order to network with governors from other trusts and to share good practice.

The Lead Governor reports to all Board of Directors' meetings held in public. Governors meet informally with Non-Executive Directors on a quarterly basis to discuss Trust issues, priorities and developments as they arise. They also attend Board assurance committees in an observer capacity. These interactions assist them in fulfilling their duty to hold the Non-Executive Directors to account.

3.22 Remuneration report

Annual statement on remuneration

In 2022/23, the Board of Directors' Remuneration and Nomination Committee maintained its overview of Executive Directors' salaries, following the principles established for Executive and senior salaries in 2015/16 (from the external review commissioned in that year).

There was an initial 3.5% pay uplift in line with the original national agreement, then a further 2% and £1600 backlog bonus was applied retrospectively. The payment date for this is June 2023.

Senior managers' remuneration policy

CUH is aware of public attention given to the levels of remuneration of senior managers within the NHS. CUH has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

To determine Board of Director level salaries, the Remuneration and Nomination Committee may use one or more of the following:

- Benchmarking data surveyed confidentially among CUH's peer group.
- NHS Employers' annual salary survey of NHS Chief Executives and Executive Directors.
- IDS NHS Boardroom pay report and other benchmark information.
- NHS and other relevant advertised jobs databases.
- The prevailing market position, including the ability to recruit and retain individuals.

Any amendments to salary are decided by the Remuneration and Nomination Committee on the basis of the size and complexity of the job portfolio. Annual salary is inclusive of other payments such as bonus, overtime, long hours, on-call, standby, etc. Additional payments do not feature in Executive Directors' remuneration. The Trust has no plans to introduce performance related pay. The salaries of the Medical Director and the Director of Improvement and Transformation are in accordance with the terms and conditions of service of the consultant contract 2003 plus a responsibility allowance determined by the Committee payable for the duration of office.

Chief Executive and Executive Director performance is measured against objectives set at the beginning of the financial year and agreed by the Remuneration and Nomination Committee.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the 'Agenda for Change: NHS terms and conditions of service' handbook (section 16); or, for those above the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Pay awards agreed nationally for other staff groups working at CUH, including staff on Agenda for Change contracts and medical and dental staff, are determined by the Department of Health/NHS Pay Review Body, which looks at salaries and pay conditions across the NHS.

The Remuneration and Nomination Committee follows Trust policies on diversity and inclusion as described in the staff report. This is in support of the Trust's workforce strategy, of which inclusion is one of the five commitments.

Service Contract Obligations

All senior managers have a standard CUH employment contract and no service contracts are in place. Each individual Executive Director and Non-Executive Director has their appointment date, unexpired term and notice period listed in table 13.

Policy on Payment for Loss of Office

All senior managers are required to have a six-month period in their employment contract. Compensation in the event of early termination for substantive directors is in accordance with contractual entitlements. There were no exceptions to this policy during 2022/23.

Future Policy table

The future policy table below gives a description of each of the components of the remuneration package for senior managers, which comprise the wider senior managers' remuneration policy.

Table 12: Future Policy table

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to assess performance
Salary			
Salary is determined using benchmark data in order to attract, reward and retain individuals of the right caliber to lead the delivery of the Trust's aims and objectives.	Agreed by the Remuneration and Nomination Committee using benchmark ranges. Salaries are reviewed annually to account for the cost of living, and any changes are normally effective from 1 April each year.	As set out in the Statement of remuneration found in Table 14	The Trust's values-based appraisal and objective setting process is used for all staff, including Executive Directors.
Pension-related benefits			
Pension benefits (which may be opted out of) are part of the total remuneration of Executive Directors to attract, reward and retain individuals to lead the delivery of the Trust's aims and Objectives.	Pension is available as a benefit to Executive Directors and follows the national NHS Pension Scheme contribution rules	Contributions and entitlements are in accordance with the NHS Pension Scheme for all employees who are members.	Not applicable.
Pension Contribution Alternative Award Policy			
There is no pension contribution alternative award policy in place.	Not applicable.	Not applicable.	Not applicable.

Table 13: Executive Director contractual terms

Executive Director	Date in post	Unexpired term	Notice
Chief Executive	16.11.15	Permanent	Six months
Chief Finance Officer	09.11.20	Permanent	Six months
Chief Nurse	23.07.18	Permanent	Six months
Chief Operating Officer	06.04.20	Permanent	Six months
Director of Corporate Affairs	15.05.17	Permanent	Six months
Director of Improvement and Transformation	01.02.18 to 17.02.23	Permanent	Six months
Director of Strategy and Major Projects	01.06.20	Permanent	Six months
Director of Workforce	01.04.14	Permanent	Six months
Medical Director	01.11.17	Less than three years	Six months

Remuneration and Nomination Committee of the Board of Directors

Membership of the committee comprises Non-Executive Directors and the Trust Chair with the Chief Executive in attendance. The Director of Workforce and Director of Corporate Affairs also attend meetings of the committee where appropriate.

The Committee met three times during 2022/23. The Committee was chaired by Ali Layne-Smith, who was appointed as Chair in March 2022.

The role of the Committee is to:

1. Act under the delegated authority of the Board of Directors to approve and oversee the arrangements for the appointment, termination and remuneration of the Chief Executive and all Executive Directors. In addition, the Committee will be responsible for agreeing the remuneration for any other posts with remuneration outside the Agenda for Change pay framework.

Statement of directors' remuneration - Subject to Audit

The Board's Remuneration and Nomination Committee oversees pay arrangements for posts whose salaries are not determined through national term and conditions. This includes but is not limited to the Executive Directors of the Trust (both voting and non-voting executive Board

members). The Committee is mindful of discharging its obligations in respect of salaries above £150,000. This salary is updated as set out in the guidance from NHS England updated in March 2018. It considers each new post and the process to be followed on an individual basis.

The Governors' Nomination and Remuneration Committee establishes remuneration for Non-Executive Directors.

NHS England published in September 2019 a new framework to align remuneration for chairs and Non-Executive Directors (NEDs) of NHS trusts and NHS foundation trusts. For NEDs this required NHS foundation trusts to move towards a standard basic remuneration of £13,000 per annum from 1 April 2021, or to provide the rationale for diverging from this in the trust's Annual Report. At the point at which the national framework was introduced, the standard remuneration for the Trust's Non-Executive Directors was £14,000 per annum and had been set at this level since 2012. As this remuneration is consistent with the peer average for 'large' foundation trusts (£14,426, as published in the annual NHS Providers Remuneration Survey, June 2021), the Council of Governors agreed in 2020 to retain the existing level of NED remuneration at £14,000 per annum and re-confirmed this position in 2021 and 2022.

The Trust's approach to the remuneration of the Chair and additional responsibility allowances for Non-Executive Directors is compliant with the national framework.

Fair pay disclosures - Subject to Audit

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2022-23 was £297,500 (2021-22, £272,500). This is a change between years of 9.17%.

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

For employees of the Trust as a whole, the range of remuneration in 2022/23 was from £6.44 to £298,074.00 (2021/22 £9.38 to £272,278).The percentage change in average employee remuneration between years 2022/23 and 2021/22 is 7.5% (2020/21 and 2021/22 3.7%).

No employees received remuneration in excess of the highest-paid director in 2022-23.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2022/23	25th percentile	Median	75th percentile
Salary component of pay	50,452	38,078	25,037
Total pay and benefits excluding pension benefits	50,452	38,078	25,037
Pay and benefits excluding Pension: Pay ratio for highest paid director	5.90	7.81	11.88

2021/22	25th percentile	Median	75th percentile
Salary component of pay	£46,527	£33,983	£23,653
Total pay and benefits excluding pension benefits	£46,527	£33,983	£23,653

Pay and benefits excluding pension: pay ratio for highest paid director	5.86:1	8.02:1	11.52:1

Table 14: Statement of remuneration 2022/23 - Subject to Audit

Name and title of senior manager	Salary (bands of £5,000) £'000	Taxable Expense payments taxable to the nearest £100	Performance pay and bonuses (bands of £5,000) £'000	Long-term performance pay and bonuses (bands of £5,000) £'000	All pension-related benefits (bands of £2,500) £'000	Other (total to the nearest £5k) £s to nearest £5k	Total (a to e) (bands of £5,000) £'000
Nicola Ayton, Chief Operating Officer	195-200	-	-	-	35-37.5	0	230-235
Dr Ewen Cameron, Director of Improvement and Transformation *	55-60	-	-	-	40-42.5	145-150	245-250
Mike Keech, Chief Finance Officer	175-180	1,800 ***			17.5-20	-	195-200
Nicholas Kirby, Interim Director of Strategy and Major Projects	110-115	-	-	-	-	-	110-115
Dr Ashley Shaw, Medical Director *	85-90	-	-	-	-	180-185	270-275
Roland Sinker, Chief Executive	295-300	11,400 ***	-	-	-	-	305-310
Claire Stoneham, Director of Strategy and Major Projects	135-40	-	-	-	32.5-35	-	165-170
Lorraine Szeremeta, Chief Nurse	170-175	-	-	-	40-42.5	-	210-215

Ian Walker, Director of Corporate Affairs	150-155	-	-	-	40-42.5	-	190-195
David Wherrett, Director of Workforce	170-175	-	-	-	20-22.5	-	190-195
Daniel Abrams, NED	15-20	-	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Dr Annette Doherty, NED	5-10	-	-	-	-	-	5-10
Professor Ian Jacobs	10-15	-	-	-	-	-	10-15
Alison Layne-Smith NED	10-15	-	-	-	-	-	10-15
Professor Patrick Maxwell, NED **	0	-	-	-	-	-	0
Dr Michael More, Chair	60-65	-	-	-	-	-	60-65
Professor Sharon Peacock, NED	10-15	-	-	-	-	-	10-15
Rohan Sivanandan NED	10-15	-	-	-	-	-	10-15

* Other remuneration for two Directors, relates to their pay in respect of clinical duties.

** Prof Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2022/23 to the University of Cambridge in recognition of his time spent at Board meetings.

*** Taxable expense payments relate to salary sacrifice lease cars.

Table 15: Statement of remuneration 2021/22

Name of senior manager	2021/22 Salary & fees (in bands of £5k) £000s (Band of £5k)***	2021/22 All taxable benefits (total to the nearest £100) £s (nearest £100)	2021/22 Annual performance related bonuses £000s (Band of £5k)	2021/22 Long-term performance related bonuses £000s (Band of £5k)	2021/22 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2021/22 Other (total to the nearest £5k) £s to nearest £5k	2021/22 Total (bands of £5k) £000s (Band of £5k)
Nicola Ayton, Chief Operating Officer*	70-75	-	-	-	17.5-20	-	90-95
Dr Susan Broster, Interim Director of Improvement and Transformation**	60-65	-	-	-	37.5-40	145-150	245-250
Dr Ewen Cameron, Interim Chief Operating Officer/ Director of Improvement and Transformation**	65-70	-	-	-	77.5-80	160-165	310-315

Michael Keech, Chief Finance Officer	165-170	900	-	-	40-42.5	-	205-210
Dr Ashley Shaw, Medical Director**	85-90	-	-	-	362.5-365	170-175	625-630
Roland Sinker, Chief Executive	270-275	11,400	-	-	-	-	280-285
Claire Stoneham, Director of Strategy and Major Projects	150-155	-	-	-	32.5-35	-	185-190
Lorraine Szeremeta, Chief Nurse	160-165	-	-	-	62.5-65	-	225-230
Ian Walker, Director of Corporate Affairs	140-145	-	-	-	45-47.5	-	185-190
David Wherrett, Director or Workforce	155-160	-	-	-	55-57.5	-	215-220
Daniel Abrams, NED	15-20	-	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Dr Annette Doherty, NED	0	-	-	-	-	-	0

Dr Michael Knapton, NED	10-15	-	-	-	-	-	10-15
Alison Layne-Smith, NED	0-5	100	-	-	-	-	0-5
Professor Patrick Maxwell, NED***	0	-	-	-	-	-	0
Dr Michael More, Chair	60-65	-	-	-	-	-	60-65
Professor Sharon Peacock, NED	10-15	-	-	-	-	-	10-15
Shirley Pointer, NED	5-10	-	-	-	-	-	5-10
Rohan Sivanandan, NED	5-10	100	-	-	-	-	5-10

* Nicola Ayton was on maternity leave until October 2021 and then on external secondment until 13 March 2022.
**Other remuneration for three Directors relates to their pay in respect of clinical duties.
*** Prof Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2021/22 to the University of Cambridge in recognition of his time spent at Board meetings.

Statement of directors' and governors' expenses

Directors and governors are reimbursed for expenses incurred on Trust business in accordance with agreed Trust policies. Where applicable, these are subject to income tax and national insurance in accordance with HMRC legislation and guidance.

Table 16: Governors' expenses 2022/23

	Mileage (Car/Cycle)	Rail/bus Travel	Taxis	Hotel Accom.	Meals/Subsistence and parking	Conference fees	Other	Total 2022/23	Total 2021/22
Samira Addo	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
John Lee Allen	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Brian Arney	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£23.00
Jessica Bawden	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Jane Biddle	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Gerri Bird	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Carol Black	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
John Clarkson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Rachel Cubberley	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Bill Davidson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Dean	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Gemma Downham	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ruth Greene	£0.00	£0.00	£31.50	£0.00	£0.00	£0.00	£0.00	£31.50	£0.00
Mairead Healy	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Melissa Lee	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Stephen Legood	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Julia Loudon	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

David Noble	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Mahad Nur	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Colin Roberts	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Polly Rushton-Ray	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Gill Shelton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Howard Sherriff	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Peter St George-Hyslop	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Neil Stutchbury	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Thomas-Gregory	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Carina Tyrrell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Will Watson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Stephen Webb	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Adele White	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Karen Woodey	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

Table 17: Directors' expenses 2022/23

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels	Meals and Parking	Other	**Total 2022/23**	**Total 2021/22**
Daniel Abrams	£0.00	£95.43	£0.00	£0.00	£0.00	£0.00	£0.00	£95.43	£0.00
Nicola Ayton	£0.00	£0.00	£0.00	£0.00	£584.25	£0.00	£0.00	£584.25	£0.00
Susan Broster	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Ewen Cameron	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Adrian Chamberlain	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Doherty	£0.00	£435.11	£0.00	£0.00	£0.00	£49.40	£10.00	£494.51	£0.00

	Travel Home to Trust	Mileage business	Rail travel	Taxi	Hotels	Meals and Parking	Other	**Total 2022/23**	**Total 2021/22**
Nicholas Kirby	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael Keech	£0.00	£0.00	£201.80	£14.70	£0.00	£41.75	£0.00	£258.25	£0.00
Ali Layne-Smith	£0.00	£68.58	£293.50	£123.07	£278.01	£103.50	£0.00	£866.66	£80.15
Patrick Maxwell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael More	£0.00	£51.89	£0.00	£101.60	£0.00	£200.67	£0.00	£354.16	£58.38
Sharon Peacock	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Ashley Shaw	£0.00	£52.12	£0.00	£0.00	£0.00	£0.00	£0.00	£52.12	£35.30
Claire Stoneham	£0.00	£0.00	£67.60	£0.00	£0.00	£17.40	£0.00	£85.00	£293.05
Roland Sinker	£0.00	£0.00	£5.00	£452.48	£0.00	£0.00	£14.99	£472.47	£79.20
Rohan Sivanandan	£0.00	£0.00	£173.70	£95.30	£229.00	£0.00	£0.00	£498.00	£99.75
Lorraine Szeremeta	£0.00	£0.00	£49.80	£0.00	£259.00	£6.10	£0.00	£314.90	£0.00
Ian Walker	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Wherrett	£0.00	£0.00	£0.00	£29.98	£0.00	£0.00	£0.00	£29.98	£0.00

Table 18: Pension benefit 2022/23

Name and title	Real increase / (decrease) in pension at pension age	Real increase / (decrease) in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash equivalent transfer value at 1 April 2022	Real increase / (decrease) in cash equivalent transfer value after deductions	Cash equivalent transfer value at 31 March 2023	Employers contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Nicola Ayton, Chief Operating Officer	2.5-5	0	20-25	0	161	19	212	27
Dr Ewen Cameron, Director of Improvement and Transformation	2.5-5	0-2.5	50-55	90-95	825	41	913	17

Mike Keech, Chief Finance Officer	0-2.5	0	15-20	0	131	6	151	10
Dr Ashley Shaw, Medical Director	0	0	45-50	105-110	1053	0	846	9
Claire Stoneham, Director of Strategy and Major Projects	2.5-5	0	5-10	0	47	8	75	22
Lorraine Szeremeta, Chief Nurse	2.5-5	0	60-65	125-130	998	38	1090	24
Ian Walker, Director of Corporate Affairs	2.5-5	0-2.5	35-40	45-50	560	32	631	21
David Wherrett, Director of Workforce	0-2.5	0	70-75	145-150	1407	35	1494	8

* Roland Sinker and Nicholas Kirby chose to not be a member of the pension scheme during the reporting period.

Table 19: Pension benefit 2021/22

Name and title	Real increase / (decrease) in pension at pension age	Real increase / (decrease) in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash equivalent transfer value at 1 April 2021	Real increase / (decrease) in cash equivalent transfer value after deductions	Cash equivalent transfer value at 31 March 2022	Employers contribution to stakeholder pension
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	£000	£000	£000	£000
Nicola Ayton Chief Operating Officer *	0-2.5	0	15-20	0	133	3	161	26
Susan Broster Director of Improvement and Transformation	2.5-5	0-2.5	35-40	60-65	570	33	625	17

Dr Ewen Cameron Director of Improvement and Transformation	2.5-5	5-7.5	45-50	85-90	731	71	825	19
Mike Keech Chief Finance Officer	2.5-5	0	15-20	0	100	6	131	24
Dr Ashley Shaw Medical Director	15-17.5	40-42.5	55-60	145-150	737	305	1053	7
Roland Sinker Chief Executive	0	0	0	0	0	0	0	0
Claire Stoneham Director of strategy and Major Projects	2.5-5	0	5-10	0	20	5	47	22
Lorraine Szeremeta Chief Nurse	2.5-5	2.5-5	55-60	120-125	916	54	998	23
Ian Walker Director of Corporate Affairs	2.5-5	0-2.5	30-35	45-50	502	35	560	21

David Wherrett Director of Workforce	2.5-5	0-2.5	65-70	145-150	1311	66	1407	23

* Nicola Ayton was on maternity leave until October 2021 and then on external secondment until 13 March 2022.

Roland Sinker chose to not be a member of the pension scheme during the reporting period.

These pension disclosures relate to directors who were members of the NHS Pension Scheme during the financial year. The figures represent estimates by the NHS Pensions Agency of the theoretical value of each director's pension "fund" at the start and end of the financial year. The difference between these two values is taken to represent the director's pension benefits for the year. Any benefits earned in this way remain in the pension scheme until the director retires in accordance with the rules of the NHS Pension Scheme. These rules are the same for both directors and staff.

Roland Sinker
Chief Executive
27 June 2023

3.23 Staff report

Staff numbers

As of 31 March 2023, the Trust had 18 directors (thirteen male and five female) and 12,111 employees (3,246 male and 8,865 female).

Table 20: Staff numbers

Average number of employees (WTE basis)	2022/23 Total Number	2022/23 Permanent Number	2022/23 Other Number	2021/22 Total Number	2021/22 Permanent Number	2021/22 Other Number
Medical and dental	1,670	677	993	1,598	652	946
Ambulance staff	0	0	0	0	0	0
Administration and estates	2,737	2,351	386	2,663	2,308	355
Healthcare assistants and other support staff	2,091	1,733	358	2,086	1,748	338
Nursing, midwifery and health visiting staff	3,910	3,437	474	3,709	3,273	436
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	922	836	86	906	821	85
Healthcare science staff	621	567	55	589	547	42
Social care staff	0	0	0	0	0	0

Average number of employees (WTE basis)	**2022/23**	**2022/23**	**2022/23**	**2021/22**	**2021/22**	**2021/22**
	Total Number	**Permanent Number**	**Other Number**	**Total Number**	**Permanent Number**	**Other Number**
Agency and contract staff						
Bank staff						
Other	0	0	0	0	0	0
Total average numbers	**11,951**	**9,600**	**2,351**	**11,551**	**9,349**	**2,202**

Recruitment and retention

To support our recruitment and retention strategy the following is in place:

- work/life balance schemes to offer opportunities for part time hours and flexible working along with comprehensive childcare facilities (two on-site nurseries and access to a local discounted holiday play scheme)
- 'Advantage' salary sacrifice scheme offering a wide range of options for staff to make tax and NI savings
- annual leave purchase scheme
- eldercare/family support schemes
- NHS pension scheme
- a range of on-site facilities – leisure and social centre (Frank Lee Centre)
- comprehensive range of staff engagement surveys and many joint working initiatives with staff and trade unions
- occupational health service including Health Assured counselling service and a range of health and well-being initiatives. The trust has enhanced its Psychological wellbeing offer for staff since in response to the Covid-19 pandemic
- onsite shopping and eating services
- range of leadership and employee development opportunities along with continuous professional development
- employee referral scheme which offers a monetary incentive for employees to refer potential nursing candidates who are successfully employed by CUH
- exit questionnaire in which leavers are contacted and given the opportunity to feed back so that we can improve our employees' experience at work
- deposit loan scheme of up to £3,000 of all staff Bands 2 – 6 to cover the first month's rent and deposit for a new property, open to both starters and existing staff for a new property, open to both starters and existing staff

- hardship loan up to £800 or 5% of salary for bands 2 - 6.
- Welcome subsidy for band 5 and 6 nurses, ODPS and Radiographers.
- Centralised admin for band 2 and 3 positions to create a talent pool of appointable candidates.

Staff turnover

Staff turnover describes the rate that employees leave an establishment and is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. This excludes all fixed term contracts, including junior doctors.

The Trust's staff turnover rate has been decreasing since July 2022, and at the end of March 2023 it was 13%.

Our role as a local employer

CUH is an important local employer and is constantly seeking ways to develop its role and to work with the local community to develop pathways into employment and training for disadvantaged groups. We offer a range of schemes: work experience, work shadowing, volunteering opportunities, and work with the long-term unemployed including through the Prince's Trust. We are committed to promoting social mobility; this is about creating a stronger, fairer society in which people from all backgrounds can realise their potential.

We have a range of learning and development opportunities which include apprenticeships to degree level and pathways to professionally registered professions for new applicants and existing employees. We value the diversity of our workforce and the strength this brings to the communities we serve.

Information about staff sickness

The information in the table below is compiled on a calendar year basis according to national requirements. It accounts for days lost due to sickness absence only and does not include any days lost due to self- isolation relating to Covid-19.

Table 21: Staff sickness

	2022/23	2021/22
Total days lost	117,659	104,845
Total staff years	10,805	10,676
Sickness absence rate	4.8%	4.4%
Average working days lost per WTE	11	10

Equality, diversity and inclusion

Equality, diversity and inclusion are key principles in how we work together at CUH and are integral to how we improve patient care, support our staff and build for the future in a way that is safe, kind and excellent.
Inclusion is a key Workforce priority. We actively seek to drive out inequality, recognising that we are stronger as an organisation that values difference and inclusion. We do not tolerate any form of discrimination, bullying or violence; we are open and inclusive, making CUH a place we all feel we belong and the best place to work.

We want every individual to feel safe and included at CUH, that they belong and can be themselves at work. And we expect that every individual plays their part in creating that culture for their colleagues too, treating others with kindness and respect and supporting each other.

Our Inclusion Workforce objectives for 2022/23

- Protecting our staff against harassment discrimination and victimisation
- Building thriving staff networks
- To become an antiracist organisation, implementing the WRES action plan
- To implement WDES action plan
- Career progression for all

Our Inclusion Service objectives for 2022/23

- We want equity of access, outcomes and experience for everyone.
- We recognise and want to address current, and often long standing, health inequalities.

Governance: The Trust's Equality, Diversity and Inclusion Committee chaired by the Chief Nurse, with Vice Chair Director of Workforce, provides governance and oversight for our Equality Diversity and Inclusion strategy, policies and action plans.
An **EDI strategy group** was formed in 2022 to:

- Articulate specific goals for CUH to seek over the next 3 years to improve EDI and reduce health inequalities among our patients;
- Develop, resource and implement an action plan for delivering these goals; and
- Embed oversight of the plan through established CUH groups (ME; EDI and Quality Committees) by December 2022.

Membership of the EDI Strategy Group

The group comprises:

- Roland Sinker, Chair (Chief Executive)
- Rohan Sivanandan (Non-Executive Director)
- David Wherrett (Director of Workforce)
- Lorraine Szeremeta (Chief Nurse)
- Ashley Shaw (Medical Director)
- Ian Walker (Director of Corporate Affairs)
- Dan Northam Jones (Director of Strategy) until parental leave; then India Miller

The EDI srategy group has initiated a work programme to drive this work forward across CUH through three phases over the first six months:

1. Gathering our baseline position – including by:
    a. Reviewing current national, regional, ICS and CUH commitments on EDI and health inequalities
    b. Assessing current data quality and completeness
    c. Drawing insights from currently available data
    d. Identifying and involving people at and around CUH with specialist expertise
    e. Identify where we have the greatest resources and potential to influence across the system (e.g. in research and innovation)
    f. Mapping current activities underway with patients, staff and our population
    g. Using this information to refine our hypotheses for our work going forward

2. Setting ambition and planning for delivery – including by:
    a. Agreeing specific goals that CUH should commit to, including measurable impacts over the next 1-2 years
    b. Identifying gaps in current activities for meeting these goals, and how to fill these
    c. Proposing appropriate coordinating mechanisms for this work on an ongoing basis
    d. Identify where cultural change may be required, and how to achieve this

e. Securing sufficient ongoing buy-in and resource to deliver the action plan

3. Planning how CUH can oversee and implement this work over the coming years – including by:
   a. Assessing what ongoing capacity is required at CUH to drive this agenda over the coming years
   b. Assessing how CUH can make EDI part of everyone at CUH's role
   c. Articulating how the EDI Committee can oversee the totality of this work
   d. Measuring the impact of our work and tracking progress against our defined goals

To resource this work an Interim Director of EDI has been appointed in March 2023 for 12 months to support during this period.

The Strategy Group and Interim Director work closely with those already working on elements of this agenda – including:

- Other CUH colleagues leads working on: Service EDI , Clare Hawkins, Head of nursing (corporate) James Taylor, project manager and Workforce Head of EDI, Monica Jacot
- ICS public health and health inequalities teams: Chris Gillings, Jonathan Bartram
- Staff networks
- Shelford Group

EDI is part of everyone at CUH's role – not just those listed above.

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

- EDI operational group – chaired by Head of Nursing corporate
- Accessible Information implementation group
- Learning Disability and autism working group
- Carers Strategy group
- Cancer Patient Partnership Group
- ACTIVE Children's and Young Peoples Active Board
- Outpatient experience group
- Maternity: Rosie Maternity Network Voice Partnership (RMNVP) engagement event held at Cambridge Central Mosque
- CUH Patient Communications Group

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

Race Equality And Cultural Heritage (REACH) staff network (previously called BAME staff network). To support race equality and inclusion which has coproduced our Workforce Race Equality Standard (WRES) action plan and the chair and members were part of the staff health task force to review the staff risk assessment during COVID. The REACH Network executive sponsor is Roland Sinker, CEO.

The Purple Network is for staff with hidden or visible disabilities, physical, or mental health conditions or who are neuro-divergent and allies to work together to promote inclusion for everyone at CUH. The Purple network has co-produced our Workforce Disability Equality Standard (WDES) action plan. Executive Sponsor until March 2023 was Ewen Cameron, Director of Transformation who has now left the Trust and a replacement being recruited

The Open Minds Network is for staff who are committed to changing the way we all think and act about mental health in the workplace and creates a safe space for staff to share ideas on how to achieve this. Executive sponsor vacancy being recruited by Director of corporate affairs.

LGBT+ staff network is a group for CUH staff members who are part of the LGBT+ community and allies who wish to support us in promoting equality and championing LGBT+ staff.

The networks support both our workforce EDI objectives and contribute to service equality objectives to tackle health Inequalities.

EDI Staff network governance group is chaired by the Head of EDI (workforce) to support our networks to thrive and was established in March 2022 after the completion of Staff network development programme in 2021/22. The purpose of the group is to provide governance and effective joint working between the EDI team and EDI staff networks to support the development and implementation of the Trust's EDI strategy and action plans.

The Network chair has formalised protected time off for network chairs and co-chairs of 15 hours per month. This has been approved and funding granted for payment of a flat sum honorarium from 1 April 2023 to network chairs following an election process Each network has an allocated budget and is developing a business plan.
Key Service EDI activity in 2021/22 included:

- The ACTIVE board for children and young people have reviewed written information for children and made the masks more child friendly; looking at the online information reviewing the CUH new website, and information about the pandemic available to children and signposting mental well

being resources for young people; creating bespoke quizzes for young people and information for young people about mental wellbeing.

- Carers' passport promoted.
- Promotion of Hidden Sunflower scheme.
- Launch of refreshed accessible public website with accessible Recite Me toolbar.
- Learning disability gap analysis undertaken and Learning disability group coproduced action plan as a result:
  - 1 of 8 NHS Trusts selected to participate in national independent voice product review which focuses on the acute care of people with a learning disability or autism
  - Consultation over an easy read leaflet for an EEG produced by clinical psychology
  - Development of easy read Friends and Family Test feedback form
  - Internal training/education and liaison with community LD teams to ensure correct support is in place
- Rosie Maternity Network Voice Partnership (RMNVP) engagement listening events held including in Cambridge central Mosque
- Supply of clear face masks developed by clinical engineering team for use in green areas during the pandemic to aid communication.
- Supply of electronic tablets in clinics and wards with interpreting software for communication with patients for whom English is not their first language
- Collection of patient demographic data: Changes to EPIC Electronic patient record now collects sexual orientation and patients can record this on My Chart
- In partnership with Cambs Heathwatch, Gypsy Traveller cultural competence training provided for clinical staff
- Cancer Patient Partnership Group – engaging with diverse community groups to discuss their needs for the design of new Cambridge Cancer Research hospital
- Health Inequalities Action Plan being developed- Linked to the NHS 5 Key Priorities and Cambridgeshire & Peterborough ICS Health Inequalities Strategy
- Overall we have a programme of work across all nine protected characteristics and addressing important cross-cutting issues. Together there are >50 initiatives around EDI related to patients in train to meet the following service equality objectives:
  - Equity of Access
  - Equity of Experience
  - Equity of Outcomes
  - Everybody Counts – and every patient's demographic details are recorded and monitored to review progress on meeting all of the above objectives.

Workforce Race Equality Standard (WRES)

Our latest 8th Workforce Race Equality Standard WRES data Report and action plan, which is coproduced with REACH Network staff and directors, was approved by the Board and is published on the Trust public website here Workforce Race Equality Standard (WRES) | CUH
The WRES action plan was refreshed to align with the East of England Anti-racism strategy. The Trust's WRES implementation group meets to ensure the action plan has traction.

The WRES action plan focuses on the following three key areas:

- Inclusive leadership and management
  - Proportionate representation in senior roles and decision making
  - Educating our leaders and supporting their commitment to antiracism
- Equitable and inclusive talent management and clinical career progression
- Protection of staff from racial harassment and abuse from patients/public and colleagues.

Key actions in 2022/23 include:

- Review of QSIS datix reporting categories to make it easier simpler to report racial harassment by patients, public or staff
- As a development opportunity a WRES project lead was recruited internally for 6 months to engage across the Trust to refresh the action plan
- The CUH WRES Project Lead is supporting leaders in each division to implement recommendations to debias recruitment as set out in the No More Tick Boxes Report (2021).
- Debiasing recruitment working group has been set up
- The REACH staff network co-chairs and EDI team produced a week of events and guest speakers in October to mark Black History month starting with the relaunch and rebranding of the REACH staff network
- 250 leaders have attended Leading Inclusively with Cultural Intelligence (CQ™) masterclasses and action planning workshops facilitated by above Difference from phase 1 during 2021 and Phase 2 of the programme in 2022. 4 CUH leaders have been trained as CQ™ facilitators to sustain this programme
- A range of anti-racism resources, videos, e-learning and webinars are available on the staff portals.
- Partnered with external organisation, BRAP, to deliver pilot workshop for teams in April 2022. BRAP to deliver corporate master classes Be Curious about Race to equip leaders to be confident talking about race and be accountable for tackling racism in the workplace.

- Diverse Interview Panel members recruited by the previous Chair of the BAME Staff network, Erica Chisanga, have been active in recruiting to posts for band 8a positions and above and all senior appointments including Divisional and Clinical Directors, Executive and Non-Executive Directors.
- Cultural Ambassadors have been informally mentoring Black and minority ethnic staffas well as being involved in disciplinary pre action reviews to seek to eliminate cultural bias and ensure fair people management processes as part of a just and learning culture
- Bi- Monthly bespoke training has been held for DIP in order to grow the pool of DIPs and roll out their involvement in recruitment and selection at all bands in the organisation by 2028
- Two webinars to raise awareness on learning opportunities and different strategies for career development for Black and minority ethnic nurses and Midwives held in 2022 organised by Cultural ambassador.

Ethnicity Pay gap report 2022 has been approved and published on our website here.

This is the first Ethnicity Pay Gap report for Cambridge University Hospitals NHS Foundation Trust, which is a welcome addition to workforce information that enables the Trust to monitor diversity and inform decision making regarding workforce inequalities. Voluntarily publishing this report illustrates our commitment to transparency, fairness and inclusion to all of our staff, patients and the wider community. At the end of March 2022, the mean ethnicity pay gap was 1.7% in favour of staff reporting as white and there was no median ethnicity pay gap. When looking further we can see that in all pay bands above band 8b or over a salary of £61,000 there is a pay gap in favour of staff reporting as white. Actions are identified at the end of this report, which are aligned to our Workforce Race Equality Standard (WRES) agenda, inclusive of the Race Disparity Ratio and our Model Employer targets. We look forward to further detailed reviews that will explore this subject in greater detail, including intersectional analysis of other protected characteristics, analysis of data relating to specific ethnic groups and further work to engage with staff and our networks on this subject to understand experience

Workforce Disability Equality Standard (WDES)

The Trust's Workforce Disability Equality Standard (WDES) action plan, co-created with disabled staff is approved by the Trust Board and published on the Trust's website here.

The Trust is a 'Disability Confident' employer and is a signatory of the 'Mindful Employer Charter' for 'Employers who are Positive about Mental Health' and the trust is a member of Purple Space.

The 4th WDES data set was submitted in July 2022. The WDES implementation group provides governance and oversees WDES action plan progress.

The three priority areas of the WDES action plan are:

- Reasonable adjustments
- Career progression
- Creating a supportive inclusive culture

Key activity in 2022/23 has included:

- Disabled staff have curated their own stories
- Promotion of the *Purple Passport* –a tool for disabled staff to have a conversation with their line manager to discuss their disability/health condition and agree reasonable adjustments.
- Purple Network and EDI team organised events to mark Disability history month. The hospital chimney was lit up in December Purple for Purple Light Up to celebrate UN International Day for Disabled Persons
- Central adjustments budget and centralised adjustments process implemented
- Neurodiversity guide coproduced with neurodiverse employees and launched March 2022
- April 2022 Discovery workshop with Lexxic to coproduce Neuro-inclusion action plan
- The Communications team and EDI team continue to work to curate additional stories of disabled and neurodiverse staff as part of My CUH Story and other work streams.
- Following discussion with the Purple Network and WDES Implementation Group, two further pilot disability awareness sessions were held in July 2022. Members of the Purple Network volunteered to attend both in order to help evaluate which is most suitable to take forward for rollout which is being further developed for outpatients services
- Open Minds network held Open Minds Performance charity event for World Mental Health Day

LGBT+ activity:

- LGBT+ awareness training sessions by the Kite Trust held virtually.

- Selection of guest speakers talks recorded and live streamed on Facebook for IDAHOBIT and collaborated with Papworth LGBT staff network
- Entered Stonewall Workplace Equality Index (WEI) 2023 which will inform future actions
- LGBT+ network took part in Cambridge Pride 2022
- Lobbying by our LGBT+ network to senior leaders at national level to request commitment to developing LGBT+ workforce equality standard metrics.

Collaboration with our external partnerships to support EDI:

- NHS Employers Diversity and Inclusion Partners Alumni programme
- WRES experts Midlands & East
- Regional East of England inclusion leads group
- Cambridgeshire and Peterborough ICS system working
- National NHS England WRES team
- National NHS England WDES team
- Employers Network for Equality and Inclusion (ENEI) member so all staff have access to resources
- Purple Space member
- The Kite Trust and Encompass Network
- Stonewall Diversity Champion Programme
- Lexxic

The following workforce polices support Equality Diversity and Inclusion:

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

Consulting staff and representatives on matters of concern and the performance of the organisation

The Trust works in partnership with staff side representatives through a number of mechanisms on matters of concern to staff and the performance of the organisation. In addition, the Trust follows a communication strategy to update and consult employees with relevant information. The following points provide examples of some of the actions taken by the Trust to keep the employees updated and provide opportunities for staff to raise their views and concerns.

- CUH Bulletin is a daily corporate email update sent to all employees email addresses on topical issues, events and any other information that CUH employees need to be aware of.
- 8:27 is a weekly Tuesday meeting which provides an opportunity for staff to hear the latest developments within the Trust and speak with the chief executive and the senior leadership team about progress on key issues. It is an open invitation to all staff to participate in the virtual forum.
- Monthly Q&A sessions with the Chief Executive and members of the leadership team. This is an open forum for all staff and provides the opportunity for them to ask questions on any subject matter.
- Management Staff Forum (MSF) is the formal body for Trust-wide consultation which meets every six weeks. The MSF is made up of two groups consisting of senior management and staff side representatives. These two groups come together in the spirit of partnership working to consider all matters regarding the CUH workforce for the benefit of both staff and patients.
- Weekly media update which is a summary of articles mentioning Cambridge University Hospitals in the media.
- The Trust's internal intranet site has a communication hub where information is held that has been communicated across the Trust via internal communications channels and a staff portal is available to provide a repository of information for staff.
- A staff Facebook page is used by staff to share feedback and discuss issues that are important to them.

Health and safety

Our five year health and safety strategy ''Safer culture, safer systems, safer workforce" sets the direction for effective health and safety management at CUH. It supports the Trust's aim and objectives as laid out in our corporate strategy and our associated workforce strategy and also supports and contributes to the provision and delivery of our values of Together – safe, kind and excellent.

A Health and Safety annual report is produced each year and provides a review of the work that has been carried out on the management of H&S at CUH over the last 12 months. Key work undertaken by the H&S team this year include:

- Review and investigation of significant H&S incidents, identifying failures and key areas of learning and providing assurance that actions identified are completed.
- Investigation of 39 incidents that required reporting to the HSE under the RIDDOR regulations. Ensuring that actions are identified, completed and any learning is shared.
- Oversight of the key H&S risks affecting the organisation and advising on mitigation and escalating as appropriate.

- Recommencement of the H&S department audit and inspection programme resulting in 42 departments being audited and inspected against a number of key standards.
- Introduction of new H&S department climate surveys that measure the attitude and perceptions of staff towards health and safety and provides and understanding of health and safety culture at CUH.
- Supporting managers and teams in the development of health and safety risk assessments, ensuring that these are suitable and sufficient as required by legislation.
- Undertaking a Trustwide Climate Survey as part of the National Quarterly Pulse Survey in Quarter 4 and analysing results and making suggestions for improvement.
- Development of a new procedure ‘Consulting with employees on health and safety’, and ensuring that all the other 37 H&S policies and procedures are consulted on and in-date. This included a review of the Trust’s Health and Safety Policy and update of the organisation’s statement of intent, signed by the Chief Executive in June 2022.
- Measuring the Trust’s performance against local key performance indicators.
- Continuing to be the Trust’s ‘competent’ advisors on all matter relating to health and safety, including providing advice on major refurbishment and capital project work and to project teams working on the Cambridge Cancer Research Hospital and Children’s Hospital.

Occupational health and wellbeing

Occupational Health and Wellbeing is the Trust’s in-house service, providing a full range of services to CUH staff, Royal Papworth Hospital NHS Foundation Trust, and a number of other organisations. The service works closely with local public health and wellbeing services to provide staff with access to a range of support and guidance on workplace health protection.

As a specialist multi-disciplinary clinical service, we work collaboratively to be as effective and efficient as we can be. We actively contribute to supporting a culture of workforce health and contribute to regional and national guidance and developments in this area. We are committed to consistently delivering on our vision of being a specialist clinical, trusted and responsive service for staff physical and mental health and wellbeing.

The service continues to meet the SEQOHS (Safe Effective Quality Occupational Health Service) accreditation quality standards.

Our services include management and self-referrals, pre-employment screening, immunisations, health surveillance, workplace adaptions, physiotherapy, return to work guidance, mental health support and health promotion.

This year, we have continued to play a key role in the Trust's management response as we continue to live with Covid, providing advice and guidance to our staff, in line with changes to national guidance, whilst supporting staff and managers in assessing and mitigating against the risks associated with COVID-19. We continue to provide the annual influenza and Covid booster vaccination programme for CUH staff, as well as a number of catch up immunisation programmes including, pertussis, diphtheria, smallpox (for protection against Mpox) and BCG for certain staff groups.

Following a successful pilot phase, the Workplace Adjustments programme is being relaunched in spring 2023. The ambition of the programme is to provide, where and when needed, workplace adjustments in a timely and effective manner to ensure that everyone working at CUH has the right support in place to enable them to do their job well.

Following an upgrade to the Occupational Health patient notes system in September 2022, improvements to streamline screening services have been made which has seen a significant positive impact on the timeliness and efficiency of these services, and in addition, reducing the overall time to recruit.

Counter fraud

CUH has taken all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and has a named individual nominated to provide the lead local counter fraud specialist function, who is an accredited counter fraud specialist. When that specialist is absent, arrangements have been made to ensure that specialist assistance is available.

Under the NHS Standard Contract for 2022-2023, all organisations providing NHS services (providers) must put in place and maintain appropriate anti-crime arrangements. CUH fully complies with this requirement.

Standards of business conduct and the Bribery Act

The Bribery Act 2010 has been in force since July 2011. This act creates the offences of offering, promising or giving a bribe, requesting, agreeing to receive or accepting a bribe, bribing a foreign public official and the corporate offence of failing to prevent bribery. We have a clear policy, which includes our zero-tolerance approach to bribery. Our stance is equally strong and clear in relation to those associated with or contracting with the Trust, and we avoid doing business with any individuals and organisations who fail to demonstrate their commitment to operate fairly, openly and honestly. Doing business transparently and preventing bribery is important in safeguarding the proper use of public money and resources, and a clear stance also provides patients, other customers, potential contractors and business partners as well as our governors and members with confidence

that we will act in a transparent and fair way. This in turn protects our trusted position within our community and our reputation as a leading national and international centre for specialist treatment, education and research.

CUH has in place a number of procedures for the prevention of bribery, including a clear raising concerns policy and procedure, and a local counter-fraud specialist. In addition, we keep a publicly-available register of interests for directors, governors and staff as well as a hospitality register. All staff have a role to play, but individuals with specific responsibility for implementing bribery-prevention procedures include the Board of Directors, the Deputy Trust Secretary, and our managers, both clinical and non-clinical.

We work closely with colleagues both within and outside the NHS to support a concerted effort to promote fair, honest and open operations and to prevent bribery, for the ultimate benefit of the patients and public we serve.

Staff survey

Staff experience and engagement

We run quarterly staff surveys, alongside the national staff survey, to help us understand what it feels like to work at CUH and to take action to make improvements based on the feedback received from staff.

The Trust has a number of listeners, who work alongside the Freedom to Speak Up Guardian, across our various divisions and corporate functions to support staff to raise concerns.

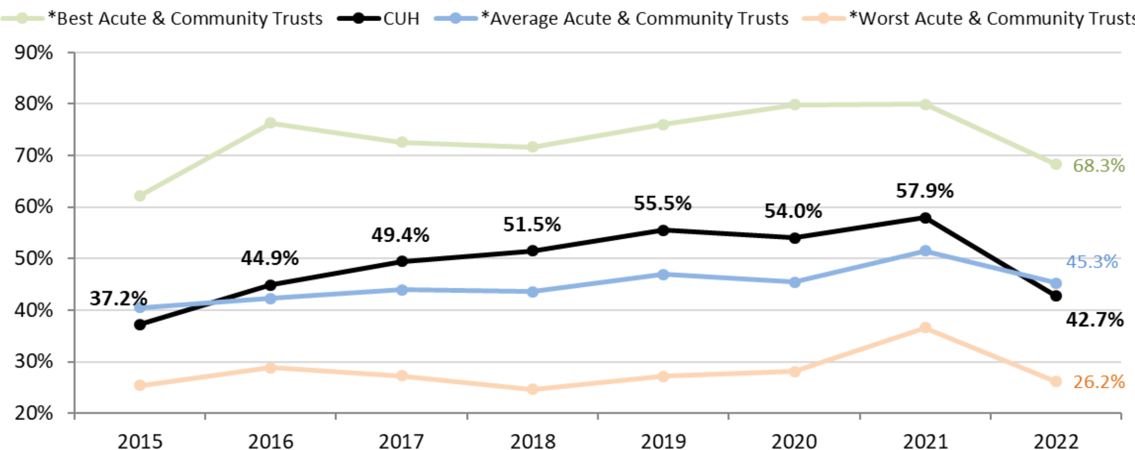
Additionally, the Trust is committed to providing an employee assistance programme and has a team of wellbeing facilitators who are able to provide compassionate, collaborative and inclusive support to improve the experience of managers and teams.

NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS ‘People Promise’, and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The National Staff Survey was open for staff to complete from October to November 2022. A total of 4,895 substantive staff responded giving us a decrease of 15% from last year and a total of 43%. This was below the National average for other acute and community Trusts of 45% who also saw a decline in response rate of around 6%. For the first time bank staff

were included in the survey. To allow for separate reporting bank staff completed a slightly abridged version with questions more pertinent to their experience. 260 bank staff responded giving a response rate of 20%. In line with last year's results there were approximately 1,200 free text comments.

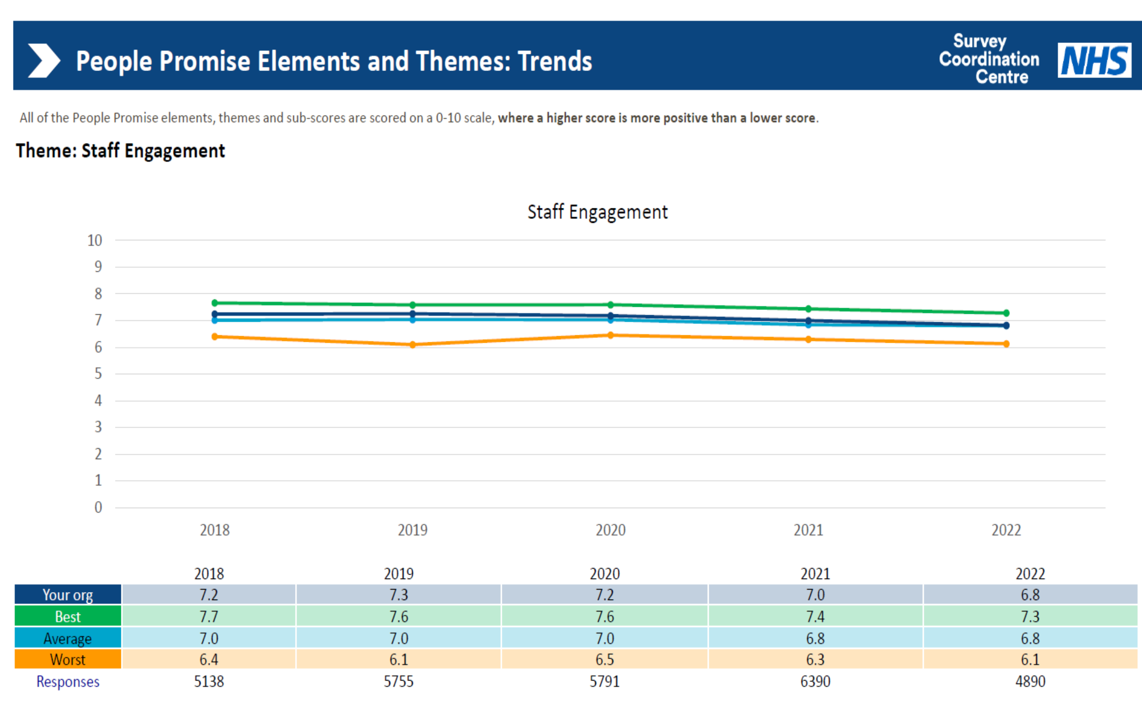


2022/23 and 2021/22

The CUH scores for each indicator together with that of the Shelford Group are presented below.

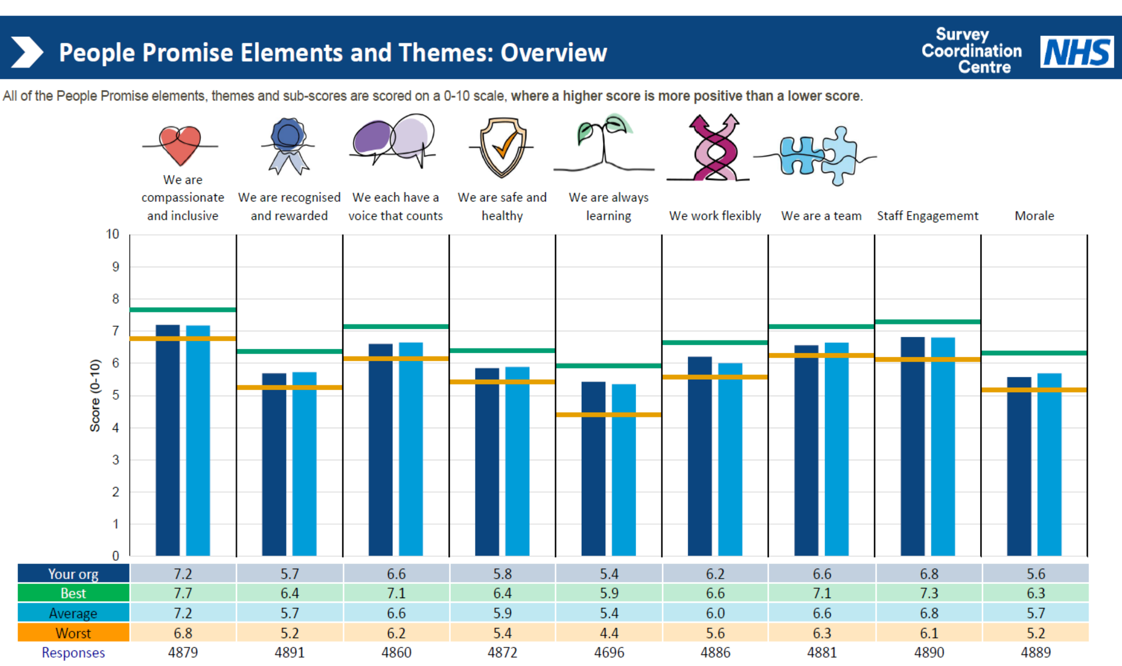
Indicators ('People Promise' elements and themes)	**2022/23**		**2021/22**	
	Trust score	Shelford group score	Trust score	Shelford group score
People Promise:				
We are compassionate and inclusive	7.2	7.2	7.3	7.2
We are recognised and rewarded	5.7	5.7	5.9	5.8
We each have a voice that counts	6.6	6.6	6.8	6.7
We are safe and healthy	5.8	5.9	6.0	5.9
We are always learning	5.4	5.4	5.4	5.2
We work flexibly	6.2	6.0	6.3	5.9
We are a team	6.6	6.6	6.7	6.0
Staff engagement	6.8	6.8	7.0	6.8
Morale	5.6	5.7	5.8	5.7

The Staff Engagement Score (out of 10) saw a further decrease of 0.2 to a position of 6.8, now placing CUH in line with the average. A decline in advocacy was also noted from 2021 to 2022 with the results in relation to staff recommending the organisation as a place to work down from 67% to 62% and as a place of treatment from 81% to 75%.



	2018	2019	2020	2021	2022
Your org	7.2	7.3	7.2	7.0	6.8
Best	7.7	7.6	7.6	7.4	7.3
Average	7.0	7.0	7.0	6.8	6.8
Worst	6.4	6.1	6.5	6.3	6.1
Responses	5138	5755	5791	6390	4890

The results for CUH see a significant shift in position in relation to the nine people promise themes, unfortunately moving from an above average position for every theme in 2021, to now being in line with the average position for six of the themes and below average for the theme of ***safe and healthy*** and ***morale***. The only exception being a slightly above average score for the theme of ***we work flexibly***.



When comparing these results to the Shelford Group, CUH score second highest in the group on the theme of ***we work flexibly***, and have no change in the theme of ***we are learning***. For the remaining themes CUH rank third, fourth and fifth alongside partner organisations demonstrating the decline in results since the pandemic.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement		Morale	
Trust Name	2022	2022	2022	2022	2022	2022	2022	2022	2021	2022	2021
University College London	7.4	5.9	6.9	6.0	5.8	6.3	6.8	7.3	7.2	5.9	5.9

Hospitals NHS Foundation Trust											
Guy's and St Thomas' NHS Foundation Trust	7.3	5.8	6.8	6.0	5.6	6.1	6.7	7.1	7.2	5.8	6.0
Imperial College Healthcare NHS Trust	7.2	5.7	6.7	5.9	5.7	5.9	6.7	7.0	7.0	5.8	5.8
Oxford University Hospitals NHS Foundation Trust	7.3	5.9	6.8	6.1	5.6	6.2	6.8	7.0	7.1	5.8	5.9
The Newcastle upon Tyne Hospitals NHS Foundation Trust	7.3	5.7	6.7	6.0	5.4	5.7	6.5	6.9	7.0	5.8	5.9
Cambridge University Hospitals NHS Foundation Trust	7.2	5.7	6.6	5.8	5.4	6.2	6.6	6.8	7.0	5.6	5.8
Sheffield Teaching Hospitals NHS Foundation Trust	7.2	5.7	6.6	5.9	5.3	5.8	6.5	6.7	6.8	5.7	5.8

King's College Hospital NHS Foundation Trust	7.0	5.5	6.5	5.7	5.6	5.6	6.6		6.7	6.7	5.5	5.5
Manchester University NHS Foundation Trust	7.0	5.5	6.4	5.8	5.1	5.6	6.4		6.5	6.7	5.4	5.5
University Hospitals Birmingham NHS Foundation Trust	6.9	5.4	6.4	5.8	5.0	5.7	6.4		6.5	6.5	5.5	5.5

Future priorities and targets

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

Analysis of staff costs - *Subject to Audit*

Table 22: 2022/23

Employee expenses	Year ended 31 March 2023 Total £000	Year ended 31 March 2023 Permanent	Year ended 31 March 2023 Other £000
Salaries and wages	571,283	571,283	-
Social security costs	59,735	59,735	-
Apprenticeship Levy	2,635	2,635	-
Pension cost – defined contribution plans employers contributions to NHS pensions	61,145	61,145	-
Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	26,757	26,757	-
Temporary staff – agency/contract staff	8,324	-	8,324

Total gross staff costs	**729,879**	**721,555**	**8,324**
Included within:			
Staff and executive directors costs	729,378	721,054	8,324
Redundancy	-	-	-
Early Retirements	501	501	-
Special Payments	-	-	-
Total employee benefits	729,479	721,555	8,324

Table 23: 2021/22

Employee expenses	**Year ended 31 March 2022 Total £000**	**Year ended 31 March 2022 Permanent**	**Year ended 31 March 2022 Other £000**
Salaries and wages	507,714	507.714	-
Social security costs	52,245	52,245	-
Apprenticeship Levy	2,433	2,433	-
Pension cost – defined contribution plans employers contributions to NHS pensions	56,379	56,379	-
Pension cost - employer contributions paid by NHSE on providers behalf (6.3%)	24,607	24,607	-
Temporary staff – agency/contract staff	5,465	-	5,465
Total gross staff costs	**648,843**	**643,378**	**5,465**
Included within:			
Staff and executive directors costs	648,147	642,682	5,465
Redundancy	-	-	-
Early Retirements	696	696	-
Special Payments	-	-	-
Total employee benefits	648,843	643,378	5,465

Expenditure on consultancy

Information regarding expenditure on consultancy can be found in the annual accounts.

Relevant Union Officials

Table 24: - What was the total number of your employees who were relevant union officials during the relevant period?

What was the total number of your employees who were relevant union officials during the relevant period? Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
43	24.25

Table 25 - Percentage of time spent on facility time: How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	8
1-50%	33
51-99%	2
100%	0

Table 26 - Percentage of pay bill spent on facility time: the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Total cost of facility time	£54,769
Total pay bill	£ 703,122,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.0077 %

Table 27 - Paid trade union activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	5.24%

Off-payroll engagements

Table 28: Highly-paid off-payroll worker engagements as at 31 March 2023 earning £245 per day or greater

Number of existing engagements as of 31 March 2023	
Of which :	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 29: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2022	
Of which:	
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	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 30: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023

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

Exit packages – subject to audit

Exit packages are accounted for in full in the year of departure.

Table 31: Exit packages

Reporting of other compensation schemes - exit packages 2022/23 Exit package cost band (including any special payment element)	**Number of compulsory redundancies Number**	**Cost of compulsory redundancies £000s**	**Number of other departures agreed Number**	**Cost of other departures agreed £000s**	**Total number of exit packages Number**	**Total cost of exit packages £000s**	**Number of departures where special payments have been made Number**	**Cost of special payment element included in exit packages £000s**
<£10,000	0	0	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0

Reporting of other compensation schemes - exit packages 2021/22 Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £000s
<£10,000	1	9	1	6	2	15	0	0
£10,001 - £25,000	1	25	0	0	1	25	0	0
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	2	34	1	6	3	40	0	0

Exit packages: other (non-compulsory) departure payments – 2022/23	2022/23 Payments agreed Number	2022/23 Total value of agreements £000	2021/22 Payments agreed Number	2021/22 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			1	6
Exit payments following employment tribunals or court orders				

Non-contractual payments requiring HMT approval* *i*				
Total			1	6
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

3.24 Code of governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently reviewed in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

From 2023/24 the NHS Foundation Trust Code of Governance will be replaced by the 'Code of Governance for NHS Provider Trusts' which comes into effect from 1 April 2023.

The Trust has reviewed compliance with the 'NHS Foundation Trust Code of Governance'. As a result of this review, we consider that CUH complies with the main and supporting principles of the code of governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B1.1. The Board of Directors has determined that all of the NEDs are independent in character and judgement. This includes the appointed representative of University of Cambridge, Professor Patrick Maxwell, the Regius Professor of Physic, notwithstanding the Trust's relationship during this reporting period with the University of Cambridge, School of Clinical Medicine and with Cambridge University Health Partners (CUHP).

In relation to the more detailed provisions of the code of governance, CUH is compliant with the provisions with the following exceptions:

B.1.3 The Chief Nurse holds a position of partnership governor at Royal Papworth Hospital NHS Foundation Trust. During the reporting period, the Director of People and Business Development of Cambridgeshire and Peterborough NHS Foundation Trust was a partnership governor on the CUH Council of Governors.

The representative of Cambridgeshire and Peterborough NHS Foundation Trust is a partnership governor appointed to reflect the views of a key partner organisation.

3.25 NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

As of 31 March 2023 the Trust is in segment 2 - Targeted support: support needs identified in finance and use of resources and operational performance.

This segmentation information is the Trust's position as at 31 March 2023.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

3.26 Well Led

The Trust commissioned an external review against NHS England's Well-Led Framework which reported in late 2016.

The recommendations of the Well-Led Review were implemented during 2016/17 and 2017/18, with updates provided to the Board of Directors. In line with a recommendation of the Well-Led Review, work was undertaken during 2017/18 to develop a formal Accountability Framework for the organisation which was endorsed by the Board of Directors in May 2018.

In the most recent Care Quality Commission inspection published in February 2019, the Trust was rated as 'Outstanding' in the 'Well-led' domain.

3.27 Statement of the Chief Executive's responsibilities as the Accounting Officer of Cambridge University Hospitals NHS Foundation Trust

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

NHS England has given Accounts Directions which require Cambridge University Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Cambridge University Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information

necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- Prepare the financial statements on a going concern basis.

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

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

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

Signed

Roland Sinker
Chief Executive
27 June 2023

3.28 Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Cambridge University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Cambridge University Hospitals NHS Foundation Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

The system of internal control integrates a number of individual controls as described in other sections of this statement, and other key policies and procedures such as the Standing Orders, identification of matters reserved to the Board, Standing Financial Instructions and Scheme of Delegation used to govern the Trust's activities, together with checks and balances provided by Board oversight, and internal and external audit reviews.

Capacity to handle risk

The Board of Directors sets the policy framework and provides leadership for the management of risk within the Trust. The Chief Nurse is the Executive Director lead for risk management.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with key controls and assurances and any gaps in those controls and assurances. The Corporate Risk Register (CRR) includes operational risks escalated by clinical divisions and corporate directorates.

Operational responsibility for risk management sits within the clinical divisions and corporate directorates. Each clinical division and corporate directorate is required to have processes in place by which risks are identified, evaluated and managed at a local level, and escalated as required in accordance with the Trust's policy framework.

The principles of risk management are included as part of the mandatory corporate induction programme and guidance and training are provided to staff through the annual refresher programme, risk management training, Trust-wide policies and procedures and feedback from audits, inspections and incidents.

The Trust also learns from good practice through a range of mechanisms including those detailed above together with clinical supervision and reflective practice, individual and peer reviews, after action reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice.

The risk and control framework

The Risk Management Strategy and Policy sets out the approach to managing risk within the organisation. The latest version of the Strategy and Policy was reviewed and approved by the Board of Directors in November 2022. It defines the roles, responsibilities and reporting lines in relation to risk management as well as the overall governance structure underpinning this at both Board and divisional/directorate level. It details the Trust's approach to identification, assessment, management, monitoring and escalation of risk and a statement of the Board's risk appetite.

As noted above, the BAF sets out the principal risks to the achievement of the Trust's strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF describes controls in place to manage each of the risks and explains how the Board is assured that those controls are in place and operating effectively. The BAF also identifies any gaps in control or assurance and the actions being taken to address these within specified timeframes.

The Risk Oversight Committee meets monthly and reviews the BAF and the CRR. It is chaired by the Chief Executive and membership includes all members of the Management Executive. The BAF and the CRR are received by the Board of Directors four times a year, detailing movements in risk and mitigating actions being taken with the aim of reducing the risk towards its target level. In addition, entries on the BAF and CRR are received and considered at each meeting of the relevant Board assurance committees to which they are assigned.

At an operational level, responsibility rests with each Divisional Director, supported by the Associate Director of Operations and Head of Nursing, for clinical divisions; and with each Executive Director for the corporate directorates. Divisional 'red-rated' risks are reviewed at divisional Performance Meetings with members of the Executive Team.

The above meetings and associated processes are intended to facilitate a seamless risk management system from Board to ward.

The Board of Directors has previously agreed the principles regarding the level of risk which the Trust is prepared to seek, accept or tolerate in pursuit of its agreed objectives. These principles are focused on quality, finance and value for money, innovation, commercial opportunities, compliance and regulatory framework, reputation and workforce. The Board of Directors has reviewed the principles and the organisational risk appetite during the financial year, specifically in the context of its continued response to the capacity challenges and industrial action.

The 2022/23 internal audit report on the BAF and risk management provides an overall assessment of 'Significant assurance with minor improvement opportunities'. The recommendations of the report have been accepted by the Executive Team and will be actioned during 2023/24. The internal audit report identified no outstanding recommendations from previous years.

As at 31 March 2023, the Trust identified through the BAF the most significant risks to the achievement of its strategic objectives as being:

- Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably restore services to pre-Covid levels and reduce waiting lists, while at the same time managing future Covid surges and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.
- A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.
- As a result of a failure to address fire safety statutory compliance priorities due to insufficient capital funding and decant capacity, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.
- There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.

- Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.
- There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.
- There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.
- There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.
- The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.
- New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.

The Trust has identified the controls in place to manage these risks and the sources of assurance that the controls are effective. It has also identified any gaps in control or assurance and the associated actions being taken to address these gaps. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk, where this is within the Trust’s ability to do so.

During 2022/23, a new development has been the introduction of medium-term risk trajectories to the BAF. The purpose of these is to indicate how the level of risk is expected to change over time in response to the implementation of actions within the Trust’s control and/or or anticipated external developments. This work is intended to support the Board in tracking risk profiles over time and assessing risk trajectories against the Trust’s risk appetite.

Quality governance

The Board of Directors has a collective responsibility for providing high quality care to the Trust's patients and has put in place a quality governance framework to ensure that quality is an integral part of the Trust's activities. The quality governance framework is kept under regular review, having due regard to the Well-Led Framework and best practice from other organisations. The Care Quality Commission (CQC) undertook a Well-Led review of the Trust in November 2018 and rated the Well-Led domain as 'Outstanding'.

The Quality Committee, in conjunction with the Performance Committee, provides assurance to the Board on the quality of patient care and compliance with national and local standards, with reference to the monthly Integrated Performance Report and other relevant reports and data. It reviews the Trust's clinical audit programme, compliance with the requirements of the Care Quality Commission, and Trust preparedness for regulatory inspections.

The Committee also oversees the implementation of the Trust's Quality Plan and its ongoing development. This includes a focus on clinical quality improvement to ensure that the Trust learns, shares and takes appropriate action in respect of safety reporting, and prospective and proactive patient safety risk detection; information and experience from outside the Trust; external reviews of Trust activity; and the results of clinical audit. It also oversees the development of and agrees priorities for the Trust's annual Quality Account.

Never Events and clinical and non-clinical incidents which are significant enough to be classified as Serious Incidents are identified by the Director of Clinical Quality and are reported immediately to Executive Directors, the Trust's lead commissioner and the CQC. A Serious Incident Executive Review Panel (SIERP) reviews Serious Incidents on a weekly basis. The incidents are detailed in the monthly Integrated Performance Report and in the Patient Safety report received by the Quality Committee. Incident information is reviewed at monthly divisional Quality meetings.

All incidents are subject to a Root Cause Analysis and learning is shared with the divisions and through the organisation. Themes are identified in the Integrated Report. The Quality Committee receives a bi-monthly report on serious incidents as part of the Patient Safety report including themes and actions taken.
For rapid learning, the After Action Review (AAR) methodology is used as a method to reflect on what happened in an incident.

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

Information governance

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

The Trust complies with the requirements of the NHS Digital Data Security and Protection Toolkit for the management and control of risks to information. The current level of compliance with the Toolkit is 'approaching standards. A plan is in place to meet the requirement that 95% of staff have completed their information governance training (currently 89%) and a programme of work is in place to replace a small number of Windows 7 and Windows 2008 devices. The next Toolkit submission is due at the end of June 2023.

The Director of Improvement and Transformation is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors. Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance policy and management framework. The Information Security and Governance Programme Board reports to the Digital Board.

During 2022/23 the Trust recorded five incidents relating to information governance, including data loss or confidentiality breach, which were classified as reportable Information Governance Incidents. These cases have been reported to the Information Commissioner's Office (ICO) and have been fully investigated. No action has been taken by the ICO in relation to these incidents.

Risks to foundation trust governance

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. The Trust's strategy was refreshed during the year and approved by the Board of Directors in July 2022.

The Audit Committee is the Board committee with primary responsibility for overseeing the Trust's governance and assurance processes and, in particular, for independently reviewing the effectiveness of the system of internal control and risk management, and ensuring that all significant risks are properly considered and communicated to the Board.

The Performance Committee, the Quality Committee and the Workforce and Education Committee provide independent and objective oversight and assurance to the Board of Directors on the Trust's performance in relation to operational standards, quality, finance and workforce. In addition, the Addenbrooke's 3 Board Committee provides assurance to the Board of Directors on the hospitals redevelopment programme and key issues and risks, with a specific focus on the underpinning clinical strategy.

As set out in the Trust's Accountability Framework, the clinical divisions are held to account and escalate issues as required through monthly Performance Review meetings with the Executive Team. Each division provides a balanced scorecard of performance information which is included in the monthly Integrated Performance Report.

Involvement of stakeholders in risk

The Trust endorses three principles which underpin the quality framework:

- Quality is at the heart of all that the Trust does.
- There is an open and transparent culture to facilitate a learning organisation.
- The organisation will work collaboratively with stakeholders to ensure the quality and safety of services and demonstrate commitment to continual improvement.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

The Trust informs and engages with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters and to engage with them on the development of the Trust's Quality Account.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular

through the Cambridgeshire and Peterborough Integrated Care Board and the Integrated Care System.

The Trust engages with public stakeholders and the local Healthwatch in discussions including consideration of risks which impact on them. Governors are involved in discussions about risks which impact on patients and members through regular meetings including of the Council of Governors and supporting meetings. They are also involved in the development of the Trust's strategy and operational plans, specifically through the Governor Strategy Group.

CQC registration

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust was inspected by the CQC in November 2018 and the inspection report was published in February 2019. The CQC inspected four core services and undertook a Trust-wide Well-Led review, together with a Use of Resources assessment by NHS Improvement. The Trust continued to be rated as 'Good' overall for Quality, with both the Caring and Well-Led domains being rated as 'Outstanding'. The Trust was rated as 'Requires Improvement' for the Responsive domain and for Use of Resources. An action plan was put in place to address the findings of the inspection.

As part of an inspection of urgent and emergency care (UEC) services in Cambridgeshire and Peterborough in March 2022, the CQC undertook a focused inspection of UEC at Addenbrooke's Hospital covering elements of the Safe, Responsive and Well-Led domains. The Safe domain was rated as 'Required Improvement', with other domains not rated. An action plan was put in place to address the findings of the inspection and has been reviewed by the Quality Committee.

The Trust is anticipating a CQC inspection of maternity services in early 2023/24 and continues to undertake regular CQC self-assessments and peer reviews.

Other compliance issues

The Workforce and Education Committee received an analysis of compliance with the Developing Workforce Safeguards in October 2019. An action plan to address areas where further work is required in relation to the safeguards is in the process of being implemented.

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

counter fraud review of the Trust's conflicts of interest process by the Trust's internal auditors in February 2022 provided positive assurance on the processes in place and compliance with these.

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 plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with

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

The key elements of the Trust's operational and financial plans have been monitored by the Management Executive and the Performance Committee has sought assurance on behalf of the Board of Directors on the delivery of the plan.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee. Non-financial audits relating to quality are considered by the Quality Committee.

The process to ensure that resources are used economically, efficiently and effectively across clinical services include divisional Performance Review meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Data quality and governance

The assessment of performance data, including quality metrics, is an integral part of the Trust's performance management system. The Trust produces a monthly Integrated Performance Report which includes operational, quality, workforce and financial data and this has been subject to continued review during 2022/23. In addition to an ongoing programme of internal review and audit of data quality, in accordance with the Trust's Data Governance policy, data quality is subject to periodic audit by the Trust's internal auditors.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, other Board assurance committees and the Internal Auditors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by the work through the year of the Board of Directors and of Board committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by the Audit Committee, and the action plans resulting to address areas for improvement.

The Head of Internal Audit opinion for 2022/23 has concluded that significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Other external assurance is provided by CQC insight reports, the outcomes of the clinical audit programme and the results of reviews and inspections by external organisations.

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

Significant internal control issues

The Board of Directors has identified the following significant internal control issues for the Trust:

- The Trust continued to face high levels of demand for urgent and emergency care alongside significant elective waiting lists due to the impact of the Covid-19 pandemic. The Trust continued to take actions through the year to improve patient flow, as well as working with partners to reduce delayed transfers of care and deliver additional physical capacity on site to support treatment. A robust clinical prioritisation and harm review process remained in place to support the management of long waiting lists.

- During 2022/23, the Trust faced periods of industrial action by members of the British Medical Association and the Royal College of Nursing which created significant challenges in continuing to provide safe patient care. Alongside supporting staff to exercise their right to take legitimate industrial action, extensive work was undertaken to plan and prepare for the impact of the strikes, including the postponement of elective activity in order to ensure the delivery of safe urgent and emergency care services. The Trust actively encouraged all parties to come together to resolve the disputes as quickly as possible.

- Insufficient decant capacity, together with increased waiting lists as a result of the pandemic, continued to impact on progress in addressing estates backlog maintenance and statutory compliance priorities (including in relation to fire safety and infection control). The Trust has taken a risk-based approach to prioritising investment within the capital resources available, while continuing to work closely with its regulators on these issues and to implement additional physical capacity on the site which will support its decant plans.

Conclusion

My review has established that Cambridge University Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

Roland Sinker
Chief Executive
27 June 2023

3.29 Sustainability and climate change report

Introduction

This report describes the commitment, approach, and performance of Cambridge University Hospitals NHS Foundation Trust (CUH) in its ongoing response to the environmental sustainability agenda during 2022/23 - specifically including the challenge of tackling climate change. The report is divided into two sections:

Section 1: outlines the frame for understanding the Trust's approach as detailed in *Our Action 50 Green Plan (Phase 1: 2022-24)* – formally approved by the Trust's Board in April 2022. Green Plans are formally required of all NHS Trusts (superseding the previous Sustainable Development Management Plans). They set out the actions NHS Trusts and Integrated Care Systems will take to meet the NHS's 'net zero carbon[1]' target in line with central direction and guidance.

Section 2: details performance and achievements during 2022/23 and provides a brief look forward to the delivery priorities for the coming year.

Section 1 - Commitment

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

Since the publication of its Long Term Plan in 2019, the NHS has recognised that it must inject more urgency into action to realise its well-established direct commitments to tackling climate change (responding to the Government's declaration of a "climate emergency"). In January 2020 the launch of a new *Greener NHS* campaign was backed up with tangible objectives and actions in the centrally issued annual Service Contracts – which have since been sustained and developed. In July, a net-zero NHS by 2045 was embedded in legislation by the Health and Care Act 2022.

The *Net Zero* plan makes it very clear why all NHS organisations need to take action to reduce their carbon emissions on route to achieving its net zero target. It sets out what the opening phase of actions should include and when they should be delivered by. These have been encompassed within CUH's *Our Action 50 Green Plan* (hereafter referred to as A50GP) which sets out how this target will be approached and actioned in the context of running our hospitals. This has built on our experience and achievement to date in delivering against the parameters of environmental sustainability.

The Trust is fully committed to the NHS Net Zero agenda and the delivery of its A50GP.

Progress is regionally and nationally monitored through quarterly returns linked to the aforementioned Standard Contract Service Conditions. This has been backed up with a flow of essential policy and guidance documents such as the *NHS Net Zero Carbon Building Standard* and the *NHS Net Zero Supplier Roadmap*, alongside important grant support, such as that available through the Public Sector Decarbonisation Scheme and the Low Carbon Skills Fund.

Internally, CUH governance and formal reporting is provided through Green Plan Working Groups, the Environmental Stewardship Committee and Trust Board – supporting all the A50GP actions, multi-disciplinary teams, the Energy and Sustainability team, the Green Champions' Community, Think Green Impact teams, events and promotions, and working ties with Cambridgeshire and Peterborough ICS and other healthcare, community and commercial partners.

Our Green Plan – mapping the way forward

The Board approval of the Trust's new Action 50 Green Plan (A50GP) at the beginning of this year was a watershed moment in terms of prioritising CUH's response to the net-zero agenda, climate emergency and wider environmental crisis.

The A50GP is the first phase of a green planning programme with the objective of halving carbon emissions by 2032 (from a 2019/20 baseline) and then reaching net-zero by 2045.

Figure 1: the CUH Green Planning timeline

ACTION FOR A CLIMATE-SAFE FUTURE
Climate Emergency

Phase 1			Phase 2		Phase 3					
22/23	23/24	24/25	25/26	26/27	27/28	28/29	29/30	2032	2040	2045
Year 1 Reporting	Year 2 Starting	Transition to Phase 2	Year 4	Year 5	Transition to Phase 3	Year 7	Year 8			
Engage organisation. 10% cut direct emissions.		Transition and integration to circular economy. Growing cuts in all emissions.			Net-zero trajectory locked-in. Approaching 50% emissions cut.			50% ALL	Net-0 direct	Net-0 ALL

Carbon emissions are deeply embedded in everything the Trust consumes – from goods, materials, equipment and medicines to energy, water and business miles. Some of these can be responded to directly (e.g. improving energy and waste management efficiencies and removing unnecessary losses), and others only indirectly (e.g. the supply of lower-carbon grid energy and more readily reusable medical devices). These all require CUH working closely with its staff, patients, suppliers and contractors. The significant number of moving parts within our supply, use, and disposal chains mean that the A50GP cannot just work on changing some individual choices – it needs to reframe the decisions about what and how we consume as a whole system.

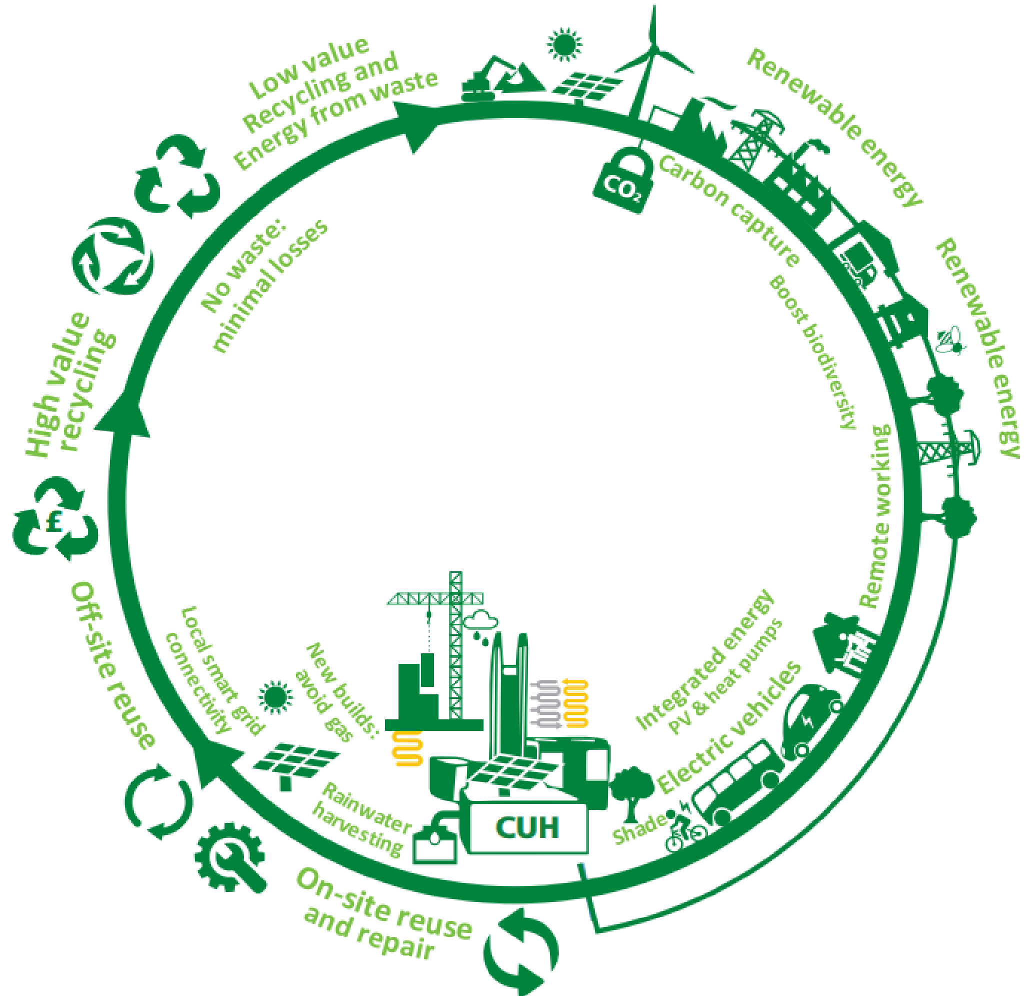
CUH's A50GP formalises this reframing and the actions we are, and will be taking to establish a new 'story' for consumption: moving away from today's high-carbon/high-waste approach that is dominated by a take-make-use-throwaway approach (referred to as the 'linear economy') and towards a net-zero/zero-waste approach that is dominated by renewable energy, reuse, repair and recycling - referred to as the 'circular economy'.

The circular economy vision provides the 'map' for guiding action (re. Figure 2). It underlies everything about our A50GP. All organisations have an environmental sustainability role depending on their position in the sub-systems of production, consumption and disposal that provide for our health, wellbeing and prosperity. For CUH, this role is as a large and intense consumer. The most obvious (relatively direct) emissions are from the fossil fuels used for heating and powering, and from anaesthetic gases, alongside travelling to and from our premises. The less obvious (indirect) ones are

'embedded' through the production and supply of all the goods, materials and services we purchase.

These embedded emissions are the most significant - making up around 75% of the Trust's carbon footprint. For CUH therefore, not 'wasting' this

Figure 2: The vision of a net-zero/zero-waste 'circular economy' and CUH's essential responsible consumer role within it.

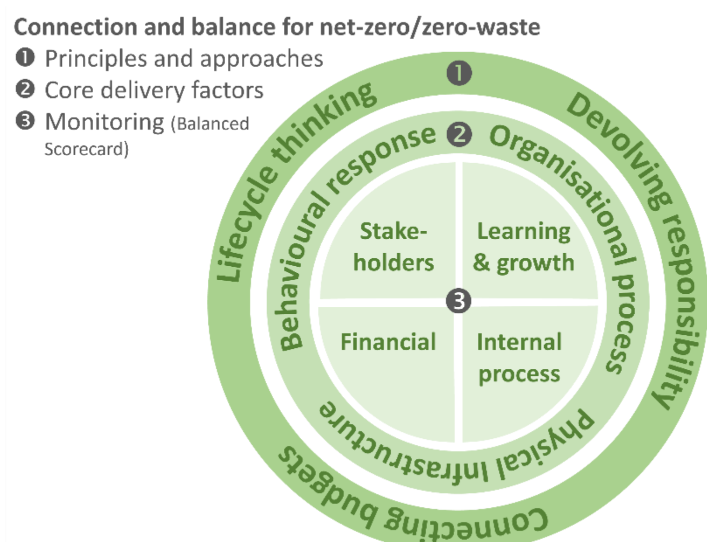


carbon so it has to be embedded all over again is of great importance – reuse, repair, and high-value recycling are essential parts of CUH being a responsible consumer in the 2020s. 'Net-zero' carbon is inextricably linked to 'zero-waste'. The progressive transition to a non-fossil fuelled renewably powered circular economy is our active vision of a sustainable future. Securing 'circularity' in what we consume is an essential part of not only reducing pollution and the loss of natural resources and habitats, but also of cutting carbon emissions as a matter of course.

From map to terrain

With ten years of experience in pressing for more environmentally sustainable healthcare, the Trust is very aware that a 'map' on its own will not get you from A to B. The local 'terrain' is just as important. The drive for net-zero must work with the reality of CUH's existing core priorities of patient care, the flow and capacity of the hospital, staff wellbeing and budgetary limitations. These priorities find expression in complex and often deep-set interplays between three essential on-the-ground factors: i.) physical infrastructure, ii.) organisational procedures and iii.) behavioural responses.

Figure 3: Our Green Plan approach to achieving connection and balance for net-zero/zero-waste.



The myriad of local relationships between these priorities and these factors provides the terrain over which our circular economy map is lain. The terrain impacts the decision-making that our route to net-zero is asking of us. If it is not accounted for and linked into green plan delivery, then the exceptional level of success required to meet the net-zero challenge is unlikely to be realised.

The fifty actions contained in CUH's A50GP have been specifically shaped with this terrain in mind. They are also being monitored through a framework designed to view progress in a balanced way across four key perspectives - referred to as the 'balanced scorecard' (BSC) approach (re. Figure 3).

Figure 3 also introduces the three main circular economy principles that lie at the heart of the A50GP's 'how to' approach to the transition from a linear economy map to a circular economy map:

- Lifecycle thinking (LCT): the carbon, pollution and resource loss impacts of all aspects of consumption are to be expressly taken account of in an integrated (circular economy) manner during the supply, use and disposal of all goods, materials and equipment (replacing the dominance of decision-making based upon cost, compliance and utility alone).

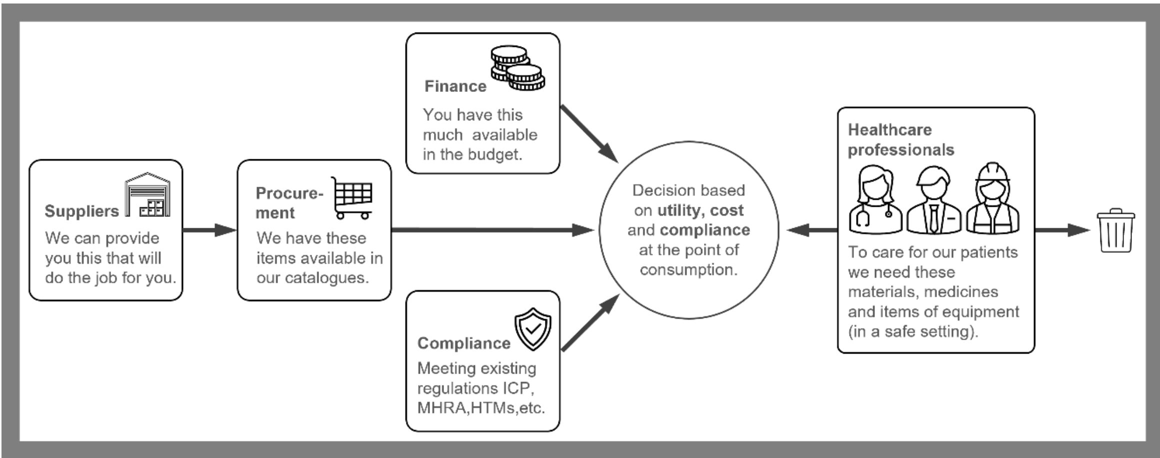
- Devolved responsibility: the essential locus of life-cycle thinking should reside with those at the point of consumption – these local

teams understand most clearly what, how and how much they are consuming and are best placed to understand and bring forward adjustments based upon LCT that also ensures they maintain the CUH values in delivery.

- Connected budgets: aligning the immensely damaging costs of ecological breakdown with today's business transactions and budget choices so as to redirect progress onto a definitively more sustainable path (it is perhaps relevant to reflect on how much we would have paid in advance to avoid the impacts of COVID-19).

These are all essential principles for navigating a way through to a climate-safe future. The challenge is applying them to the existing terrain of an already complex system - one driven by an inviolable set of pre-existing healthcare priorities and values. The circular economy principles can be readily aligned in theory, but in practise there is currently only very limited space, understanding and process for the all-important purchasing decisions to account for wider environmental impacts (climate change, pollution, and the loss of natural resources) and strongly related wider social impacts (workforce and local community equity, diversity, and inclusion) in a

Figure 4: The wider environmental impacts (tied to climate change, pollution, and the loss of natural resources) plus wider social impacts (tied to workforce and local community equity, diversity, and inclusion) conventionally struggle to be effectively included in procurement choices. Decisions are typically prioritised on utility, cost, and compliance at the point of consumption.



product's value, supply, and disposal chains.

This year has seen the introduction of a major shift in purchasing policy that should open new opportunities to secure a climate-safe future through the all-important decisions over what, how and how much we consume. From April 2022 all NHS procurements have been required to include a minimum 10% net-zero and social value weighting.

From previous survey work, we know that most of our staff want to work in ways that will actively contribute to a climate-safe future for their patients, staff, and community. With three-quarters of CUH's carbon emissions

embedded in the goods, materials and equipment it purchases, the transition to more sustainable procurement practise becomes a pivotal activity. The means for identifying goods that have been produced with low-carbon footprints, and designed with operational consumption paths for reuse, repair, remanufacture and recycling, is far from fully developed. This is an area with much space and urgency for innovation and opportunity.

There is a risk that the 10% net-zero and social value weighting becomes a superficial compliance exercise. CUH has worked hard throughout the year to include relevant criteria in all tender specifications and to work collaboratively with suppliers to convert them into material outcomes. This is a very challenging exercise, with much resistance and uncertainty built into existing practice. With the foundation in place, CUH will now be building additional guidance (with ICS colleagues) together with the essential element of inclusion within contract management (to assure delivery against the commitments made in tender documents).

Policies

The process of incorporating central NHS carbon reduction direction and targets within the drafting of the Trust's Green Plan, has brought forward the lengthy process of reviewing and updating all other relevant CUH policies and procedures.

Policies that have delivered incrementally through largely advisory guidance will need to be strengthened if CUH is to contribute effectively to the NHS carbon reduction targets of a 50% cut within ten years and then moving onto net-zero within fifteen years after that.

The current subject-specific policies and procedures include: a comprehensive Travel Plan that appropriately embraces the wider Cambridge Biomedical Campus; the Trust's Environmentally Sustainable Design and Construction Protocol; the Waste Management Policy and Waste Disposal Procedures; and several policies relating to aspects of energy and water management. These are all refreshed and updated on a regular basis and will now need to include increased alignment with more demanding carbon reduction and climate adaptation objectives.

Central NHS guidance is supporting this process through such documents as the new Health Technical Memorandum on the Safe and Sustainable Management of Healthcare Waste (HTM-07-01), Procurement Policy Notes 06/20 and 06/21, and the NHS Net Zero Building Standard.

2022/23 has also seen the Trust substantively progress the design phases for two important new build projects: the Cambridge Children's Hospital (CCH), and the Cambridge Cancer Research Hospital (CCRH), alongside a comprehensive masterplan review process for the redevelopment of the CUH campus as "Addenbrooke's 3". A unified approach and required standards for net-zero enabled sustainable design have been built into the Stage 3 designs for the two new hospital buildings. These have been

carefully tailored to account for the publication of the NHS net-zero standard for new hospital buildings and existing and emerging Local Plan land-use policies. Both projects have now successfully secured planning permission. CCRH is a leader in its response to carbon reduction in the national New Hospital Programme, and CCH is working to further innovate through the inclusion of *Passivhaus* design (a certifiable international standard that provides a very high level of occupant comfort whilst rigorously minimising energy for heating and cooling).

Both major new builds and the Addenbrooke's 3 programme are integral elements to the future decarbonisation of CUH's estate. In 2022/23 this has been further boosted by the new Movement Surgical Hub (currently under construction) which includes ground-breaking solarised air-source heat pump and cooling systems.

Through the securing of a Low Carbon Skills Fund grant, the main CUH campus now has in place a comprehensive Heat Decarbonisation Plan.

Partnerships and collaboration

Partnerships, networks of shared interest and less formal collaborative working arrangements are fundamental aspects of the sustainability journey for any organisation and the communities it serves.

Throughout 2022/23 the Trust has continued to provide close associate support to the Regional Greener NHS Team and member network. The role and accountability of the regional approach has developed significantly to much more formally facilitate the shared responsibilities that NHS organisations across the region now have in rapidly adjusting to a net-zero trajectory (e.g., as expressed in the ongoing development of Standard Contract Service Conditions). Through this relationship CUH has also taken a lead on collaborative projects relating to sustainable procurement and sustainable care pathways.

Within **Cambs & Pboro ICS, CUH directly supporting** Social Value, 'gloves-off', and greener JFP work-stream.

Strongly related to this, has been growing collaborative work within the environmental sustainability agenda of the emerging Cambridgeshire and Peterborough Integrated Care System (ICS).

As part of the Shelford Group (a collaboration between ten of the largest teaching and research NHS hospital trusts in England), CUH has contributed to the specific Sustainability Working Group and led on a distinct renewable energy and power purchase agreement workstream.

CUH has continued to actively support Cambridge City Council's Cambridge Climate Change Charter and Climate Change Leaders group. The Charter, run on the ground by Cambridge Carbon Footprint, offers guidance and information on how companies and individuals can act in more environmentally friendly ways that fit in with their objectives and day-to-day

activities. Active participation in the project offers opportunities for CUH to develop its role as an 'anchor' institution within the local community.

In 2022/23 we have further developed, or maintained, productive relationships for the purposes of advancing environmental sustainability with the following additional external partners: South Cambridgeshire District Council, Cambridge County Council, Greater Cambridge Partnership, Cambridgeshire and Peterborough Combined Authority, NHS England/Innovations, East of England Health Estates and Facilities Management Association, Cambridge Sustainable Food, Cambridge Carbon Footprint, Cambridge Cycling Campaign, University of Cambridge, Cambridge Institute for Manufacturing, Cambridge Institute for Sustainability Leadership, Cambridge Judge Business School Circular Economy Centre, Medical Research Council, AstraZeneca, Cambridgeshire and Peterborough NHS FT, Royal Papworth Hospital, University College London Hospitals NHS FT, University Hospitals Sussex NHS FT, Cambridge Cleantech and local community groups.

Section 2 – Performance

The following sections report on progress and activities in relation to:

- the use of utilities (energy and water) in building services;
- the purchasing of goods, materials and services and its corollary in waste management;
- transport and travel;
- the role of awareness raising and behaviour change, and;
- adaptation to the impacts of climate change.

The report then concludes with a look ahead to the coming year.

Sustainable Energy and Water Consumption (premises)

Energy

The two primary energy sources for the Trust's premises are natural gas for space and water heating, and electricity for powering plant, lighting and healthcare equipment (with on-site bulk storage oil available as a backup for either if required). In terms of both carbon and cost there are important distinctions between the two primary sources. In 2022/23 44% of the energy used was in the form of electricity but this accounted for 76% of the total energy cost and 46% of the carbon emissions when compared to gas. This year, due to the ongoing contribution of low carbon sources to the national grid, the carbon intensity of electricity has come even closer to that of natural gas.

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

Carbon emissions (CO_{2e}) from the on-site consumption of heat and power continue to fall (re. Figure 5).

Figure 5: CO_{2e} emissions from energy use in premises 2019/20-2022/23

	2019/20	2020/21	2021/22	2022/23
Grid electricity tonnes CO2e	12,390	10,247	9,581	8,608
Natural gas tonnes CO2e	10,610	10,611	10,681	10,239
Backup fuel oil tonnes CO2e	134	160	136	82

Heat and power use in Trust buildings make up the majority of the direct carbon emissions that CUH is committed to reducing by 10% by the end of 2024, 50% by 2032 (both from a 2019/20 baseline) and driving down to net-zero by 2040. To date, for these two elements, the Trust has achieved an 8.2% reduction.

These reduction targets, as established across the NHS in 2020 and embodied in CUH's A50GP, are a very necessary 'climate emergency' ramping up of a longer-term programme of carbon reduction that the Trust has been delivering since 2013. This has been achieved by: a.) working hard to reduce energy consumption through infrastructure improvements as demand for the hospitals' services and the intensity of use have grown, and b.) through the increasing contribution of low carbon electricity generation to the national grid.

From a monetary perspective, these measures have always been beneficial. The spiralling increase in gas and electricity prices throughout the year has lent even greater weight to their significance.

It is essential to note, however, that grid electricity remains five or six times more expensive per unit (kilowatt hour) than gas[2].

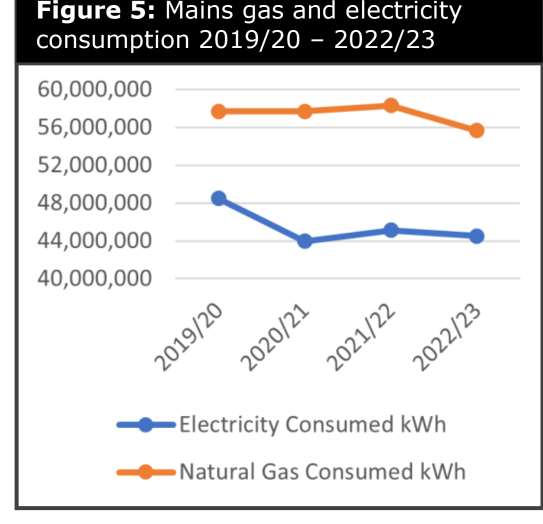
The differential in price between the two utilities means that it is even more important that every kilowatt hour is very carefully managed in all new build and retrofit/backlog maintenance projects. Managed to take full account of each of the following parameters:

[2] This remains the case for CUH despite the recent cost escalation (the Trust has been buffered from the extremes in short to medium term fluctuations in price as it participates in an aggregate framework contract with a thirty month buy-ahead window).

a.) ‘lean’: i.e., energy consumption is driven down to the lowest level possible (e.g. minimising demand through passive measures such as fabric insulation and summertime shading);

b.) ‘clean’: i.e., power is used as efficiently and with as little waste as possible (e.g. carefully automated control of pumps/motors/fans, LED lighting, and heat pumps with exceptional coefficients of performance), and;

Figure 5: Mains gas and electricity consumption 2019/20 – 2022/23



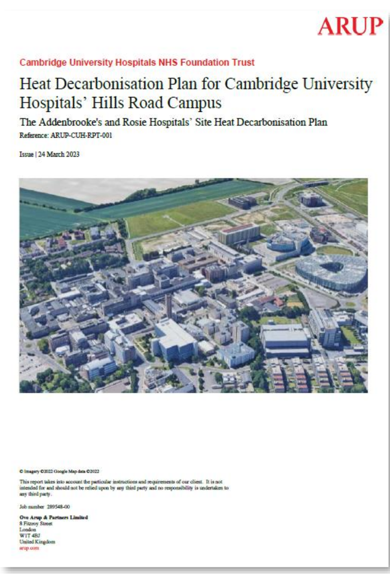
c.) ‘green’: i.e., options for on-site behind-the-meter renewable energy sources are always assessed (e.g. electricity from roof-mounted photovoltaic solar panels) and the potential for power purchase agreement over local ‘private wire’, or grid connected larger installations is rigorously examined.

With hospital activity levels returning to pre-pandemic levels and beyond, the demand for on-site energy supply is high. It is only sustained efforts to improve the efficiency of centralised boilers, incineration plant and the full range of building services that is holding consumption down.

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

- requests for air-conditioning in response to warmer weather conditions;
- higher electrical equipment levels per square meter (e.g. information technology);
- increasing intensity in the use of the hospitals’ services and facilities;
- growth in the deployment of medical imaging and other new equipment that have high electrical power requirements, and;
- the transition to electric vehicles and the associated charging infrastructure requirements.

Heat decarbonisation


ARUP

Cambridge University Hospitals NHS Foundation Trust

Heat Decarbonisation Plan for Cambridge University Hospitals' Hills Road Campus

The Addenbrooke's and Rosie Hospitals' Site Heat Decarbonisation Plan

Reference: ARUP-CUH-RPT-001

Issue | 24 March 2023

Since 2020 the Trust has been piloting and pursuing measures to decarbonise its heating. This entails a progressive transition from using gas fired boilers to electrically powered heat-pump technology. As introduced above, CUH secured a Low Carbon Skills Fund (LCSF) grant this year to work with specialist consultants on the drafting of a Heat Decarbonisation Plan (HDP) for the main Hills Road campus. Switching from a gas-fired steam-driven district heating system to one that is an electrically powered low temperature hot water district network is immensely challenging in terms of investment, timing, access and the requirement for very significant additional grid electrical capacity and its effective local distribution. The HDP has allowed first delivery steps to be mapped out in the form of a further LCSF bid to take the opening phases into detailed design with the objective of submitting a Public Sector Decarbonisation Scheme capital bid in the coming autumn.

From the above it very clear that the embedding a 'lean', 'clean' and 'green' approach to the provision and consumption of energy (in all aspects of the Trust's physical infrastructure, organisational procedures, and behavioural responses) has never been as important as it is now.

Lean

Reducing energy demand by design (being lean) has continued to prove to be the hardest objective of the three in a modern acute teaching hospital. This year has seen the returning demand and backlog catch-up for on-site services grow.

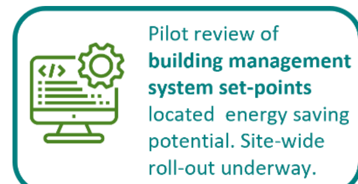
The risk and reality of summertime overheating, and the subsequent increasing requests for portable air-conditioning, continues to put pressure on network capacity. Where possible, the roll-out of low energy solutions such as window film treatments, blinds in combination with portable fans has continued. Although only partial and fragmented solutions, these measures are helping to manage summertime over-heating in vulnerable areas of the estate.

CUH security **reporting on lights left on overnight**. Resolution taken up with occupants and cleaning teams.

The Trust continues to encourage all staff to turn off equipment when not required, and safe to do so to, ensure that the demand for energy is not higher than it needs to be, and to try where possible to limit occupation levels during heatwave events.

Planned Preventative Maintenance of all local air-conditioning units set to include time/temp set-points saving checks.

Recognising that heating, ventilation and air-conditioning equipment is often not in the direct control of the occupants or local managers of their area, a full review of all Building Management System (BMS) and non-accessible local equipment set-points has proved to be a very valuable exercise and a full review is now fully in train across the site.

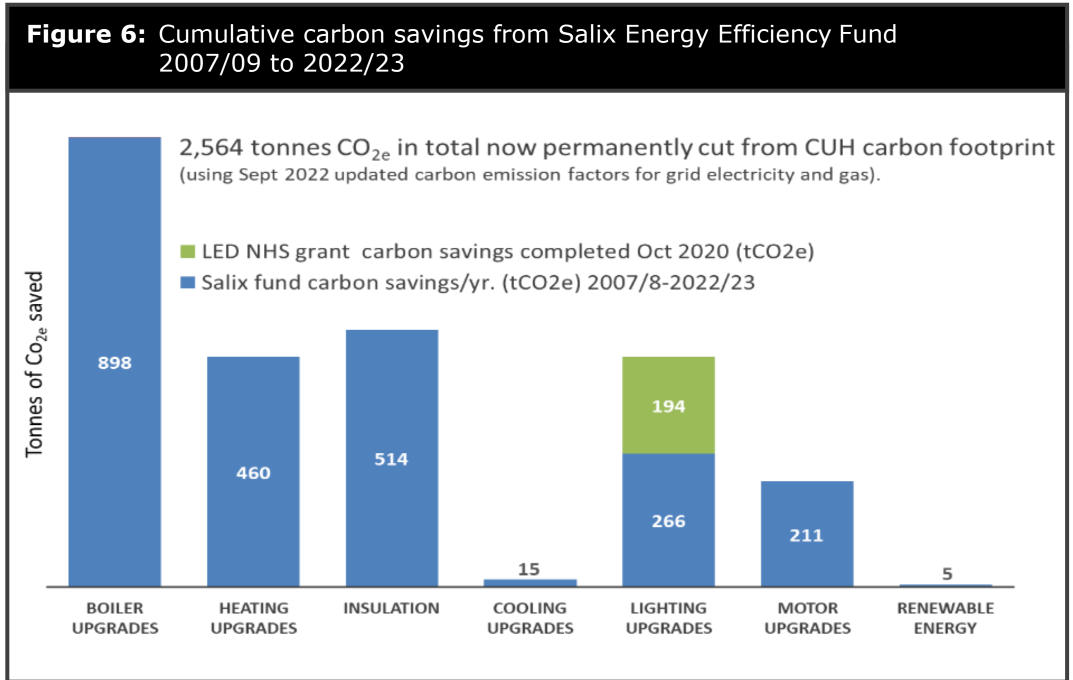


Accurate measures of energy consumption are an essential aspect of demand reduction. This is best provided by automated meter reading (AMR) which generates half-hourly profiles of consumption and can identify peak demands, operating baseloads and energy being consumed when it is not needed. A project to introduce streamlined and lower cost technology to improve the effectiveness and coverage of AMR has proved very successful. Full transition will be completed in the coming year.

Clean

Improving the efficiency with which building services (plant, equipment, and controls) consume energy, and thereby reduce their carbon emissions, is an area in which the Trust has a strong track record of delivery (re. Figure 6).

Figure 6: Cumulative carbon savings from Salix Energy Efficiency Fund 2007/09 to 2022/23



Across an estates portfolio that can date back 60 years, the use of capital project refurbishment, backlog maintenance, external grants, and the Trust's dedicated 'revolving' energy efficiency fund (independently validated through the fund's partner, Salix Finance) are all invaluable in driving down emissions.

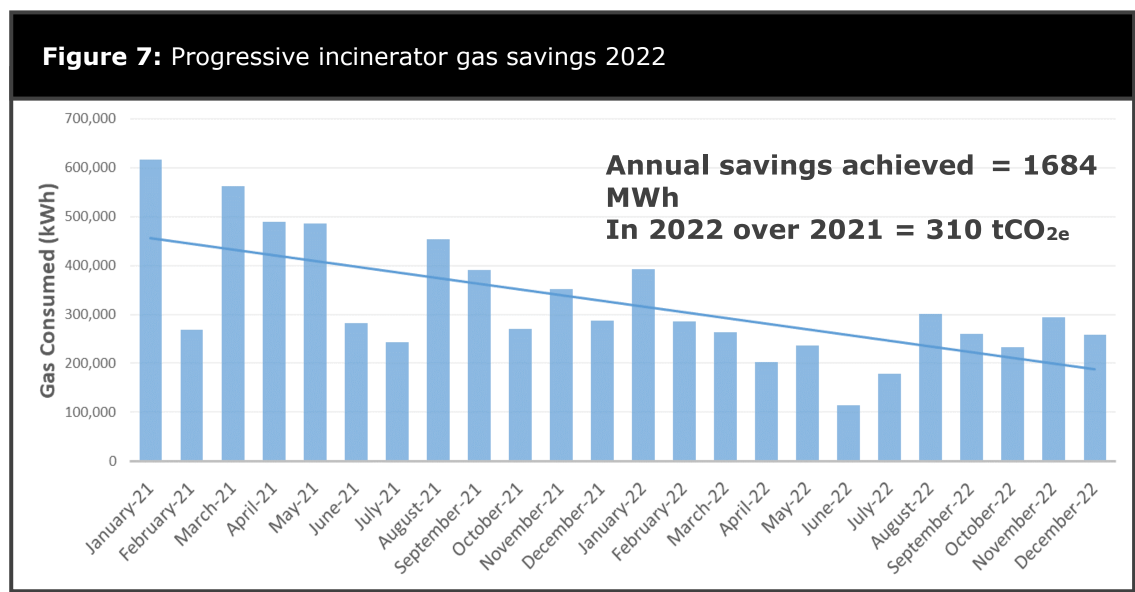
This year, we have continued the ongoing roll-out of fluorescent light fitting upgrades with high efficiency LED units. These have not only permanently cut consumption by approximately 33tCO_{2e} and saved approximately £18,000 per year in running costs, but also significantly improved the lighting quality wherever they have been installed.

Rolling programme of energy saving measures - additional 33tCO2e saved from lighting (35% cover) & other projects.

Approximately 35% of the Trust's internal lights have been upgraded to date (almost all external lighting is now LED). In order to maintain the momentum, the Trust will continue to use its dedicated revolving energy efficiency fund and fully tendered supply-and-install contract to sustain the roll-out in the coming year.

CUH is one of very few NHS hospitals to own and operate its own clinical waste incinerators. The two units bring the twin benefits of being hugely beneficial in terms of effective waste management whilst helping to keep the hospital warm from the recovered heat. The engineering team who run this essential plant 24/7 all year, have delivered exceptional results this year from a programme of continuous improvement and innovative upgrade to the waste incineration process. Not only have these bespoke improvements delivered in the region of a 1,700MWh reduction in gas demand for burning,

Figure 7: Progressive incinerator gas savings 2022



with a saving of over 300 tCO_{2e}/annum, but they are also improving operating conditions and strengthening resilience. (re. Figure 7).

Green

Once energy consumption has been driven down by minimising demand and raising efficiency in use, the final step is to provide the lowest carbon ('green') form of generation available.

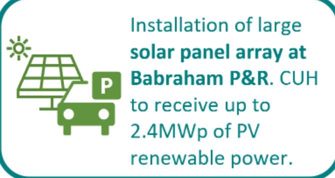
For many hospitals this is difficult and CUH is no exception: clear and accessible roof space for solar panels is often in short supply; burning

biomass comes with significant storage problems and inherent sourcing and transportation issues; wind turbines come at a scale that typically makes them unacceptable, and; the greening of the national electricity grid, in combination with the net-zero agenda, has now rendered the low-carbon credentials of gas-fired combined heat and power (CHP) redundant.

At CUH, relatively small-scale photovoltaic (PV) solar arrays have already been installed on the roof of The Rosie. There is approximately 100kWp installed and in order to ensure every renewable kilowatt hour is used to best effect the two most recent installations have been tethered directly to large building services plant with innovative power electronics (incorporating battery storage). Both installations have been running exceptionally well even in extreme weather conditions (very hot or very cold).

90kWp of high efficiency solar PV panels committed to roof of new Mobility Surgical Hub - saving approx. 16tCO2e/yr.

2022/23 presented an outstanding opportunity to bring this solarised heat-pump technology to bear in the orthopaedic theatres unit for the proposed new Movement Surgical Hub. This approach has since been fully adopted and the new facility is currently under construction with modular heat-pump/chiller solarised technology (built off-site) incorporating approximately 90kWp of roof-mounted PV panels (due for completion autumn 2024).



Another alternative for directly increasing the supply of renewable electricity is to physically connect CUH's on-site high voltage network with a local commercial-scale renewable energy generation site. These direct local opportunities are rare, but the Trust is currently in partnership with Cambridgeshire County Council on what is known as a 'private-wire' power purchase agreement (PPA) to bring in surplus electricity from a 2.5MWp PV array that the Council is currently installing above the parking bays on their Babraham Park and Ride site. This locally sourced renewable power link is due to be energised for spring 2024.

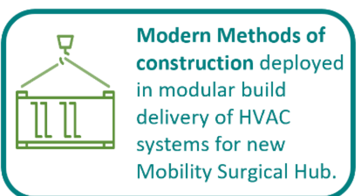
The Trust is also reviewing an additional locally sourced commercial private-wire supply option. An independent market assessment into the value and opportunities for PPAs tied to more remote generation via the wider regional/national grid has also been carried out. The latter has also been tied into options to potentially aggregate demand via CUH's membership of the Shelford Group of hospital trusts, and is being fed into a parallel East of England Greener NHS regional project.

Lean, clean, and green new build

Throughout the year, CUH and its development partners, have been progressing the design specifications for both the new Cambridge Children's Hospital (CCH) and the Cambridge Cancer Research Hospital (CCRH) to RIBA Stage 3. As new builds, these facilities will define the opening standard for

Net-zero enabled, designs for CCH (Passivhaus pilot) & CCRH. Campus Heat Decarbonisation Plan completed.

net-zero design on site – setting this standard in their own right and also as part of the wider master planning programme. With the new NHS Net Zero Building Standard being formally released, the Trust has been able to ensure that these two flagship projects are fully embedded in leading the way for CUH's net-zero ambitions.



The design teams for both projects have worked hard to understand and secure compliance with the new standard and its core focus on driving down energy use intensity for each new building. Specifications have been shaped that really push the boundaries of what is required of lean, clean, and green net-zero enabled premises whilst also incorporating the benefits of modern methods of construction. The slightly more advanced designs for CCRH have been fully endorsed by the NHS New Hospital Programme with the environmental sustainability designs recognised as class leading. CCH is endeavouring to push even further through working with the acclaimed Passivhaus Institute to follow their exceptionally progressive energy-saving design methodology.

Water

Water consumption across the site has historically been relatively stable at approximately 33,000m^3/month.
For operational and safety reasons, much of the water is treated, tanked and subject to a carefully managed pipe flushing regime. Due to hospital regulatory issues, methods of reducing mains water consumption on campus have restrictions: especially in relation to the very necessary priority of infection control. The pipe flushing and upgrade regime is under constant review and development to ensure safety whilst minimising consumption.

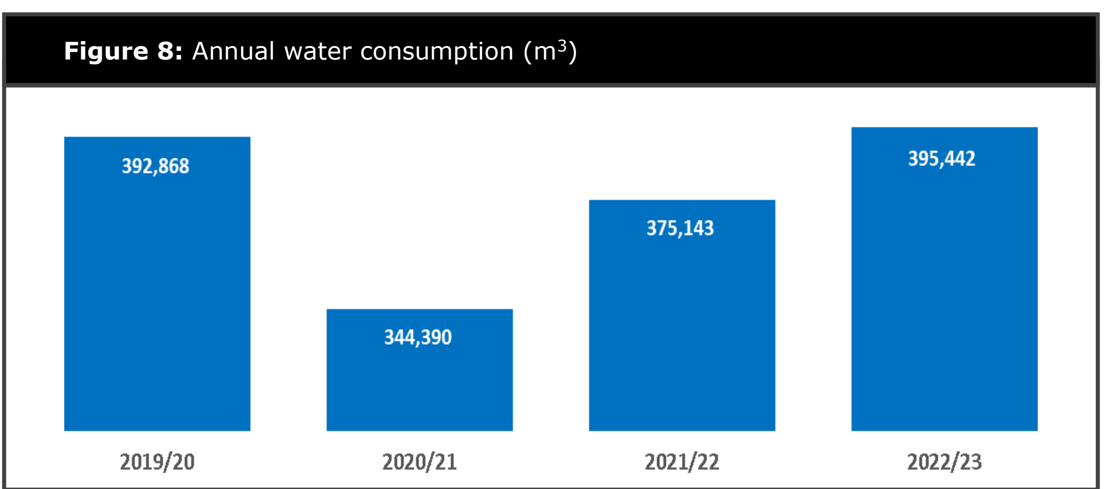


Figure 8: Annual water consumption (m^3)

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

Sustainable Procurement and Waste Management

Using the indicative emissions factors (provided by the central Greener NHS team) against spend for the main procurement categories, the carbon embedded in purchased goods, materials, and equipment for 2022/23 is over seven times greater than that for gas and electricity used to heat and power the Trust's buildings. It should be noted that this excludes the majority of PPE that has been provided to CUH through central distribution outside of standard procurement recording as an ongoing post-pandemic residual practice (due to come to an end in 2023/24).

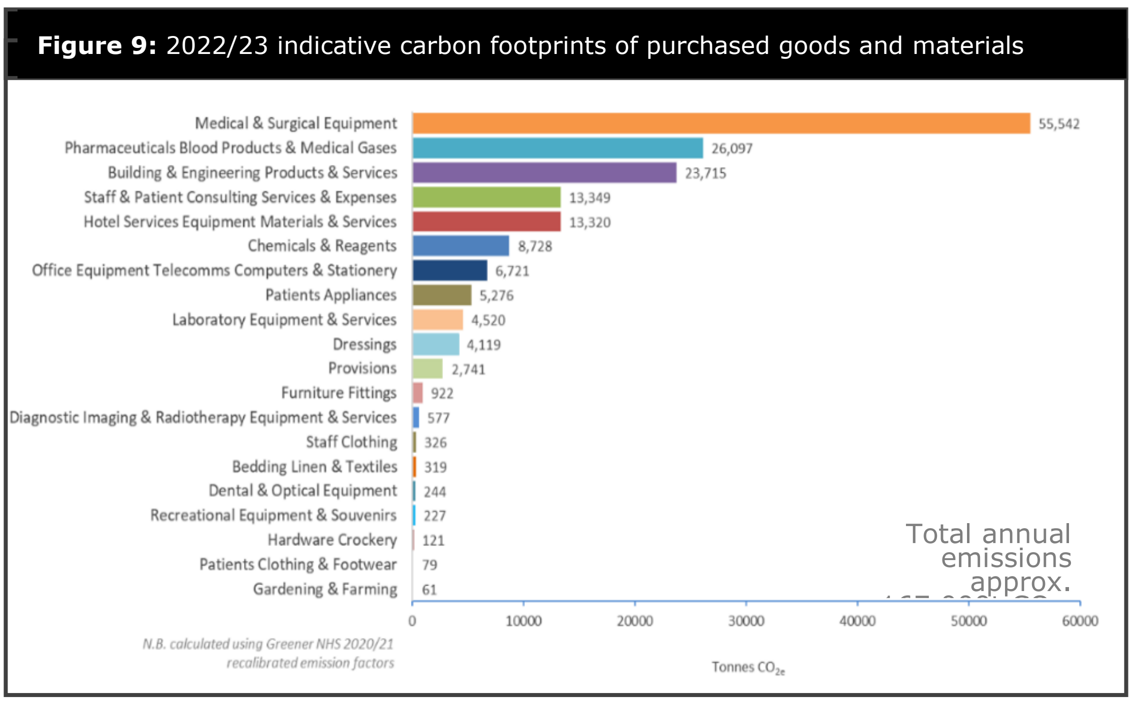
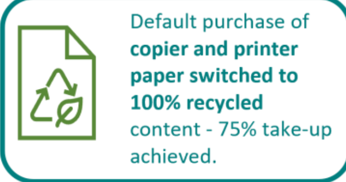
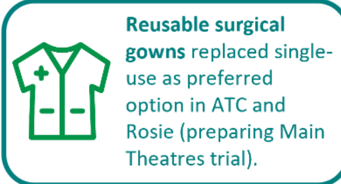


Figure 9: 2022/23 indicative carbon footprints of purchased goods and materials

As introduced in Section 1 of this report, CUH (as a very intense consumer of goods, materials and equipment) has a crucial role to play in the transition from a fossil-fuelled take-make-use-throwaway 'linear economy' way of working to a renewably powered reuse, repair, remanufacture and recycling 'circular economy' way of working. As a responsible consumer, the infrastructure, process, and behaviours need to be in place that clearly recognise the leftovers from what we consume as ongoing resources and not as waste. The importance of this responsible stewardship towards carbon that has already been emitted on our behalf (as well as the pollution and the natural resources extracted/harvested) has already been illustrated in terms of the map and terrain that needs to be navigated (re. Figures 2 and 4). Some steps are relatively straightforward, such as the switch to 100% recycled paper, but the majority are far more complicated – requiring the careful integration of clinical, procurement, financial and compliance-related decision-making.



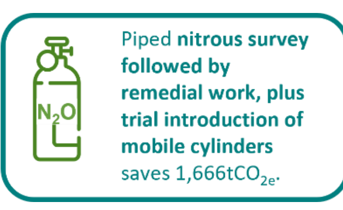


Tender specification for net-zero and social value

2022/23 has provided an exceptional opportunity to embed this within contractual supplier relationships through the introduction of a regulatory requirement to include a minimum 10% weighting in all tender assessments for criteria in support of net-zero and social value outcomes. CUH has fully embraced this directive and has shaped a specification requirement across both carbon and waste foot-printing and their improvements as a collaborative commitment between suppliers and CUH. Some of these tender returns are now becoming contractual relationships and the testing of the commitments to baselining and subsequent improvement will be exercised through the contract management process. The new linen contract (incorporating options to expand the provision of reusable surgical gowns and the recycling of clinical area single-use curtains) and the histopathology service equipment contract are both key test cases for this approach.

This is potentially one of the biggest strides forward in tackling the Scope 3 emissions embedded in the purchase of goods, materials and equipment – through directly tackling the Scope 1 and 2 emissions within the supply chain and indirectly by avoiding emissions through reuse, repair, remanufacture and higher value recycling.

Anaesthetic gases



Towards the end of last year CUH Maintenance teams deployed an innovative technique for identifying leaks from its medical gas distribution networks for nitrous oxide (N_20, used as an anaesthetic agent for certain cases in theatres) and Entonox (50% nitrous oxide and 50% oxygen used as an analgesic predominantly in maternity delivery units but also in other locations such the Emergency Department). Theatre teams were also quantifying and reviewing their use of the volatile anaesthetic gas desflurane. These three gases all had two things in common: they had high global warming potentials (310 for N_20 and 2,540 for desflurane) and were both released directly into the atmosphere. Combined, the gases accounted for approximately 10% of the CUH direct carbon footprint.

Throughout this year a multidisciplinary team working in conjunction with the Trust's Medical Gases Committee have successfully trialled the switch from the inherently leaky N_2O theatre piped network to the use of mobile cylinders. The Entonox piped network has been repaired (considerably less leaky than the pure N_2O theatre network). Theatre anaesthetists have also significantly controlled and reduced their use of desflurane. The Rosie Delivery Unit has also been trialling the use of a mobile destruction unit for exhaled Entonox.

Taken together, these measures are estimated to have already reduced direct carbon emissions by over 2,000 tCO_{2e}/annum.

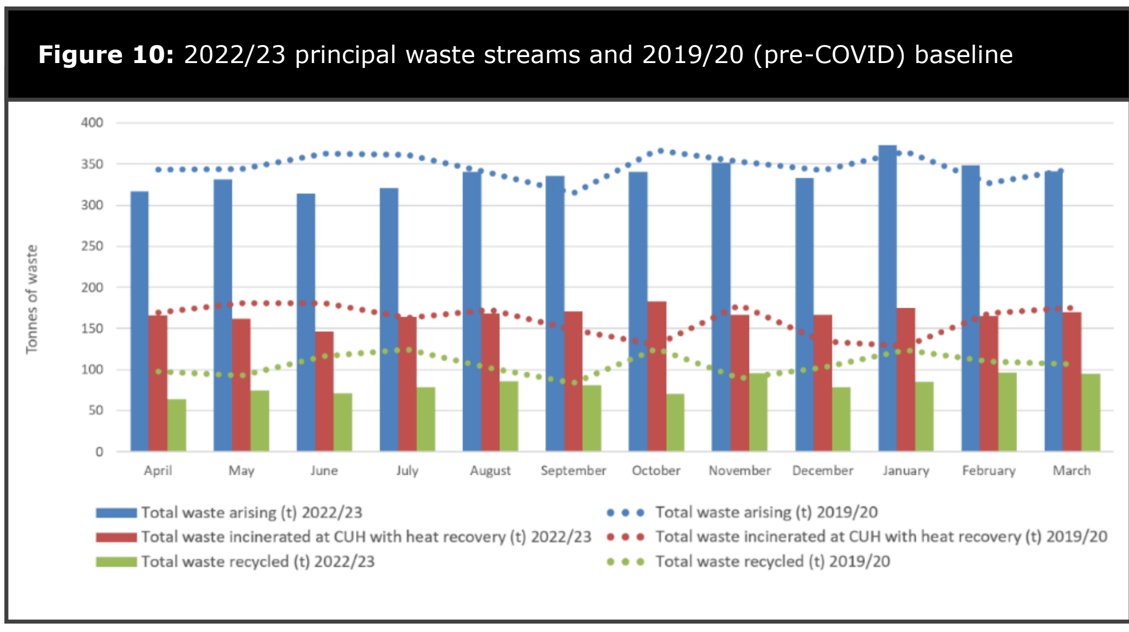
Waste arising

The COVID crisis inevitably disrupted waste segregation processes as infectious and PPE disposal escalated dramatically. The 2022/23 figures still retain a degree of the legacy of this disruption.

This, combined with an increase in intensity in clinical activity (e.g. reducing the elective surgery backlog) has resulted in a rise in the incinerated clinical waste fraction.

It is envisaged that this is also reflected in the continuing struggle to meet pre-COVID levels of recycling. A return that has been further constrained by restrictions in what is contractually acceptable as domestic recycling (green bag) waste. The quality of the waste in terms of compliance with effective segregation practice has been much improved, it is raising the recycling fraction that is proving a longer-term challenge.

Figure 10: 2022/23 principal waste streams and 2019/20 (pre-COVID) baseline



This year, the Trust continued to sustain an impressive six re-use, seventeen recycling and two energy-from-waste streams alongside repairs, where possible to medical devices through Clinical Engineering and to furniture and building services site infrastructure through the Estates and Facilities Maintenance teams.

The on-line intranet Swap Shop and Equipment Team/Portering Supervisor are still tirelessly finding new homes for larger redundant or no longer wanted items.

As an acute hospital campus, there are waste types for which value retention is not an option. CUH produces significant quantities of healthcare waste which is often hazardous or contaminated. This means it is bound by tight regulations as to how it can be disposed of: re-use and recycling are not available disposal routes for these types of waste. The Trust incinerates clinical and offensive waste on site in what is, essentially, total destruction - with the exception of the recovery of heat from the combustion process that is then used to warm the premises.

As with energy and water, however, we depend upon staff, patients and visitors to use the sustainable waste infrastructure that the Trust puts in place as effectively and responsibly as possible. For waste management this means users putting items in the correct bin or collection points when they are ready for disposal. The potential for bagged waste to hide mistakes and errors in this sorting at source are both perennial and significant in terms of safety and sustainability. To help prevent this from happening all clinical staff are required to complete a waste segregation e-learning module (for which we now have comprehensive compliance).

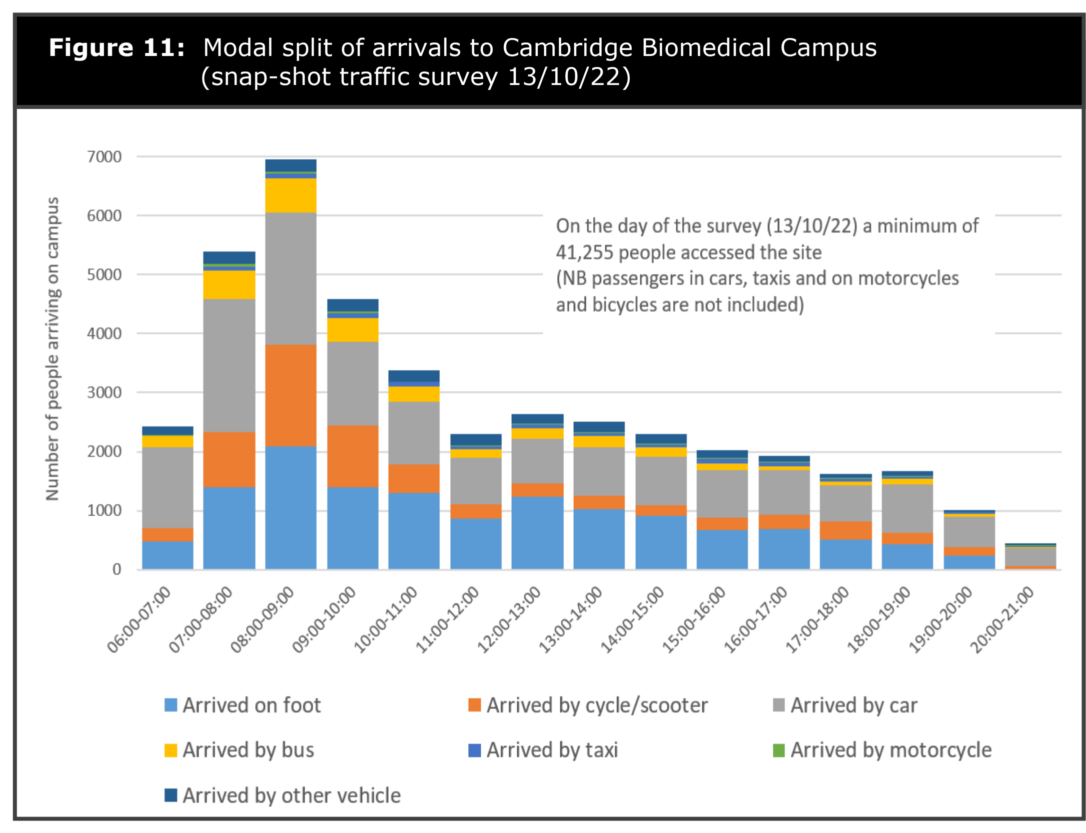
The goods-in and waste-out processes generate significant vehicle movements 24/7 in arrivals and exits from the CUH Service Yard. A pilot air quality and visual evidence gathering technology was installed in March (with a regional Greener NHS grant). Outcomes will be reported in the coming year.

Sustainable Travel

The Trust has a long track record of successfully enabling more sustainable modes of travel for work. Since 1993 the percentage of staff travelling to work by car has halved. This has been an outstanding and very necessary achievement as the total number of staff coming to work at CUH has grown from around 4,000 to approximately 11,500 over the same period. This engagement and delivery with the importance of sustainable travel was recognised this year by selection for CUH to join the Greener NHS's Step Up A Gear programme for exemplar healthcare organisations.

Of all the topic areas relating to what and how CUH consumes, travel miles and transport choice were transformed the most by the COVID-19 crisis. In terms of reducing carbon emissions, and improving air quality, several aspects have been positive, and some are now embedded as elements of standard working practice.

Figure 11: Modal split of arrivals to Cambridge Biomedical Campus (snap-shot traffic survey 13/10/22)



The two most significant changes involve replacing travel and attendance on site for physical meetings with remote IT-based virtual screen contact. These incorporate: i.) the use of telephone consultations and telemedicine to replace outpatient face-to-face contacts where appropriate and possible – this now stands at the NHS target level of 25% of all outpatient appointments, and ii.) the shift to working from home where a presence on site is not necessarily essential to operational delivery and where service contact can be replaced through virtual on-line meetings.

Figure 12: 2019-2023 comparative monthly recorded travel data

Both of these factors will have continued to reduce the number of people physically accessing the CUH campus. With only very high level data available it is not really possible to quantify this reduction with any accuracy and, consequently, offer an associated carbon reduction figure. An indication of the modal split by travel type is illustrated in Figure 11 (it should be noted that this snapshot data is for the whole of the Cambridge Biomedical Campus and not just the CUH demise).

There are, however, some proxies that indicate the nature of change: for example the CUH business travel and on-site cycle parking figures illustrated in Figure 12. All three indicate a marked difference from the pre-COVID 20129/20 baseline. Only the figures for the pool car business miles appear to be rebuilding to their previous level.

The greyfleet mileages (staff using their own vehicles on CUH business) have increased significantly over both last year and baseline. This is likely to be as an unintended consequence of some of the sustained levels of working from home but will need further investigation to be more fully understood. This situation runs counter to the Green Plan action to

transition these miles to public transport or low carbon pool vehicle alternatives.

The number of bicycles parked on site has also not picked up this year as anticipated. This may again be a product of sustained working from home for some staff alongside the provision of the free for staff park-and-ride bus service from Babraham and Trumpington Meadows.

The two on-site courtesy buses remain the only electric vehicles within the Trust's existing fleet of lease vehicles. However, the opportunity to facilitate the installation of an array of electric vehicle charging points for the fleet (up to thirty-five vehicles) has come forward this year in the form of the interim early parking allocation for the Cambridge Cancer Research Hospital. The primary location for the charging of staff vehicles is expected to be the Babraham Park and Ride site when its full conversion to solar powered EV charging bays is completed in the spring of 2024.

Approximately 20% take-up of **electric vehicles through CUH salary sacrifice** benefit scheme.

The Trust's salary sacrifice scheme for the lease/purchase of private vehicles by staff is actively promoting the take-up of ultra-low emission and electric cars – it now includes over 25 vehicles of this type.

The Trust has continued to work closely with the City Council, County Council, Greater Cambridge Partnership (GCP), and Cambridgeshire and Peterborough Combined Authority to input into a wide range of important consultations to improve sustainable travel links to and from the campus. Active collaboration with the local bus companies has also continued to prove invaluable in both restoring and significantly improving public transport, access routes and park-and-ride facilities. The installation of solar-powered EV charging points across the Babraham Park-and-Ride site is expected to provide the majority of required capacity for staff vehicles.

The Campus Cycle Hub has helpfully extended its opening hours to include weekends as the experienced team continue to look after the Campus cyclists' repair and servicing needs.

On-site, an additional 30 cycle parking spaces have been provided near the residences and outside of the Frank Lee Centre as part of a GCP grant assisted scheme that has been focused on improving cycle security with the installation of important supplemental CCTV in five new locations.

The local Voi electric bicycle and scooter share scheme has continued to expand activity on Campus throughout the year in term of both vehicle numbers and take-up. It consistently provides important additional

sustainable travel options for all staff, patients and visitors making short journeys to and from site (e.g., from the local park-and-ride sites).

Important agreements have now been signed off and site pre-enablement works begun for the construction of the new Cambridge South Railway Station.

Sustainable Behaviour Change

CUH's ongoing upgrade to the physical infrastructure and delivery systems of energy and water efficiency, waste segregation, travel choices and life-cycle-assessed procurement are all essential aspects of the transition to a secure and more sustainable future. This, however, is only part of the picture. An essential element of these infrastructure upgrades and process changes is to ensure they are used and taken up effectively by real people in real situations: our staff, patients and visitors across a large, complex and intense hospital campus.

Facebook: Posts November '22- March '23: 110. March '23 reach = 4180 (+ 370 reactions).

Few people want to see resources wasted or to cause avoidable damage to our natural environment. The pressures of a busy hospital often mean, however, that the environmental impacts of our day-to-day actions can easily be overlooked. Requests to power-down, recycle more or catch the bus will struggle to make a real difference on the ground unless they are tailored to individual teams and workspaces.

A50GP staff engagement sessions: 8 Concourse events. 27 scheduled talks, visits & team meets.

CUH sustainability team attending **new staff inductions** to highlight benefits and participation .

Of all the action sets within the A50GP, the one covering staff engagement is almost certainly the most important in this opening phase of delivery. Unless all levels of the organisation are engaged with the extensive transformation required to secure a climate-safe future then all other infrastructure and process actions will struggle or fall short.

No. of staff in **CUH Green Champions Community:** 262. Newsletter sent every month.

The launch of the A50GP began in earnest in November with a very high profile 'Green Takeover' week. This has since been followed up and sustained with a stream of 110 Facebook posts with a reach of over 4000 and over 350 reactions a month. These posts are built around a themed staff engagement calendar that has provided 8 Concourse events and 27 scheduled talks, visits or team

CUH **Think Green Impact:** 28 teams registered. **LEAF** (labs) pilot: 3 teams.

Environmental sustainability proposed as **personal objective in 2023 ADRs.**

meetings. The reintroduction of in-person new starter days has revived the roll-out of the Sustainability Team stall to help new staff access the benefits of an organisation actively responding to the climate crisis. This includes encouragement to join the Trust's vibrant Green Champion Community with over 260 members who are kept directly informed via newsletter and email of opportunities to take action and get involved in CUH's net-zero/zero-waste journey. All this work is backed up by an increasingly strong presence on the newly upgraded Connect intranet pages as content is updated and upgraded through the transfer process.

In February the new improved Think Green Impact programme was re-launched after a successful conclusion to the 2022 round with six teams securing various levels of audited awards. The promotion around the new launch has been highly successful with 28 teams now registered. Alongside this, three of the Trust's laboratory-based teams are piloting an equivalent programme designed specifically for their unique environment – entitled LEAF (the Laboratory Efficiency Assessment Framework).

All of the above will help staff to think about setting themselves a net-zero or wider environmental sustainability objective as this is now scheduled to be included in the Annual Development Review process.

Being prepared for the impacts of climate change

The cumulative concentration of manmade greenhouse gasses in the atmosphere has already committed us to experience a significant degree of climate change. In Cambridge the most immediate of these is likely to be felt through building overheating from summer heat-waves. Cambridge held the record in the UK for the hottest outside air temperature on record at 38.7°C (101.7°F) in the summer of 2019 – this was subsequently overtaken nationally this summer, whilst Cambridge itself recorded a maximum of 41°C.

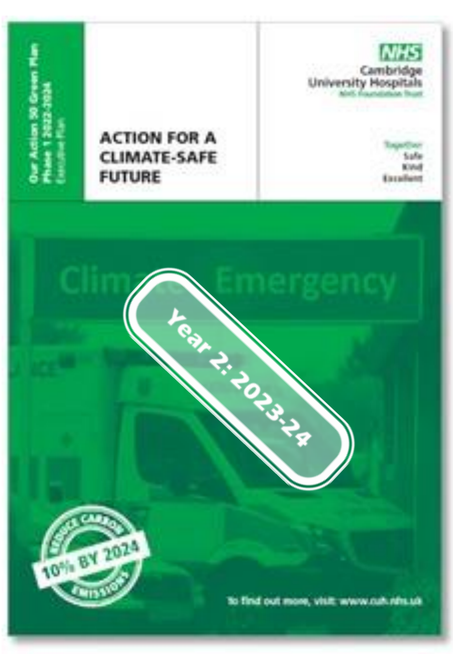
Heatwaves and extended periods of hot weather put significant pressure on the hospitals' ventilation and cooling systems and create extended spikes in electricity consumption and carbon emissions. Air-conditioning is not only costly to purchase and run (with a corresponding increase in carbon emissions) but it is also disruptive to install and in many cases not a viable option due to space constraints for the units, ducting and pipe-runs – especially in older buildings not designed to accommodate such services. Reflecting these constraints, portable air-conditioning units are now provided in a carefully controlled manner in the summer months for critical clinical areas. However, as climate change raises the likelihood and intensity of summertime heatwaves it is increasingly important to seek out and bring forward low energy solutions.

The Trust has had some success in trialling the deployment of a new solar rejection film for windows with a southerly aspect alongside the installation of small two-way window or wall-mounted fans (with timer controls to facilitate overnight 'free' cooling). When packaged up with the all-important local behavioural and management responses, these interventions begin to provide an accessible low carbon and relatively low-cost solution to mitigating seasonal over-heating. The retrofitting of 'brise soleil' units is also an option that has been trialled, but effective and accessible fixing can be problematic. The impact and development of these low energy interventions will continue to be monitored for their effectiveness.

Surface water flooding from more frequent and intense storm events is also an anticipated outcome of climate change. The Trust has experienced some impact from such events over the past five years in the south-western corner of the site – most significantly on 17th July 2015 when a 1-in-190 year heavy rainfall and flooding event caused the Trust to declare a 'major incident'. In response to this, and working with Cambridge City Council, a Surface Water Management Plan (SWMP) for CUH and mitigation outline business case was drafted. Some viable interventions from this have been previously implemented to reduce the risk of flooding in the future.

Looking forward: delivering Year 2 of *Our Action 50 Green Plan*

The new CUH Green Plan has not only provided a clear programme of action, but also a coherent reference point for the organisation: establishing how it will take forward its twenty year commitment of working for a climate-safe future as part of the healthcare services it provides day-in-day-out. The Trust has made excellent Year 1 progress in delivering the plan's fifty actions. Each of these individual deliverables is important in their own right as contributors to cutting carbon, pollution and resource loss. Securing a climate-safe future, however, hinges upon their connectivity to each other, to their next steps (few actions standalone in time) and, most importantly, to the running of the organisation as a whole.



At the core of this is how quickly and comprehensively we can integrate lifecycle thinking (for renewable energy, product reuse, repair, remanufacture and high value recycling) into relevant, practical and material ways across the thousands of choices made every day in the running of a major acute teaching hospital.

Having introduced, communicated, and successfully launched a swathe of actions that have put the A50GP's direct carbon reduction target within ready reach, the Year 2 activities will therefore put a priority focus on the essential integration of lifecycle thinking into CUH's decision-making. 2022-23 has opened the door to helping this happen in three crucial areas covering the fundamentals of i.) behavioural response, ii.) organisational process, and iii.) physical infrastructure:

i.) strongly communicating the plan over a range of channels has raised the appetite of staff across the Trust for a programme of more formal e-learning and additional visualisation on the 'how' of delivery;

ii.) the introduction of a 10% tender assessment weighting for net-zero and social value provides a formal channel to develop carbon and waste reduction improvement plans in a constantly rolling wave of contract management across the Trust's services;

iii.) the new Heat Decarbonisation Plan provides the engineered vehicle for progressively removing the combustion of fossil fuels from the CUH campus (in the provision of heating related building services) and thereby the foundation for aligning this with the development of Addenbrooke's 3.

3.30 Other issues

The activities and policies of the CUH in the areas of social, environmental, community and human rights are outlined earlier in this chapter and specifically the equality and diversity report and sustainability and climate change report.

Roland Sinker
Chief Executive
27 June 2023

Cambridge University Hospitals NHS Foundation Trust Accounts Year Ended 31 March 2023

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

Independent auditor's report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust
Report on the audit of the financial statements

Opinion on the financial statements
We have audited the financial statements of Cambridge University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2023 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2023/23, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as of 31 March 2023 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material

misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Chief Executive Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2022/23; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2022/23; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of Cambridge University Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Suresh Patel, Key Audit Partner

For and on behalf of Mazars LLP

30, Old Bailey, London, EC4M 7AU

29 June 2023

FOREWORD TO THE ACCOUNTS

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust ("the Trust") acts as an acute hospital and the main teaching hospital for the University of Cambridge. The Trust serves the local Cambridge area and also provides specialist services to the wider population throughout the East of England and beyond. The Trust hosts a number of clinical networks and the Cambridge Biomedical Research Centre.

These accounts for the year ended 31 March 2023 have been prepared by Cambridge University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed

Roland Sinker
Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023

	Note	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Operating income from patient care activities	2	1,139,214	1,047,910
Other operating income	2	215,434	177,785
Total operating income from continuing operations		1,354,648	1,225,695
Operating expenses of continuing operations	3	(1,348,900)	(1,230,060)
Operating surplus/(deficit)		5,748	(4,365)
Finance Income and costs			
Finance income	6	3,749	-
Finance expense	6	(7,344)	(6,485)
PDC dividend charge		(3,352)	(3,229)
Net finance costs		(6,947)	(9,714)
Other gains/(losses)	6	10	(517)
(Deficit) for the year		(1,189)	(14,596)
Other comprehensive income/(expenditure)			
Will not be reclassified to income and expenditure:			
Impairment charged to the revaluation reserve	8	(1,770)	(572)
Revaluations	8	11,369	3,721
Total comprehensive income/(expense) for the year		8,410	(11,447)
Allocation of (losses) for the year:			
(Deficit) for the year attributable to:			
Government		(1,189)	(14,596)
Total comprehensive income/(expense) for the year attributable to:			
Government		8,410	(11,447)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	7	19,756	24,169
Property, plant and equipment	8	487,172	434,608
Right of Use Assets	8	49,521	
Receivables	10	2,227	2,174
Total non-current assets		558,676	460,951
Current assets			
Inventories	9	13,393	11,625
Trade and other receivables	10	68,469	50,326
Cash and cash equivalents	11	226,386	224,151
Total current assets		308,248	286,102
Current liabilities			
Trade and other payables	12	(265,416)	(213,456)
Borrowings	13	(13,789)	(9,050)
Provisions	14	(13,298)	(6,349)
Other liabilities	12	(91,945)	(109,101)
Total current liabilities		(384,448)	(337,956)
Total assets less current liabilities		482,476	409,097
Non-current liabilities			
Borrowings	13	(114,102)	(86,554)
Provisions	14	(9,462)	(13,126)
Total non-current liabilities		(123,564)	(99,680)
Total assets employed		358,912	309,417
Taxpayers' equity			
Public dividend capital		615,959	583,288
Revaluation reserve		47,026	37,510
Income and expenditure reserve		(304,073)	(311,381)
Total taxpayers' equity		358,912	309,417

These financial statements were approved by the Board and signed on 27th June 2023 on its behalf by:

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2023

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' equity at 01 April 2022	309,417	583,288	37,510	(311,381)
Implementation of IFSR16 on 1 April 2022	8,414			8,414
(Deficit) for the year	(1,189)	-	-	(1,189)
Transfers between reserves	-		(83)	83
Impairments charged to the revaluation reserve	(1,770)	-	(1,770)	-
Revaluations	11,369	-	11,369	-
Public dividend capital received	32,671	32,671	-	-
Public dividend capital repaid	-	-	-	-
Taxpayers' equity at 31 March 2023	358,912	615,959	47,026	(304,073)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR YEAR ENDED 31 MARCH 2022

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' equity at 01 April 2021	294,950	557,374	34,432	(296,856)
(Deficit) for the year	(14,596)	-	-	(14,596)
Transfers between reserves	-	-	(71)	71
Downwards revaluations charged to the revaluation reserve	(572)	-	(572)	-
Revaluations	3,721	-	3,721	-
Public dividend capital received	28,375	28,375	-	-
Public dividend capital repaid	(2,461)	(2,461)	-	-
Taxpayers' equity at 31 March 2022	309,417	583,288	37,510	(311,381)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Cash flows from operating activities		
Operating (deficit) from continuing operations	5,748	(4,365)
Non-cash income and expense		
Depreciation and amortisation	32,546	24,950
Impairments	-	18,064
Income recognised in respect of capital donations (cash and non-cash)	(235)	(2,723)
(Increase)/decrease in receivables	(20,635)	11,804
(Increase)/decrease in inventories	(1,768)	(661)
(Decrease)/increase in trade and other payables	52,327	51,887
Increase in other liabilities	(17,156)	21,005
Increase/(decrease) in provisions	3,039	1,883
Other movements in operating cash flows	1	-
Net cash generated from / (used in) operations	53,867	121,844
Cash flows from investing activities		
Interest received	3,749	-
Purchase of intangible assets	(740)	(3,811)
Purchase of property, plant and equipment and investment property	(66,689)	(79,898)
Sales of property, plant and equipment and investment property	331	-
Receipt of cash donations to purchase capital assets	235	2,251
Net cash (used in) investing activities	(63,114)	(81,458)
Cash flows from financing activities		
Public dividend capital received	32,671	28,375
Public dividend capital repaid	-	(2,461)
Movement in loans from the Department of Health and Social Care	(6,398)	(6,398)
Capital element of lease liability repayments	(4,721)	-
Capital element of PFI, LIFT and other service concession payments	(1,852)	(1,708)
Interest on loans	(1,903)	(2,127)
Interest element of lease liability repayments	(420)	-
Interest element of PFI, LIFT and other service concession obligations	(4,847)	(4,402)
PDC dividend (paid)/refunded	(913)	(4,943)
Net cash generated from financing activities	11,617	6,336
(Decrease)/increase in cash and cash equivalents	2,370	46,722
Cash and cash equivalents at 1 April	224,016	177,294
Cash and cash equivalents at 31 March	226,386	224,016
Cash with the Government Banking Service	226,386	224,151
Bank overdrafts (GBS and commercial banks)	-	(135)
Total cash and cash equivalents as in SoCF	226,386	224,016

The Foundation Trust held £0.1k cash at bank and in hand at 31 March 2023 (year ended 31 March 2022, £0.1k) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

NOTES TO THE ACCOUNTS

IFRS Accounting Policies

1 Accounting policies and other information

NHS England has directed that the financial statements of NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Revenue from contracts with customers

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

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

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Revenue from NHS contracts

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

The Trust does not currently accrue for incomplete spells due to the decision to stop this process as a result of the Covid-19 pandemic. This is then replaced by the block funding values agreed for our key commissioners in line with the 2022/23 funding regime. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Due to the current block funding regime in place with NHS commissioners the total monthly NHS commissioner bills, based on patient activity, are adjusted back to align with the agreed block values, except for areas where variable billing remains in place i.e. some variable services, drug and device expenditure.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

1.4 Other forms of income

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 Statement of Comprehensive Income once conditions attached 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 at 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 of Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 Expenditure on employee benefits

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

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

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. It is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably and is above £5K

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

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

Subsequently, land and buildings are measured at valuation and all other Property, plant and equipment assets are held at depreciated historical cost.

Land and specialised buildings are valued at depreciated replacement cost on a modern equivalent asset (alternative site) basis. Non-specialised buildings are valued at existing use value. Valuations are carried out by professionally qualified District Valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust. The land and buildings valuation was undertaken as at the prospective valuation date of 31 March 2023, applying the modern equivalent assets valuation (alternative site) basis which is consistent with IAS (International Accounting Standard) 16.

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

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

Depreciation

Items of property, plant and equipment are depreciated, less any residual value, on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Properties not yet in use are held as assets under construction and are not depreciated.

Buildings, installations and fittings are depreciated on their current value for existing use over the estimated remaining life of the asset as assessed by professional valuers.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Land	Infinite
Buildings	1 – 60 years
Plant and Machinery	5 – 15 years
Information Technology	5 – 12 years
Furniture and fittings	7 – 10 years
Transport Equipment	7 years

Revaluation gains and losses

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset (alternative site) basis.

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

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

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

Impairments

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

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Donated, government grant and other grant funded assets

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

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

Private Finance Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment.

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

The finance cost is allocated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.
Expenditure on research is not capitalised, it is recognised as an operating expense in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operating of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use by reference to an active market. Where no active market exists, intangible assets are valued at the lower of depreciated historical

cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The estimated life of purchased computer software is between 2 and 12 years.

1.9 Inventories

Inventories comprise mainly consumable medical products.

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost formula for drugs and the first in first out cost formula for all other inventories. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Cash and cash equivalents

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

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

1.11 Financial assets & financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provision of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices 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 cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

Amortised cost financial assets are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through profit and loss" are impaired. Financial assets are impaired and impairment losses are recognised if they meet the requirements of the expected credit loss model.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

De-recognition

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

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

1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or

nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as lessor

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

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (2021-22: minus 1.30%). All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

A nominal short-term rate of 3.27% (2021-22: minus 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

A nominal long-term rate of 3.51% (2021-22: 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf is £373.5m (year ended 31 March 2022, £528.8m). This is not recognised in the Trust's accounts.

1.14 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance, based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.15 Value Added Tax

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

1.16 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.

1.17 Losses and special payments

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

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

1.18 Critical judgments in applying accounting policies

The following are the judgements, apart from those involving estimates (see below) that management has made in the process of applying the NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The Trust's PFI scheme has been assessed and recognised on the Statement of Financial Position under IFRIC 12. The PFI scheme has been valued by the District Valuer on a Depreciated Replacement Cost (DRC) basis as at 31 March 2023. The £10.2m unitary charge is based on actual charges made by the PFI provider. The Department of Health and Social Care model has been used to determine the apportionment between the repayment of the liability, financing costs, the charges for services and lifecycle maintenance.

Key sources of estimation uncertainty

The most significant estimate within the accounts is the value of land and buildings. The land and buildings have been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2023. The District Valuer is independent of the Trust and is certified by the Royal Institution of Chartered Surveyors. The valuer has extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty. The carrying amount of land and buildings as at 31 March 2023 is summarised in the Note 8 'Property, Plant, and Equipment' to the Statement of Financial Position.

1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 17 Insurance Contracts
The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted. The impact of this standard has been assessed by the Trust and is thought to not impact the financial statements by anything more than trivial amounts.

IFRS 16 Leases – application of liability measurement principles to PFI and other service concession arrangements

From 1 April 2023, the measurement 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 liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. The effect of this has not been quantified due to the lack of guidance issued by NHS England.

2. Operating income

IFRS 8 requires the disclosure of results of significant operating segments; the Trust considers that it only has one operating segment, healthcare.

2.1 Income from patient care (by nature)

Income from activities	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Acute services		
Block contract / system envelope income	881,314	924,322
High cost drugs income from commissioners	165,296	31,964
Other NHS clinical income	4,623	36,972
All other services		
Private patient income	8,042	8,497
Elective recovery fund	26,577	17,126
Additional pension contribution central funding	26,757	24,607
Agenda for change pay offer central funding	21,117	-
Other clinical income	5,488	4,422
Total income from patient care activities	1,139,214	1,047,910

In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS England, providers' accounts are required to account for the additional expenditure arising from the 6.3% pension contributions paid by NHS England and related income on a gross basis.

2.2 Income from patient care (by source)

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Income from activities		
NHS England	580,663	460,364
Clinical commissioning groups	128,671	569,233
Integrated Care Boards	411,654	-
Department of Health and Social Care	73	-
NHS other (including Public Health England)	4,623	5,395
Non NHS: private patients	8,042	8,497
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	934	395
Injury cost recovery scheme	4,554	4,026
Total income from activities related to continuing operations	1,139,214	1,047,910

2.3 Other operating income

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Other operating income		
Research and development (IFRS 15)	68,417	53,686
Education and training (excluding notional apprenticeship levy income)	46,732	45,437
Non-patient care services to other bodies	62,139	46,794
Reimbursement and top up funding	726	1,399
Other (recognised in accordance with IFRS 15)	30,454	20,468
Education and training - notional income from apprenticeship fund	2,440	2,421
Donations/grants of physical assets (non-cash) - received from other bodies (including independent charities)	-	472
Cash donations for the purchase of capital assets - received from other bodies	-	921
Cash grants for the purchase of capital assets - received from other bodies	235	1,330
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	2,178	2,834
Rental revenue from operating leases	2,113	2,023
Total other operating income related to continuing operations	215,434	177,785
Total operating income	1,354,648	1,225,695

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

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Income recognised this year	934	395
Cash payments received in-year (relating to invoices raised in current and previous years)	349	240

3. Operating expenses (by type)

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	3,104	2,387
Staff and executive directors costs	729,378	648,147
Non-executive directors	87	88
Supplies and services – clinical (excluding drugs costs)	194,812	183,831
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	2,177	2,835
Supplies and services - general	31,678	21,701
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	183,681	166,217
Consultancy	305	207
Inventories written down (consumables donated from DHSC group bodies for COVID response)	73	369
Establishment	21,345	17,994
Premises - business rates collected by local authorities	3,644	3,571
Premises - other	81,389	70,418
Transport (business travel only)	679	368
Transport - other (including patient travel)	3,546	2,472
Depreciation	27,406	20,450
Amortisation	5,140	4,500
Impairments net of (reversals)	-	18,064
Increase in impairment of receivables	7,254	9,806
Change in provisions discount rate	(615)	22
Audit services - statutory audit (net of VAT)	103	94
Internal audit	98	98
Clinical negligence - amounts payable to NHS Resolution (premium)	24,319	22,119
Legal fees	701	438
Insurance	337	411
Research and development	13	11
Education and training	4,276	2,057
Education and training - notional expenditure funded from apprenticeship fund	2,440	2,421
Operating lease expenditure	-	6,668
Lease expenditure - short term leases (<= 12 months)	236	-
Lease expenditure - irrecoverable VAT	371	-
Early retirements	501	696
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,478	1,203
Car parking and security	736	3,975
Hospitality	151	143
Other losses and special payments	372	259
Grossing up consortium arrangements	13,556	10,881
Other operating expenses	4,129	5,139
Total operating expenses of continuing operations	1,348,900	1,230,060

4. Staff

4.1 Employee expenses

	Year ended 31 March 2023 Total £000	Year ended 31 March 2023 Permanent £000	Year ended 31 March 2023 Other £000
Salaries and wages	571,283	553,914	17,369
Social security costs	59,735	59,735	-
Apprenticeship levy	2,635	2,635	-
Pension cost - employer contributions to NHS pension scheme	61,145	61,145	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	26,757	26,757	-
Temporary staff - agency/contract staff	8,324	-	8,324
Total gross staff costs	729,879	704,186	25,693
Staff and executive directors costs	729,378	703,685	25,693
Early retirements	501	501	-
Total employee benefits	729,879	704,186	25,693

	Year ended 31 March 2022 Total £000	Year ended 31 March 2022 Permanent £000	Year ended 31 March 2022 Other £000
Salaries and wages	507,714	507,714	-
Social security costs	52,245	52,245	-
Apprenticeship levy	2,433	2,433	-
Pension cost - employer contributions to NHS pension scheme	56,379	56,379	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	24,607	24,607	-
Temporary staff - agency/contract staff	5,465	-	5,465
Total gross staff costs	648,843	643,378	5,465
Staff and executive directors costs	648,147	642,682	5,465
Early retirements	696	696	-
Total employee benefits	648,843	643,378	5,465

In line with the DHSC GAM additional guidance and the detailed guidance provided by NHS, providers' accounts are required to account for the additional expenditure arising from the 6.3% pension contributions paid by NHS England and related income on a gross basis.
However, during 2021/22 and 2022/23 the NHS Business Service Authority collected only 14.38% from employers. Central payments have been made by NHS England and the Department of Health and Social Care for their respective proportions of the outstanding 6.3% on local employers' behalf and expenditure has been uplifted to show these contributions to Trust expenses.

The pension cost (excluding additonal pension contribution paid by NHS England) for the 2023/24 financial year is estimated at £64.2m.

5. Operating income and expenditure miscellaneous

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

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Minimum lease receipts	2,113	2,023

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

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
On land leases:		
- not later than one year;	1,079	1,030
- later than one year and not later than five years;	4,318	3,971
- later than five years.	12,707	12,764
Total lands leases	18,104	17,765
On building leases:		
- not later than one year;	1,013	993
- later than one year and not later than five years;	1,190	1,816
- later than five years.	2,686	3,141
Total building leases	4,889	5,950
Total leases	22,993	23,715

5.4 Limitation on auditor's liability

There is no specified limitation on the auditors liability.

6. Finance income and expense

6.1 Finance revenue

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Interest on bank accounts	3,749	-

6.2 Finance expenditure

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Interest on loans from the Department of Health and Social Care		
Capital loans	1,831	2,051
Finance costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	2,211	2,301
Contingent finance costs	2,636	2,101
Interest on lease obligations	420	-
Total interest expense	7,098	6,453
Unwinding of discount on provisions	246	32
Total finance expenditure	7,344	6,485

6.3 Gains/(losses) on disposal of assets

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Gains on disposal of other property, plant and equipment	331	-
Losses on disposal of other property, plant and equipment-owned	(319)	(517)
Losses on disposal of other property, plant and equipment-leased	(2)	-
Total	10	(517)

6.4 Impairments of assets

	Year ended 31 March 2023 £000	Year ended 31 March 2022 £000
Changes in market price	-	15,820
Abandonment of assets in the course of constructio	-	2,244
Total impairments charged to operating deficit	-	18,064
Revaluations charged to the revaluation reserve	1,770	572
Total impairments	1,770	18,636

7. Intangible assets

7.1 Intangible assets for the year ended 31 March 2023

	Software
	£000
Gross cost at 1 April 2022	51,852
Additions - purchased	740
Reclassifications	(13)
Disposals	(150)
Gross cost at 31 March 2023	52,429
Amortisation at 1 April 2022	27,683
Provided during the year	5,140
Disposals	(150)
Amortisation at 31 March 2023	32,673
NBV total at 31 March 2023	19,756

7.2 Intangible assets for the year ended 31 March 2022

	Software
	£000
Gross cost at 1 April 2021	48,438
Additions - purchased	3,693
Disposals	(279)
Gross cost at 31 March 2022	51,852
Amortisation at 1 April 2021	23,462
Provided during the year	4,500
Disposals	(279)
Amortisation at 31 March 2022	27,683
NBV total at 31 March 2022	24,169

Intangible assets represent a comprehensive electronic patient record system called e-Hospital.

8. Property, plant and equipment

8.1 Property, plant and equipment for the year ended 31 March 2023

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2022	514,519	42,500	206,649	59,300	59,791	122,168	364	17,299	6,448
Additions - purchased	66,087	-	17,642	2,007	33,037	10,016	-	3,341	44
Additions - assets purchased from cash donations/grants	235	-	235	-	-	-	-	-	-
Impairments charged to revaluation reserves	(1,770)	-	(698)	(1,072)	-	-	-	-	-
Reclassifications	13	-	6,638	-	(8,434)	1,805	-	4	-
Revaluations	1,050	1,050	-	-	-	-	-		-
Disposals	(10,780)	-	-	-	-	(6,453)	-	(2,162)	(2,165)
At 31 March 2023	569,354	43,550	230,466	60,235	84,394	127,536	364	18,482	4,327
Depreciation									
At 1 April 2022	79,911	-	11,526	-	-	52,283	15	10,420	5,667
Provided during the year	23,051	-	10,577	1,559	-	9,364	50	1,305	196
Revaluations	(10,319)	-	(8,760)	(1,559)	-	-	-	-	-
Disposals	(10,461)	-	-	-	-	(6,134)	-	(2,162)	(2,165)
At 31 March 2023	82,182	-	13,343	-	-	55,513	65	9,563	3,698
Net book value									
Owned	408,559	43,550	204,476	-	84,114	67,045	299	8,447	628
On-SoFP PFI contracts	60,235	-	-	60,235	-	-	-	-	-
Owned - equipment donated from DHSC, UKHSA and NHSE for COVID response	3,515	-	-	-	-	3,515	-	-	-
Government granted	1,844	-	232	-	-	1,140	-	472	-
Donated	13,019	-	12,415	-	280	323	-	-	1
At 31 March 2023	487,172	43,550	217,123	60,235	84,394	72,023	299	8,919	629

8.1 Property, plant and equipment for the year ended 31 March 2022

	Total	Land	Buildings	PFI asset	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost or valuation									
At 1 April 2021	474,735	40,264	194,987	57,322	48,989	109,670	15	16,233	7,255
Additions - purchased	73,769	-	15,067	2,499	33,489	19,024	349	3,304	37
Additions - donations of physical assets (non-cash)	472	-	-	-	-	-	-	472	-
Additions - assets purchased from cash donations/grants	2,251	-	816	-	-	1,435	-	-	-
Downwards revaluations charged to the revaluation reserve	(572)	-	-	(572)	-	-	-	-	-
Impairments charged to operating expenses	(26,361)	-	(26,361)	-	-	-	-	-	-
Reclassifications	-	-	22,140	51	(22,687)	285	-	-	211
Revaluations	2,236	2,236	-	-	-	-	-	-	-
Disposals	(12,011)	-	-	-	-	(8,246)	-	(2,710)	(1,055)
At 31 March 2022	514,519	42,500	206,649	59,300	59,791	122,168	364	17,299	6,448
Depreciation									
At 1 April 2021	80,737	-	9,699	-	-	52,293	15	12,238	6,492
Provided during the year	20,450	-	10,124	1,485	-	7,719	-	892	230
Impairments charged to operating expenses	(8,297)	-	(8,297)	-	-	-	-	-	-
Revaluations	(1,485)	-	-	(1,485)	-	-	-	-	-
Disposals	(11,494)	-	-	-	-	(7,729)	-	(2,710)	(1,055)
At 31 March 2022	79,911	-	11,526	-	-	52,283	15	10,420	5,667

Net book value									
Owned	355,821	42,500	182,063	-	59,511	64,212	349	6,407	779
On-SoFP PFI contracts	59,300	-	-	59,300	-	-	-	-	-
Owned - equipment donated from DHSC, UKHSA and NHSE for COVID response	3,955	-	-	-	-	3,955	-	-	-
Government granted	1,314	-	-	-	-	1,314	-	-	-
Donated	14,218	-	13,060	-	280	404	-	472	2
At 31 March 2022	434,608	42,500	195,123	59,300	59,791	69,885	349	6,879	781

No assets were held under finance leases or hire purchase contracts, with the exception of the PFI asset, which is financed by a PFI contract recognised on the Statement of Financial Position.

Note 8.2 Right of use assets for the year ended 31 March 2023

	Total	Land and Buildings	Plant & machinery	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Gross cost or valuation				
Recognition of right of use assets for existing operating leases on initial application of IFRS 16 on 1 April 2022	50,987	47,167	3,820	2,085
Additions-lease liability	3,052	2,427	625	22
Disposals/derecognition - lease termination	(263)	-	(263)	-
At 31 March 2023	**53,776**	**49,594**	**4,182**	**2,107**
Depreciation				
Brought forward at 1 April 2022	-	-	-	-
Provided during the year - right of use asset	4,065	2,704	1,361	422
Provided during the year - peppercorn leased asset	290	209	81	-
Disposals/derecognition - lease termination	(100)	-	(100)	-
At 31 March 2023	**4,255**	**2,913**	**1,342**	**422**
Net book value				
At 31 March 2023	**49,521**	**46,681**	**2,840**	**1,685**

9. Inventory

9.1 Inventory movements for the year ended 31 March 2023

Carrying value	**Total £000**	**Drugs £000**	**Consumables £000**	**Energy £000**
At 1 April 2022	11,625	3,772	7,641	212
Additions	262,709	184,533	78,017	159
Additions (donated) - from DHSC	2,178	-	2,178	-
Inventories consumed (recognised in expenses)	(263,046)	(183,681)	(79,365)	-
Write-down of inventories recognised as an expense	(73)	-	(73)	-
At 31 March 2023	13,393	4,624	8,398	371

9.2 Inventory movements for the year ended 31 March 2022

Carrying value	**Total £000**	**Drugs £000**	**Consumables £000**	**Energy £000**
At 1 April 2021	10,964	3,249	7,483	232
Additions	237,398	166,740	70,655	3
Additions (donated) - from DHSC	2,834	-	2,834	-
Inventories consumed (recognised in expenses)	(239,202)	(166,217)	(72,962)	(23)
Write-down of inventories recognised as an expense	(369)	-	(369)	-
At 31 March 2022	11,625	3,772	7,641	212

10. Trade receivables

10.1 Trade receivables and other receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables (IFRS 15): invoiced	19,756	13,796
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	63,164	41,961
Allowance for impaired contract receivables / assets	(27,748)	(20,628)
Prepayments (non-PFI)	9,827	9,272
PDC dividend receivable	92	2,531
VAT receivable	3,034	3,107
Clinician pension tax provision reimbursement funding from NHSE	35	37
Other receivables	309	250
Total current receivables	68,469	50,326
Non-current		
Clinician pension tax provision reimbursement funding from NHSE	2,227	2,174
Total non-current receivables	70,696	52,500

Prepayments and accrued income are neither past their due date nor impaired.

Other trade receivables become due immediately as we offer no credit terms.

In line with IFRS9, the Trust recognises impairment losses on other trade receivables when there is a breach of contract following a risk assessment based on future, present and historical information. This is deemed to have occurred if the outstanding receivable has not been settled within 3 months of the invoice date, if a medical insurance company has underpaid or any other relevant information that suggests an impairment.

10.2 Allowances for credit losses (doubtful debts)

	Contract receivables and contract assets	Contract receivables and contract assets
	31 March 2023 £000	31 March 2022 £000
At 1 April	20,628	10,910
New allowances arising	10,901	13,310
Reversals of allowances (where receivable is collected in-year)	(3,647)	(3,504)
Utilisation of allowances (where receivable is written off)	(134)	(88)
At 31 March	27,748	20,628

11. Cash and cash equivalents

11.1 Cash and cash equivalents movements

	31 March 2023 £000	31 March 2022 £000
At 1 April	224,016	177,294
Net change in year	2,370	46,722
At 31 March	226,386	224,016

11.2 Breakdown of cash and cash equivalents

Total cash and cash equivalents balance at period end is broken down into:

	31 March 2023 £000	31 March 2022 £000
Cash at commercial banks and in hand	2,541	-
Cash with the Government Banking Service	223,845	224,151
Bank overdrafts (GBS and commercial banks)	-	(135)
Total cash and cash equivalents as in SoFP	226,386	224,016

12. Trade Payables

12.1 Trade and other payables

Current	31 March 2023 £000	31 March 2022 £000
Trade payables	23,735	26,860
Capital payables (including capital accruals)	27,988	28,355
Accruals (revenue costs only)	180,365	125,978
Annual leave accrual	9,021	8,757
Social security costs	15,551	14,519
Other payables	8,756	8,987
Total current trade and other payables	265,416	213,456

12.2 Other liabilities

	31 March 2023 £000	31 March 2022 £000
Deferred income: contract liability (IFRS 15)	53,582	65,882
Deferred income: other (non-IFRS 15)	12,644	10,694
Deferred grants	25,719	32,525
Total other liabilities	91,945	109,101

13. Borrowings

Current	**31 March 2023 £000**	**31 March 2022 £000**
Bank overdraft-commercial	-	135
Normal Course of Business Capital loans from the Department of Health and Social Care	6,991	7,063
Lease liabilities	5,024	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,774	1,852
Total current borrowings	13,789	9,050
Non-current		
Normal Course of Business Capital loans from the Department of Health and Social Care	39,948	46,346
Lease liabilities	35,719	-
Obligations under PFI, LIFT or other service concession contracts	38,435	40,208
Total non-current borrowings	114,102	86,554
Total borrowings	127,891	95,604

13.1 Reconciliation of liabilities arising from financing activities

	DHSC loans 31 March 2023 £000	PFI, LIFT and other service concession obligations 31 March 2023 £000	Lease Liabilities 31 March 2023 £000	DHSC loans 31 March 2022 £000	PFI, LIFT and other service concession obligations 31 March 2022 £000	Lease Liabilities 31 March 2022 £000
Carrying value at 1 April	53,409	42,060	-	59,883	43,768	-
Cash movements:						
Financing cash flows - principal	(6,398)	(1,852)	(4,721)	(6,398)	(1,708)	-
Financing cash flows - interest (for liabilities measured at amortised cost)	(1,903)	(2,210)	(420)	(2,127)	(2,301)	-
Non-cash movements:						
Impact of implementing IFRS 16 on 1 April 2022	-	-	42,573	-	-	-
Additions	-	-	3,052	-	-	-
Interest charge arising in year (application of effective interest rate)	1,831	2,211	420	2,051	2,301	-
Termination of lease	-	-	(161)	-	-	-
Carrying value at 31 March	**46,939**	**40,209**	**40,743**	**53,409**	**42,060**	**-**

13.1 Reconciliation of the carrying value of lease liabilities

	31 March 2023
	£000
Carrying Value at 1 April 2022	-
IFRS 16 implementation - adjustments for existing operating leases	42,573
Lease additions	3,052
Interest charge arising in year	420
Termination of leases	(161)
Lease payments (cash outflows)	(5,141)
Carrying value at 31 March 2023	**40,743**

13.2 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023
Undiscounted future lease payments payable in:	**£000**	**£000**
- not later than one year;	5,024	434
- later than one year and not later than five years;	12,461	1,300
- later than five years.	30,852	-
Total gross future lease payments	**48,337**	**1,734**
Finance charges allocated to future periods	(7,594)	(322)
Net lease liabilities at 31 March 2023	**40,743**	**1,412**
Of which:		
- Current	5,024	434
- Non-Current	35,719	978
	40,743	**1,412**

13.3 Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFSR16 as at 1 April 2022

	Total
	01 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	37,611
IAS 17 operating lease commitment discounted at incremental borrowing rate	34,196
Short-term leases (<= 12 months)	(26)
Irrecoverable VAT previously included in IAS 17 commitment	(576)
Differences in the assessment of the lease term	8,979
Lease liability on 1 April 2022 for existing operating leases	**42,573**
Total lease liabilities under IFRS 16 as at 1 April 2022	**42,573**

14. Provisions

14.1 Provisions for liabilities and charges

	31 March 2023	31 March 2022
Current	**£000**	**£000**
Pensions relating to other staff	58	45
Pensions Injury benefits	145	140
Legal claims	82	-
Clinician pension tax reimbursement	35	37
Other	12,978	6,127
Total current	13,298	6,349
Non-current		
Pensions relating to other staff	349	440
Pensions Injury benefits	1,457	2,003
Legal claims	-	101
Clinician pension tax reimbursement	2,227	2,174
Other	5,429	8,408
Total non-current	9,462	13,126
Total provisions	22,760	19,475

The provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill health, these are not funded by the NHS Pension Scheme. The full amount of such liabilities is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement.

14.2 Provisions for liabilities and charges analysis

	Total £000	Pensions - Early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Clinician pension tax reimbursement £000	Other £000
At 1 April 2022	19,475	485	2,143	101	2,211	14,535
Change in the discount rate	(2,605)	(71)	(544)	-	(1,990)	-
Arising during the year	8,155	-	-	45	2,007	6,103
Utilised during the year - cash	(2,549)	(45)	(114)	(57)	(11)	(2,322)
Reversed unused	(7)	-	-	(7)	-	-
Unwinding of discount	291	38	117	-	45	91
At 31 March 2023	22,760	407	1,602	82	2,262	18,407
Expected timing of cash flows:						
In one year or less	13,298	58	145	82	35	12,978
In more than one year but not more than five years	6,077	165	413	-	70	5,429
In more than five years	3,385	184	1,044	-	2,157	-
Total	22,760	407	1,602	82	2,262	18,407

14.3 Clinical negligence liabilities

	31 March 2023 £000	31 March 2022 £000
Amount included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Cambridge University Hospitals NHS Foundation Trust	373,463	528,800

15. Related party transactions

The Trust is a body corporate established by order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties.

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

In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central and local Government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in respect of deduction and payment of PAYE, and Cambridge City Council in respect of payment of rates.

During the year, none of the Board members, members of the key management staff or parties related to them have undertaken any material transactions with the Trust, with the exception of the University of Cambridge, which is a related party by virtue of the fact that Professor Patrick Maxwell is both a Non-Executive Director of the Trust and Regius Professor of Physic with the University. All transactions between the Trust and University are undertaken on an arms-length basis.

Cambridge University Health Partners (CUHP) is regarded as a related party by virtue of the fact that the Trust is one of the five partners and Mr Roland Sinker is a shared director. There were no material transactions with CUHP in the year ended 31 March 2023, the expenditure in the disclosure note relates to the Trust' s contribution towards membership for 2022-23.

15 Related party transactions

15.1 Related party transactions

	Year ended 31 March 2023 Revenue £000	Year ended 31 March 2023 Expenditure £000
Department of Health and Social Care	61,354	-
DHSC group bodies	1,180,407	59,751
Other Government bodies	5,141	156,289
University of Cambridge	11,707	19,718
Cambridge University Health Partners	-	51
	1,258,609	235,809

	Year ended 31 March 2022 Revenue £000	Year ended 31 March 2022 Expenditure £000
Department of Health and Social Care	46,177	-
DHSC group bodies	1,092,217	40,081
Other Government bodies	5,380	141,456
University of Cambridge	11,295	12,887
	1,155,069	194,424

15.2 Related party balances

	31 March 2023 Receivables £000	31 March 2023 Payables £000
Department of Health and Social Care	4,762	2,372
DHSC group bodies	51,880	32,308
Other Government bodies	9,665	24,533
University of Cambridge	9,719	15,215
Cambridge University Health Partners	-	-
	76,026	74,428

	31 March 2022 Receivables £000	31 March 2022 Payables £000
Department of Health and Social Care	1,560	481
DHSC group bodies	28,970	39,962
Other Government bodies	12,034	22,901
University of Cambridge	6,584	12,114
	49,148	75,458

16. Contractual capital commitments

	31 March 2023 £000	31 March 2022 £000
Property, plant and equipment	10,941	13,500
Total contractual capital commitments	10,941	13,500

17. Private Finance Initiative (PFI) scheme

The PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 128 bed Elective Care, Genetics and Diabetes Centre at the Trust. The centre became operational in April 2007. The contract start date of the PFI scheme was 13 February 2007 and the end date is 12 February 2037.

The facilities within the centre include Diabetes Research Facilities which are utilised by the University of Cambridge. These facilities are funded by the University of Cambridge and the Medical Research Council and have no effect on the Trust's cost structures.

The contract requires the Trust to make a unitary payment that totals £10.2m annually. It is charged monthly and adjusted for any penalties relating to adverse performance against output measures describing all relevant aspects of the contract.

17. PFI

17.1 On-SoFP PFI obligations (finance lease element)

	31 March 2023 £000	31 March 2022 £000
Gross PFI liabilities of which liabilities are due		
In one year or less	7,297	6,699
In more than one year but not more than two years	7,942	6,570
In more than two years but not more than five years	24,060	21,546
In more than five years	90,513	88,769
Gross Liabilities	129,812	123,584
Finance charges allocated to future periods	(89,603)	(81,524)
Net Liabilities	40,209	42,060
Net PFI obligation of which liabilities are due		
In one year or less	1,774	1,852
In more than one year but not more than two years	2,108	1,774
In more than two years but not more than five years	6,521	6,415
In more than five years	29,806	32,019
Total	40,209	42,060

17.2 Total On-SoFP PFI commitments

	31 March 2023 £000	31 March 2022 £000
Total future payments committed in respect of PFI arrangements		
In one year or less	12,797	11,242
In more than one year but not more than two years	13,117	11,523
In more than two years but not more than five years	41,352	36,326
In more than five years	141,908	140,496
Total	209,174	199,587

Under IFRS the unitary charge is apportioned between the repayment of the liability, financing costs and the charges for services. The service charge is recognised in operating expenses under "Premises" and the finance costs are charged to finance costs in the Statement of Comprehensive Income.

The Trust has not entered into any 'off-Statement of Financial Position' arrangements.

17.3 Analysis of amounts payable

	31 March 2023	31 March 2022
	£000	£000
Unitary payment payable to PFI operator consisting of:		
- Interest charge	2,211	2,301
- Repayment of finance lease liability	1,852	1,708
- Service element	1,478	1,203
- Capital lifecycle maintenance	1,988	1,921
- Contingent rent	2,636	2,101
Total amount paid to service concession operator	10,165	9,234

18. Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with ICBs and the way those NHS organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s Standing Financial Instructions and policies agreed by the Board of Directors. Treasury activity is subject to review by the Trust’s internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Credit risk

The Trust can borrow within affordable limits and NHS England will assess the affordability of material borrowing. The Trust can invest surplus funds in accordance with NHS England's guidance on Managing Operating Cash. This includes strict criteria on permitted institutions, including credit ratings from recognised agencies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to manage the risks facing the Trust in undertaking its activities. The Trust has low exposure to credit risk.

Liquidity risk

The Trust's net operating income is received under legally binding contracts with ICBs, which are financed from resources voted annually by Parliament. The Trust has financed capital expenditure from internally generated resources, and net borrowing within its affordable limits. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

The main potential market risk to the Trust is interest rate risk. The Trust's financial liabilities carry nil or fixed rates of interest. Cash balances are held in interest bearing accounts for which the interest rate is linked to bank base rates and changes are notified to the Trust in advance. The Trust is not, therefore, exposed to significant interest-rate risk.

18. Financial Instruments

18.1 Carrying value and fair value of financial assets

	31 March 2023 Financial assets at amortised cost £000	31 March 2022 Financial assets at amortised cost £000
Financial assets as per SoFP		
Receivables (excluding non financial assets) - with DHSC group bodies	58,038	29,553
Receivables (excluding non financial assets) - with other bodies	(295)	5,826
Cash and cash equivalents	226,386	224,016
Total	284,129	259,395

18.2 Carrying value and fair value of financial liabilities

	31 March 2023 Financial liabilities at amortised cost £000	31 March 2022 Financial liabilities at amortised cost £000
Financial liabilities per the SoFP		
DHSC loans	46,939	53,409
Obligations under leases	40,743	-
Obligations under PFI, LIFT and other service concession contracts	40,209	42,060
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	23,060	11,416
Trade and other payables (excluding non financial liabilities) - with other bodies	218,177	179,395
Total	369,128	286,280

18.3 Maturity of financial liabilities

	31 March 2023 £000	31 March 2022 £000
In one year or less	261,570	212,295
In more than one year but not more than two years	20,752	23,300
In more than two years but not more than five years	53,481	44,987
In more than five years	137,705	112,499
Total	473,508	393,081

19. Losses and Special Payments

Losses and special payments (approved cases only)

	31 March 2023 Total number of cases Number	31 March 2023 Total value of cases £000's	31 March 2022 Total number of cases Number	31 March 2022 Total value of cases £000's
Losses of cash due to				
Theft, fraud etc.	8	1	5	1
Other causes	-	-	7	-
Total losses	8	1	12	1
Special Payments, Ex gratia payments in respect of				
Loss of personal effects	77	45	61	18
Personal injury with advice	7	45	2	17
Total special payments	84	90	63	35
Total losses and special payments	92	91	75	36

20. Events after reporting period

The Government has announced a formal pay offer to Agenda for Change unions for staff subject to Agenda for Change pay, terms and conditions. Subject to the offer being agreed, staff would receive two one-off non-consolidated pay awards on top of their existing 2022/23 pay award, which includes:

- A non-consolidated award worth 2.0% applied equally across all Agenda for Change bands
- A one-off "backlog bonus" with tiered payments worth between £1,250 and £1,600

The Trust has followed the guidance to account for the costs of an additional pay award for 2022/23. The NHS Staff Council subsequently agreed the 2022/23 pay award plan which will be paid out in June 2023.

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