Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton University Hospital
NHS Foundation Trust

Annual Report and Accounts 2019/20

Incorporating hospital and community health services, teaching and research

Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2019/20

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

Annual Report

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Homerton University Hospital NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2019/20

ANNUAL REPORT

ANNUAL ACCOUNTS

including the consolidated Annual Accounts for the financial year 2019/20.

1 Performance Report

1.1 Overview of performance

The purpose of the Performance Report is to provide an overview of our organisation, its purpose, the key risks to achieving our objectives, and our performance during the year.

Chairman and Chief Executive's overview

Welcome to our 2019/20 Annual Report

Covid-19

This report for the financial year 2019/20 has been prepared during the coronavirus pandemic which spread to London early in 2020 and reached full force in March leading to dramatic changes to all NHS services and to the national lockdown which is still largely in place. As we write, a slow resumption of services is just beginning as the number of Covid-19 infections tails off (at least for a while).

Covid-19 had a marked effect on our finances and performance only in the last month of 2019/20, so it may be invisible in much of what follows in this report which gives an account of our activities for the year as a whole. However, it has been such a challenge and had such far-reaching consequences, we start with it.

In the space of a very few days, our hospital and community services had to be transformed both to provide for the rush of admissions of Covid-19 patients and to protect staff and patients from infection. All non-urgent admissions and surgery and most outpatient appointments and clinics were cancelled and our main theatres were reconfigured to provide critical care beds for patients requiring ventilation. In the community, services were reorganised to provide care by telephone and video, as well as at home, in a way which protected the vulnerable and our staff, yet met continuing needs. With many staff having to isolate themselves for a period in order to limit infection, many staff had to work outside their normal services.

We have never seen anything like this emergency in our lifetimes. We pay tribute to staff throughout the Trust for their determination and commitment to do their best for our patients and our communities despite the risks. We also mourn the deaths associated with the pandemic of many patients and of three members of our staff – Mr Abdul Chowdhury, Michael Allieu and Sophie Fagan.

2019/20 as a whole

The year before the pandemic had seen continuing public concern about the challenges affecting the NHS, with rising waiting times both in Accident and Emergency and in other services. There was a continuing need to find new efficiencies in order to deliver high quality care to increasing numbers of patients with progressively more complex needs. The implications of Brexit for our staff and for future staffing were also much debated, though the practical consequences were largely deferred until 2021 by the agreement on a transitional period.

In the circumstances the Trust continued to make good progress both in maintaining relatively low waiting times for its patients, maintaining and in some respects improving our quality of care, and in helping to develop a more integrated health and care system in City and Hackney with our local Clinical Commissioning Group (CCG), other health care organisations and GPs, the London Borough of Hackney and the City of London Corporation.

Quality and Patient Care

The safety and quality of care is our first responsibility. This depends of course on the quality of the frontline clinical teams who deal directly with patients. But it also depends on the supporting services for example from pharmacy, pathology, procurement and estates.

We measure ourselves by our patient feedback in regular surveys and by monitoring our performance on waiting times and a range of other quality indicators against other similar trusts. We also have a structured process to learn from serious incidents and from complaints. Further details are reported in our Quality Account which, owing to the coronavirus outbreak, will be published as a separate document later this year.

There remain areas in which we want to improve but we are pleased that on many of the objective measures we have continued to do well compared with our peers. Like all NHS trusts we are subject to examination by the Care Quality Commission. Our most recent report rated the whole Trust “Good”, but our Emergency Department and our Medical Services were rated as Outstanding”. In the course of 2019/20 both the Trust and the Mary Seacole Nursing Home were subject to inspection. The report on Mary Seacole rated it Good in all respects. The report on the Trust’s acute services is still awaited.

Financial Performance

The Trust continued to perform well financially. After achieving our control total last year, resulting in additional funding from the Government, we are pleased to have achieved the same in 2019/20. This has enabled us to increase again our cash position which puts us in a stronger position to invest in the quality and reach of the services we provide to our patients.

Strategic Development

The Trust’s strategy is to become, with our partners a truly integrated care and health system in City and Hackney while playing a wider role in the provision of a range of acute services across our wider region of north east London.

As far as Hackney and the City are concerned, the year saw continued work to develop more integrated care pathways across our own acute and community services, GPs, the local authorities, and other health and care agencies and to establish these in eight “neighbourhoods”. Two notable steps forward were the decision by GPs to base the new Primary Care Networks in the neighbourhoods and the decision by the Local Authority and CCG to commission the community services from a provider alliance of Homerton, the GP Confederation and East London Foundation Trust.

At the end of the financial year, with the advent of the coronavirus crisis, all partners were drawn together into a Strategic Operational Command Group, chaired by our Chief Executive, to ensure all the services pooled their information and collaborated effectively.

There have been a number of developments in the East London Health and Care Partnership (ELHCP) and the North East London Integrated Care System (ICS, previously STP). In the crisis it has taken on a leadership role in coordinating the NEL response and now for the recovery programme. It remains committed to integrating care and health across the region through three Integrated Care Partnerships, one of which is for City and Hackney.

The Trust not only works as part of ELHCP but also with the inner ELHCP providers and commissioners, between whom there are many flows of patients. The inner area includes the two acute Trusts, Barts and Homerton. In 2019/20 we worked together, along with Lewisham and Greenwich NHS Trust on building a pathology partnership with its hub in the Royal London laboratories. The Boards of all three Trusts approved the outline business case but further work has been delayed by the Covid-19 pandemic. We expect the Final Business Case to be prepared by July 2020, which continues to be the subject of complex negotiations between the three Trusts.

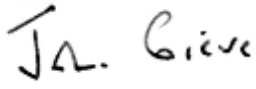
People

None of what we have achieved would have been possible without the excellent performance of all our staff and the support of the organisations with which we work. We are both very conscious of and grateful for this.

We thank the Governors for their support and challenge over the year. It is a great help to the Trust to have their contribution to our governance and the connection they bring to our local area and to our key stakeholders. 2019 saw the retirement of John Bootes who has been Lead Governor for many years. His clinical and long experience of the NHS has been invaluable and he has brought authority and commitment to our meetings. We will miss him and we thank him and other retiring governors during the year for their contribution to Homerton. We thank Hilda Walsh who led the Governors on an interim basis and we welcome Jo Boait, our newly elected Lead Governor, and a number of new Governors to our Council.

Turning to the Board, Frances O'Callaghan as Director of Strategic Implementation and Partnerships has left to head up the North Central London single CCG and we wish her every success. We welcome Claire Hogg who has joined us on secondment to replace Frances, and also our new Workforce Director, Tom Nettel who joined us in November 2019.

On the Non-Executive side, we welcome Rommel Pereira and Andrew Hudson - to our Board following the resignation of Dr Shree Datta and the retirement of Vanni Treves for whose contributions we are grateful. In particular, we pay tribute to Vanni for his inimitable mix of wit and incisiveness at our meetings and his contribution to the Trust for many years, and we mourn his death not long after he stepped down from the Board.



Sir John Gieve
Chair
23 June 2020

Tracey Fletcher
Chief Executive
23 June 2020

About Homerton

Homerton University Hospital NHS Foundation Trust is an integrated care trust which provides hospital and community health services for Hackney, the City and surrounding communities. The Trust provides a full range of adult, older people's and children's services across medical and surgical specialties.

The Trust operates acute services from a single site: Homerton University Hospital, which has almost 500 beds spread across 11 wards, a nine bed intensive care unit, and maternity, paediatric and neonatal wards. There are three day surgery theatres and six main operating theatres and the types of surgery performed include general surgery, trauma, orthopaedics, gynaecology, maxillofacial, urology and ear nose and throat (ENT).

Community services operate from over 60 partner sites in Hackney and the City of London, and include sexual health, locomotor services, school nursing and diabetes eye screening. The Trust also provides continuing health care at the Mary Seacole Nursing Home in Hoxton, east London.

A range of specialist care is offered in obstetrics and neonatology, foetal medicine, fertility, HIV and sexual health, asthma and allergies, bariatric surgery and neuro-rehabilitation across east London and beyond.

The clinical services are organised in three divisions within the Trust: surgery and women's health (SWSH); children's services, diagnostics, outpatients and sexual health (CSDO); and integrated medical and rehabilitation services (IMRS). The corporate directorates which operate in support of the divisions include finance, estates and facilities, governance, information technology and workforce.

The Trust's strategic vision in 2019/20

Homerton was one of the first NHS trusts to gain foundation status in 2004. Since this time, the Trust has maintained its reputation as a high performing NHS provider, delivering quality patient and service user care, whilst maintaining compliance with all key performance and regulatory requirements.

The Trust's strategy 'Achieving Together' sets out the Trust's ambitions and priorities for building on our current high standards and establishing the Trust as one of the country's foremost health providers, with a reputation for quality, innovation and leading the way on service integration.

In consultation with a wide range of Trust staff and key stakeholders, three strategic priorities were identified: Quality, Integration, and Growth; each supported by clear aims and objectives to realise our mission:

'Safe, caring, effective health and social care provided to our communities with a transparent, open approach.'

We recognise that successful delivery depends as much on the approach we take, as on the priorities themselves. We have developed a set of organisational values which describe the approach we will take in delivering the services and the standards we will uphold and set out in the document 'Living our Values'.

We have a number of initiatives supporting our strategic direction to ensure we maintain high standards of operational performance. These include a continued focus on organisational development and workforce engagement; a productivity and efficiency strategy; and a quality agenda designed to further embed high-quality provision and a positive patient experience.

In 2019/20 the Trust continued to work with health and care partners across north east London as part of the East London Health and Care Partnership. The partnership includes eight councils and 12 NHS organisations who are working together to develop plans and services to meet the needs of people in north east London. The Trust has also been a core partner and leader in developing integrated working with commissioners and providers of health and social care at a local level. This programme aims to deliver a joined up, effective and financially sustainable local system which listens to and meets local people's needs and works as part of the wider north east London footprint.

The Trust's strategic objectives in 2019/20

The Trust's objectives in 2019/20 included:

Quality

- Safe – Continuously strive to improve patient safety and provide harm free care.
- Effective – Provide services based on the latest evidence and clinical research.
- Positive patient experience – Ensure all patients have an excellent experience of our services through providing person-centred care that takes into account each patient's or service user's needs, concerns and preferences.

Integration

- Pathways – Ensure care pathways, across the health system, are designed around the needs of the individual.
- Prevention – Focus on early intervention to improve health and wellbeing and reduce the cost of health care provision.
- Partnership – Create seamless services in which organisational boundaries are not evident to the patient or service user.

Growth

- Scale – Ensure core services are of a sufficient scale for long term sustainability and effectiveness.
- Reputation – Develop a national reputation and profile for leading the way in the provision of high quality and innovative health care services.
- Turnover – Establish an ability to respond to the financial and quality challenges facing health care providers by increasing turnover

Key risks to delivering our strategic objectives

The risks that threaten achievement of our strategic objectives are identified within the Board Assurance Framework, which is reviewed regularly by the Board of Directors and Risk Committee. The Trust's risk management processes are designed to assess the impact of all risks identified on the Trust's Risk Register, and ensure that they are appropriately mitigated and managed.

The key risks that could impede us from achieving our strategic objectives are set out in our annual governance statement on page 55.

Throughout the year the Board of Directors reviewed the risks that may prevent the Trust from achieving its objectives, complying with its NHSI Licence Conditions and fulfilling the requirements of the operating and financial plan. The Board also assessed outcomes through regular review of performance reports.

During the year the Trust also made appropriate preparations for the impact of the UK's departure from the European Union. All trusts were provided with guidance by the Department for Health and Social Care to support their preparations for the possibility of a no-deal departure from the EU on 31 October 2019. The Trust complied with this guidance in full and was an active participant in discussions across the region. Internally a Brexit Board, chaired by the Chief Executive Officer, was established to oversee this activity and the Trust Board was updated regularly. Following a general election, Parliament ratified the withdrawal agreement, and the UK left the EU on 31 January 2020.

The last weeks of the financial year were dominated by the preparations for and the onset of the coronavirus pandemic. At the end of March, in line with the national instructions, we stopped all non-urgent elective work and cancelled most outpatient appointments both in the hospital and the community. We reorganised the hospital to increase the number of intensive care beds to over 30, and segregated some wards to deal with Covid-19 patients. Where possible we substituted face to face appointments with phone or video consultations.

At its peak we had 117 patients suffering from Covid-19 in the hospital and 18% of our workforce away from work because of the need to isolate themselves.

Going concern disclosure

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

Performance against strategic priorities 2019/20

We have recorded a number of achievements during the year:

- We remain one of the best performers for A&E services in London and nationally; consistently delivering over 90% for the 4-hour wait target and achieving 93.75% overall against the 95% target in 2019/20
- We continue to achieve good compliance against the key operational and quality requirements with a strong performance against the 18 week referral to treatment standard and improving access to psychological therapies
- We met our financial control total and we remain a break- even Trust
- Homerton has an active Research and Innovation (R&I) department which supports staff research to improve patient experience. This year's award winner was a collaboration between the neonatal research team and the fetal medicine team with the primary aim of studying the outcomes of pregnancies and infants with fetal growth restriction born in the last 10 years
- The Trust won the 2019 CHKS Top Hospitals programme quality of care award. The awards celebrate excellence throughout the UK and are given to acute sector organisations for their achievements in healthcare quality and improvement
- Our Lighthouse Programme, introduced to support overseas nurses, was shortlisted in the best international recruitment experience category of the Nursing Times Workforce Awards
- Professor Jacqueline Dunkley- Bent, Chief Midwife presented four of our midwives with silver awards. Silver awards recognise and celebrate midwives who go above and beyond their roles providing excellent care, leadership and inspiration every day to colleagues, women and families regardless of their position or band
- Three Homerton nurses received the Chief Nursing Officer silver award
- We introduced video conference systems to enable face to face patient consultations
- We achieved our best ever response rate of 56% in the 2019 staff survey
- We delivered harm free care to 97% of Homerton patients
- Homerton linked up with the Science Museum providing snap shots of hospital life and interviews with staff as part of the NHS section of the museum's medicine exhibition in The Wellcome Galleries

1.2 Performance Summary

Review of financial performance

The Trust had an Income & Expenditure (I&E) surplus of £8.3m for the financial year 2019/20, compared to the planned surplus of £6.9m. The main source of income for the Trust is contracts with commissioners in respect of health care services, the Trust's main commissioner being City and Hackney Clinical Commissioning Group.

A comparison of planned and actual performance (excluding impairments) is shown in the table below.

	Plan	Actual	Variance
2019/20	**£m**	**£m**	**£m**
Income			
Clinical contracts	307.0	321.2	14.2
Other income	27.5	27.4	-0.1
PSF Funding	4.5	4.9	0.4
Total income	339.0	353.6	14.6
Expenses			
Pay	-222.8	-237.9	-15.1
Non pay	-95.7	-93.9	1.8
Total expenses	-318.5	-331.8	-13.3
EBITDA*	20.5	21.8	1.3
Depreciation and amortisation	-9.1	-10.4	-1.3
PDC dividends	-4.5	-4.4	0.1
Net interest	0.0	0.2	0.2
Sub-total	-13.6	-14.6	-1.0
Net Surplus	6.9	7.2	0.3
Impairment	0.0	1.1	1.1
Net Surplus (exc impairment)	6.9	8.3	1.3

*Earnings Before Interest, Tax, Depreciation and Amortisation

Income was £14.6m (4.6%) above plan, however this includes £8.9m for additional income relating to superannuation contributions which has a corresponding pay adjustment for the same value. Other income above plan was driven by increases in activity in accident and emergency, elective, outpatient and community services. Sustainability and Transformation Funding (STF) income totalled £4.5m for the year and was higher than plan by £0.4m due to receipt of £0.4m 2018/19 PSF.

The Trust achieved £10.7m of savings during the year as part of its Quality, Innovation, Productivity and Prevention (QIPP) agenda. Projects included staffing and skill mix reviews, reduction in premium rates for additional clinical workload, service reconfiguration, negotiation with suppliers and more efficient use of our capacity.

Capital expenditure and liquidity

Capital expenditure for the year totalled £11.489m, of which £5.3m related to new and replacement medical equipment including Ultrasound machines and incubators, £2.8m related to IT projects and £3.4m related to Estates projects, the most significant of which was the refurbishment of Thomas Audley Ward.

The Trust's liquidity position improved in-year due to the income and expenditure surplus of £7.2m and improved performance on the collection of aged debt. The Trust ended the year with debtors £2.4m lower than at the last year-end and the closing cash balance £20.0m higher.

The Trust strives to pay all suppliers in line with the agreed terms for each supplier but in any event no later than 30 days from receipt of goods or services or the invoice date if later.

The Trust's treasury management strategy is routinely reviewed by the Audit Committee, a Committee of the Board. The Committee has not identified any immediate liquidity concerns. The Trust is confident that it has sufficient funds to remain as a going concern

Operational performance

The Trust performed strongly during 2019/20 and delivered the majority of the national operational standards during this period. For the standards that the Trust did not meet, it should be noted that in relation to the A&E waiting time standard, the Trust performed comparatively well compared to the majority of its London-peers, as well as nationally. With regard to MRSA, it is important to note that the target was missed due to one hospital-acquired case.

The following table sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all NHS trusts, were required to report to NHS on a range of measures quarterly.

Key Performance Indicators	2019/20 Target	2019/20 Performance
A&E patients discharged < 4hrs	**95%**	**93.75%**
Cancer		
2 Week Wait	**93%**	**97.86%**
31 Day Target	**96%**	**99.30%**
62 Day Target	**85%**	**86.93%**
Infection Control		
MRSA	**0**	**1**
***Clostridium difficile* (*C.diff*)**	**12**	**8**
18 Week RTT Indicator		
Incomplete Pathways	**92%**	**95.13%**
IAPT Indicators		
6 week target	**75%**	**96.81%**
18 week target	**95%**	**99.60%**

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month. Details of performance against key quality indicators that were prioritised throughout 2019/20 are presented in the Quality Account which will be published later this year.

Tracey Fletcher

Chief Executive

23 June 2020

2. Accountability Report

2.1 Directors' report

Trust Board

The Board, led by the Chairman, sets the strategic direction of the Trust and is responsible for the organisation's decision-making and performance to ensure the delivery of high quality, safe and efficient services.

The Board usually meets 11 times a year in public and when necessary, can convene special meetings. The Board comprises up to seven non-executive directors and six executive directors. The Chairman leads the Board and ensures its effectiveness. The Board monitors the delivery of objectives and targets and provides leadership with regard to strategy, operational performance, risk, quality assurance and governance.

The Chairman and non-executive directors are held to account by the Council of Governors. Board members are invited to attend Council of Governors meetings which are held regularly throughout the year. Joint Board of Directors and Council of Governors meetings are also held twice a year. The Chief Executive is accountable to the Board for the management of the Trust's operational business.

The Board held six seminars during the year to discuss strategic issues, to receive statutory safeguarding training and to hear about service developments.

Board members

Directors' details, together with their committee membership, are confirmed below. Board members declare their interests at the time of their appointment and on an annual basis. The register of directors' interests is published annually. It can be found on our website on the Board of Directors' pages or a copy may be obtained from the Company Secretary:

Email address: huh-tr.companysecretary@nhs.net
Telephone: 020 8510 5555.

Directors are also required to confirm they meet the "fit and proper person" condition set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. All directors have met the requirements of the "fit and proper person" test.

Non-executive directors

The term of office for non-executive directors is three years. Thereafter, and subject to satisfactory appraisal, a non-executive director is eligible for consideration by the Council of Governors for a further three year term. The Chairman and non-executive directors may be removed by the Council of Governors in accordance with the constitution.

Sir John Gieve, Chairman

Sir John Gieve joined the Trust in 2011 as a non-executive director and was appointed chair from 1 April 2019. He was Deputy Governor of the Bank of England from 2006 to 2009.

Before that he was a civil servant, including three years as a Managing Director of the Treasury and Permanent Secretary to the Home Office between 2001 and 2005. He currently holds a number of chairman and director positions for a range of private and third sector organisations including Chair of Nesta, the innovation foundation.

Sir John chairs the Nomination and Remuneration Committee and is a member of the Risk Committee and the Trust's Charitable Funds Committee.

Jude Williams, Deputy Chair and Senior Independent Director

Jude Williams was formally Lead Governor on the Council of Governors at Homerton prior to her appointment as a non-executive director in May 2014. She has a career in public health strategy and policy development with a particular focus on health inequalities, staff health and public and patient involvement. She worked in east London throughout the 90s as a director within the Health Authority followed by national level work in the Department of Health and as Head of Public Health in the Healthcare Commission. She currently undertakes executive level coaching and advises the Home Office on their approach to eradicating gang related violence.

Jude is the Trust's Freedom to Speak Up Champion.

Martin Smith

Martin Smith joined the Board in November 2014. He was a London Borough Chief Executive for a decade, for Ealing until 2016, and before that Tower Hamlets. Martin led Ealing through a period of rapid change accelerated by the unprecedented financial challenge of the austerity agenda. He also led on the health agenda on behalf of the chief executives of all 33 London Councils. Martin is a qualified Chartered Public Finance Accountant, was statutory chief financial officer in two organisations and currently chair's the Trust's Audit Committee.

Cherron Inko-Tariah MBE

Cherron Inko-Tariah joined the Board in November 2018 and is an author, consultant, facilitator and coach. Cherron is a former civil servant and has undertaken leadership roles in various policy and strategic positions across Whitehall.

In 2011, Cherron received an MBE for her services to Government and for her work in the faith community with young people.

In 2012, Cherron left the Civil Service to follow her passion; staff networks and the positive impact they can have on individuals and organisations. Cherron has since founded The Power of Staff Networks consultancy where she provides a wide range of services.

Cherron is a member of the Audit Committee and is the Trust's Diversity Champion.

Rommel Pereira

Rommel Pereira was appointed to the Board in June 2019 and has a track record in finance, business transformation, technology, customer service, procurement and business development.

Until the end of 2018, he was an Executive Director at the Bank of England and prior to this he was an Executive Director of the Financial Services Compensation Scheme. His earlier career included senior management roles at JP Morgan Chase and the Metropolitan Housing Partnership.

His recent non-executive roles include the Shepherds Bush Housing Group and he currently chairs the Audit Committee's at One Housing Group and the London Ambulance Service NHS Trust.

Rommel is a member of the Audit Committee.

Andrew Hudson

Andrew Hudson joined the Board in August 2019 and has extensive strategy and operations experience in central and local government and the voluntary sector.

Andrew worked for the Treasury during the 1990s, and was head of the health team during the first comprehensive spending review.

He worked for Essex County Council, becoming Deputy Chief Executive (Finance and Performance) between 2002 and 2004. He re-joined central government as CEO of the Valuation Office Agency, and became Director General, Public Services at the Treasury for three years.

His current roles include being Chair of the Centre for Homelessness Impact, Vice Chair of Volunteering Matters and a non-executive director at the Clarion Housing Group.

Andrew chairs the Risk Committee.

Executive directors

Tracey Fletcher, Chief Executive

Tracey Fletcher became Chief Executive in January 2013. She re-joined the Trust in 2010 as Chief Operating Officer, having previously been with Homerton for many years. She has extensive experience in health care management, having begun her career in a mental health trust followed by a community trust prior to joining Homerton.

Tracey is a member of the Charitable Funds Committee and Risk Committee.

Dylan Jones, Chief Operating Officer

Dylan Jones was appointed Chief Operating Officer in January 2013. Previous roles at the Trust include Divisional Director of the Integrated Medical and Rehabilitation Services Division (2011 to 2013) and General Manager for the General and Emergency Medicine Division (2008-11).

Before that Dylan worked at the former Barts and the London NHS Trust, and NHS trusts in South Wales.

Dr Deblina Dasgupta, Medical Director

Dr Deblina Dasgupta was appointed as Medical Director in July 2018 having previously worked at Homerton Hospital for 13 years as a Consultant Physician in Geriatric and General Medicine. She was an Associate Medical Director from 2016 and since 2012 the Clinical Lead for Elderly Care, Stroke and Intermediate Care.

Deblina has been a leader in developing simulation training in geriatric and general internal medicine in London and an innovator in establishing the pioneering Integrated Independence Team for City and Hackney.

Deblina has led the successful medical productivity programme to improve patient journeys across the hospital and the community. She was Regional Chair of the British Geriatric Society (BGS) between 2009 and 2012 and England Council Member of the BGS during the same period.

Deblina is a member of the Risk Committee

Catherine Pelley, Chief Nurse and Director of Governance

Catherine Pelley joined the Trust in June 2018 on an interim basis and was appointed substantively in January 2019. Catherine has over 34 years NHS experience including care of older people, health visiting, working as part of a neighbourhood nursing team and working with families affected by drug and alcohol issues. She has also served as a service commissioner in Brent and Harrow and later as a director of commissioning in Hertfordshire.

Catherine has worked at NHS England focusing on patient experience and safeguarding children, and also with NHS Improvement as a nurse fellow developing resources to support ward managers and team leaders. Catherine has been awarded the honour of becoming a Queen's Nurse.

Catherine is a member of the Risk Committee.

Phill Wells, Director of Finance

Phill Wells was appointed Director of Finance in October 2018. He joined the Trust after 16 years as a civil servant where he had worked at both the Cabinet Office and the Department for Work and Pensions where he latterly held the position of Finance Director. Phill is a member of the Chartered Institute of Public Finance Accountants.

Phill chairs the Charitable Funds Committee.

Tom Nettel, Director of Workforce and Organisational Development

Tom Nettel joined the Trust in November 2019. He was previously the Director of Workforce, Improvement and Strategy at the Royal National Orthopaedic Hospital in Stanmore. Tom began his NHS career in 2006 in East Kent as a national graduate scheme trainee in human resources. He worked for four years in HR at Ealing and Northwick Park hospitals.

Tom rates one of his achievements to be helping transform staff experience at the Royal National Orthopaedic Hospital; which resulted in the Trust becoming a leading organisation nationally for positive staff experience in the NHS.

Other directors who attended the Board during the reporting year:

Iain Patterson, interim Director of Workforce

Iain Patterson provided interim cover for the Director of Organisational Transformation position from January 2019 to October 2019 having previously been the Trust's Associate Workforce Director. Professionally Iain is a Fellow of the Chartered Institute of Personnel and Development.

Board members who stood down during the year:

Vanni Treves CBE

The late Vanni Treves was a non-executive director from September 2012 until August 2019.

Dr Shree Datta

Dr Shree Datta was a non-executive director from November 2018 to December 2019.

Frances O' Callaghan

Frances O'Callaghan was Director of Strategic Implementation and Partnership from October 2018 to February 2020.

Further details of the expertise and knowledge of Board members who stood down this year can be found in our 2018/19 Annual Report.

Directors' Board attendance

The directors' record of attendance at Board meetings during 2019/20 is confirmed below.

Non-executive director	Board attendance	Executive director	Board attendance
Sir John Gieve	10/10	Tracey Fletcher	10/10
Dr Shree Datta	5/7	Deblina Dasgupta	9/10
Andrew Hudson	5/6	Dylan Jones	10/10
Cherron Inko-Tariah	10/10	Tom Nettel	4/4
Rommel Pereira	6/8	Frances O'Callaghan*	9/9
Martin Smith	9/10	Iain Patterson*	5/6
Vanni Treves	1/4	Catherine Pelley	10/10
Jude Williams	10/10	Phill Wells	9/10

* The Director of Strategic Implementation and Partnership and interim Director of Workforce attended Board meetings in a non-voting capacity.

Directors submit written comments on the papers when they are unable to attend Board meetings.

Board committees

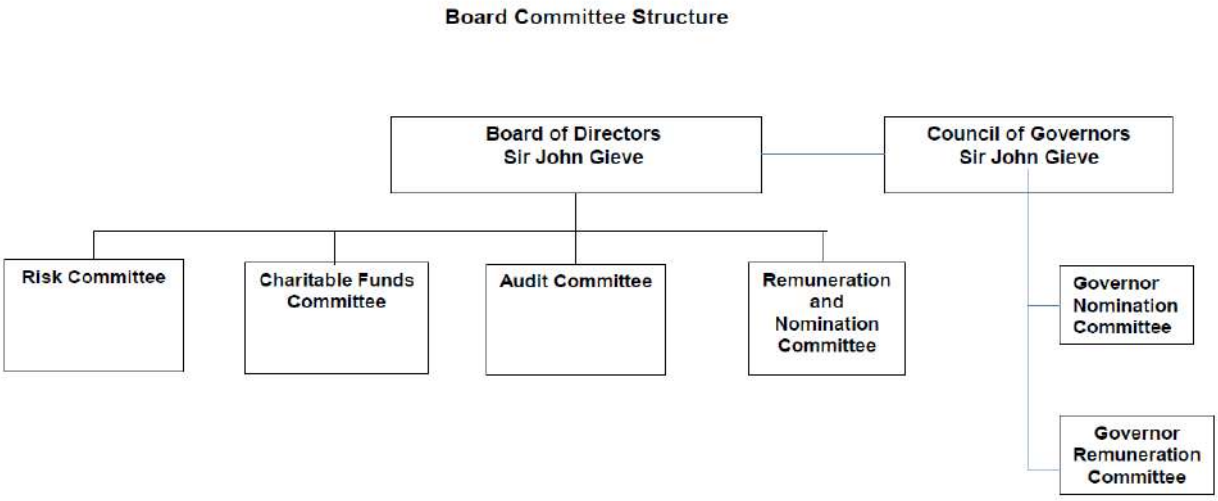
The Board committee structure is set out below. The committees provide assurance to the Board on the delivery of the Trust's objectives and other key priorities and their individual responsibilities are set out in the terms of reference.

Contacting the Board

Board members may be contacted via the Trust's Company Secretary:

Email address: huh-tr.companysecretary@nhs.net

Telephone: 020 8510 5555



Audit Committee

Membership and attendance

The Audit Committee is chaired by Martin Smith, a non-executive director, and includes two other non-executive directors. Cherron Inko-Tariah was a non-executive member of the Audit Committee throughout 2019/20. Jude Williams was a member until she stood down from the committee and was replaced by Rommel Pereira from October 2019. The Audit Committee met six times in 2019/20.

Name	Attendance
Martin Smith (chair)	6/6
Cherron Inko-Tariah	4/6
Rommel Pereira	4/4
Jude Williams	1/2

How the Audit Committee discharges its responsibilities

The Audit Committee's primary purpose is to provide assurance on the adequacy and effective operation of the Trust's overall system of control. It is directly accountable to the Board. The Committee assures the Board of Directors that probity and professional judgment is exercised in all financial matters. It advises the Board on the adequacy of the Trust's systems of internal control and its processes for securing economy, efficiency and effectiveness.

Significant issues considered

During the year the Committee considered thirteen reports from the Internal Auditors that sought to provide assurance to the Trust on the overall adequacy and effectiveness of the risk management, control and governance processes.

Overall, the internal auditors concluded that the organisation had an adequate and effective framework for risk management, governance and internal control. Their work identified further enhancements to ensure that it remained adequate and effective. During the year, the Internal Auditors provided seven reasonable assurance and four partial assurance opinions with the remaining report being advisory which did not result in a formal opinion.

One no assurance opinion was issued in 2019/20 in relation to the management of a contract.

For all reports, management provides an action plan to address any issues identified. Progress against these action plans is reviewed at each Audit Committee and further testing is undertaken by Internal Audit to ensure their recommendations are embedded in the organisation. The Committee has also reviewed key policy documents and discharged its duties by reviewing the schedule of tender waivers to ensure any such waivers are in line with the Trust's policy. Other areas of the Committee's work include: reviewing the Trust's progress on budget setting and business planning; considering the Trust's medium term financial strategy; reviewing clinical audit arrangements; considering the Trust's compliance with the Overseas Visitors Mandatory Up Front Charging legislation and reviewing the Trust's proposals for implementing NHS Improvement's Costing Transformation Programme.

The Audit Committee has also considered significant financial matters as part of its ongoing work, including consideration of debtor balances and their recoverability (note 16 to the accounts), and the valuation and accounting treatment of the Trust's property estate (note 14.1 to the accounts).

Auditors

The Trust's Internal Auditors are RSM and they were re-appointed in January 2019. Their role is to provide the Trust with an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives and to provide independent support to help management improve the organisation's risk management, control and governance arrangements.

The external auditors are KPMG LLP, appointed by the Council of Governors in December 2016. Their fees for audit services undertaken in 2019/20 were £67,825, excluding VAT, for the current year audit and £10,000, excluding VAT, relating to the audit of Quality Accounts.

KPMG's accompanying report on the Trust's financial statements is based on their audit conducted in accordance with International Financial Reporting Standards and the Financial Reporting Manual issued by NHS Improvement. Their work includes a review of the Trust's system of internal control which is used to inform the nature and scope of their audit procedures.

The Trust's external auditors may perform non-audit work 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. There was no non-audit work carried out during 2019/20.

Remuneration and Nomination Committee

The Remuneration and Nomination Committee determines the pay and employment policy for the executive directors and other staff designated by the Board. Remuneration is reviewed with due regard to benchmarking information and survey data of other comparative senior posts within the NHS. The committee also considers the performance of the executive directors.

The Committee is chaired by Sir John Gieve, Chairman of the Board and all of the non-executive directors are members. The Committee met on one occasion in 2019/20.

Details of salary and pension entitlements for Board members are set out in the Remuneration Report on page 29.

Risk Committee

The Risk Committee was established by the Board to support the development of the Trust's risk management systems and processes. It ensures that the Trust Risk Register is fit for purpose and that risks are subject to robust scrutiny to achieve the Trust's principal objectives and deliver its core business. The Committee receives annual compliance reports from key areas of the business to provide assurance to the Board that quality and risk management arrangements are appropriate and robust.

The Risk Committee is chaired by Andrew Hudson and met four times in 2019/20.

Homerton Hope – the Trust's Charitable Fund

The Trust's Charitable Fund (known as Homerton Hope) was established in March 1997 and is an NHS charity as defined within the NHS Charities guidance.

The Trust is the charity's corporate trustee, which means that the executive and non-executive directors share the responsibility for ensuring that the Trust fulfils its responsibilities in managing the charitable fund. The Trust Board has delegated this responsibility to the Charitable Funds Committee, which comprises the Director of Finance (chair), the Trust Chairman, the Medical Director and the Chief Executive.

The Director of Finance is responsible for the day-to-day management and administration of the charitable fund, and in particular, for ensuring that expenditure is in accordance with the objectives and priorities agreed by the Charitable Funds Committee and the Trust Board.

Charity objectives

The charity is funded by donations and legacies received from patients, their relatives, the general public, and other organisations. The charity's objective is "to provide support for any charitable purpose or purposes relating to the National Health Services provided by Homerton University Hospital NHS Foundation Trust including services provided to the community"

This objective is met by ensuring that all expenditure by the charity relates to one of the following three areas:

- Patient expenditure – Purchase of items of equipment, provision of services, and the provision of facilities not normally provided by, or in addition to, normal NHS provision;
- Staff expenditure – Purchase of educational material and conference/course fees in addition to those provided from the Trust's training and development budgets. Enhanced staff facilities and services that improve staff wellbeing; and
- Capital equipment - Purchase of equipment in addition to that provided by NHS funds through the Trust's Capital Programme.

Review of achievements

During 2019/20, the charity continued to support a wide range of charitable and health related activities, benefiting patients and staff in a variety of areas. Generally, funds are used to provide specialist staff, goods and services which would not have been possible using NHS funding. Some of the activities which continued over the past year are described below.

Peer navigators project

With the help of another donation from the MAC Aids Fund the Charity has been able to support the running of a peer navigators' programme. This project helps patients build confidence to seek employment, navigate the complex and ever changing social care system, and also provide support in living well with HIV.

Art programme

The therapeutic value of art in health and in speeding recovery is well documented. The Trust has always displayed art work in its wards, corridors and courtyards. Based in the heart of Hackney, the hospital provides an excellent blank canvas for artists to display their work to patients, staff and visitors. We are looking for further funding to be able to continue our art therapy sessions in the Elderly Care Unit, the Graham Ward Stroke Unit and the Regional Neurological Rehabilitation Unit (RNRU).

Christmas presents for inpatients

The charity continued its annual tradition of providing small gifts to patients who were staying in hospital during Christmas 2019.

Staff welfare

The charity provided funding for a number of courses, conferences and award ceremonies attended by staff including food and entertainment for the summer staff barbeque. Contributions were also made to support the work of the Healthy Homerton Project.

Patient welfare

Over the last year charitable funds were used to purchase a number of items of equipment and to provide additional services to benefit patients, for example:

- Maternity angel suite refurbishment
- Starlight parent room refurbishment
- Memorial bench
- Sofas and chairs for bereavement suite

Donations

The charity mainly receives donations from organisations such as Justgiving and Virgingiving websites and from members of the public. Total funds received were in excess of £12,500 (excluding fees). We received £45,000 from patient donations. The charity also received £40,000 from MAC Aids for the peer navigator role.

We also received:

- £1000 from Royal Parks half marathon event and £2075 from the London marathon

- Grants of £9300 in total from the Bawden Fund, D'Oyley Carte Charitable Trust, Greggs and Groundwork
- We received £650 from Waitrose and John Lewis Partnership community matters programmes
- Sales of teddy bears from WH Smith raised £318
- The Co-op community programme raised £6448 towards our children's unit

The charity continues to actively fund raise through a variety of activities, including trading stalls, collection boxes and a large collection box in the main entrance. Our new card payment machine, installed in December 2019 has received donations in excess of £700 in donations.

Our charity may also be supported via eBay selling and PayPal donations.

Board, committee and directors' evaluation

The Board of Directors is satisfied that its balance of knowledge, skills, and expertise is appropriate to fulfil its function in accordance with the requirements of the NHS Foundation Code of Governance and the Trust's Terms of Authorisation.

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Lead Governor of the Council of Governors to seek the views of directors and governors. The performance of non-executive directors is evaluated annually by the Chairman.

The Chief Executive reviews the performance of the executive directors during their annual appraisal.

Governors and members

A foundation trust is accountable to the communities it serves and members of the public are invited to become members and contribute to the development of services. Members may also attend Council of Governors' meetings and if elected, become governors of the Trust.

The Trust has two membership constituencies as set out in the constitution:

- Public
- Staff

Membership is open to any member of the public over the age of 16 who lives in the London Borough of Hackney, the City of London or the outer area. The outer constituency includes Tower Hamlets, Waltham Forest, Newham, Redbridge, Barking, Havering, Camden, Islington, Haringey, Enfield, Lambeth, Southwark, Westminster and Epping Forest District. There is no separate patient constituency.

The staff constituency is divided into clinical and other staff categories. Any staff on permanent employment contracts or those who have worked at the Trust for at least 12 months, including contractual staff or those holding honorary contracts, will be welcomed as members unless they choose to opt out.

The Trust is committed to recruiting a diverse membership which is reflective of the community that it serves. There is no set limit on the number of people who can register as members within the eligibility criteria. The public membership continues to be broadly representative of the local population in terms of ethnicity and gender but is under represented in the 16-39 age category.

The Trust ended the year with 4,760 public members and 3,647 staff members which remains a relatively stable position.

Membership engagement and strategy

The Trust's Membership Strategy (2017-2020) sets out the engagement and communication priorities to engage with members and to increase Homerton's membership, with particular emphasis on recruiting younger people. The Trust has established a Membership Engagement and Communication Committee, which has oversight of membership activities and is chaired by a public governor.

During the year, membership recruitment sessions, supported by governors, were held at the hospital and other venues across the borough. 'Memberlink' newsletters were sent to all public members providing information, election details and news about the Trust's services. Governors also include updates about their work in '*Homertonlife*', the Trust's magazine.

A member is able to vote for, or stand for election as a candidate to become a governor. There is an opportunity for interested members to ask questions about the role at the Annual Members' Meeting or at membership engagement events.

Council of Governors

The Council of Governors represents the views of patients, public members and staff and it comprises elected public and staff members, together with representatives of partner organisations, local authorities and commissioners. The governor role is voluntary and the Council is primarily responsible for assuring the performance of the Board.

The Council has 26 Governors including:

- 14 Public Governors (elected)
- 6 Staff Governors (elected)
- 6 Appointed Governors nominated from partnership organisations.

On 31 March 2020, 25 of the 26 governor seats were occupied.

Governors normally hold office for three years and are eligible for re-election or re-appointment at the end of their first or second term. Governors may not hold office for more than nine consecutive years.

The Council also elects one of its members to be the lead governor. Jo Boait was appointed as Lead Governor in February 2020, replacing John Bootes who had held the position since July 2014.

The following table confirms the names of our governors, their terms in office and attendance at Council meetings during 2019/20.

Name	Constituency	Current Term	End of Term	Meetings Attended
Elected Governors				
Julia Bennett	Public (Hackney)	third	Sept 2021	4/5
Ahmad Bismillah	Public (Hackney)	first	Sept 2022	3/3
Neil Burgess	Public (Hackney)	first	Sept 2021	2/5
Dr Coral Jones	Public (Hackney)	second	Sept 2022	3/5
Stuart Maxwell	Public (Hackney)	third	Sept 2021	4/5
Nafisa Patel	Public (Hackney)	first	Sept 2022	3/3
Saleem Siddiqui	Public (Hackney)	second	Sept 2022	5/5
Christopher Sills	Public (Hackney)	second	Sept 2022	5/5
Samantha Tulloch	Public (Hackney)	first	Sept 2022	2/3
Jo Boait	Public (City)	first	Sept 2022	3/3
James Torr	Public (City)	first	Sept 2022	3/3
Mary Rose Thomson	Public (Outer)	first	Sept 2020	4/5
Jane Bekoe	Staff (Clinical)	first	Sept 2022	1/3
Dr Helen Cognoni	Staff (Clinical)	second	Sept 2021	2/5
Suzanne Levy	Staff (Clinical)	second	Sept 2020	2/5
Hilda Walsh	Staff (Clinical)	third	Sept 2022	5/5
Ibrahim Hafeji	Staff (Non Clinical)	first	Sept 2020	3/5
Arun Prapathan	Staff (Non Clinical)	first	Sept 2022	2/3
Appointed Governors				
Malcolm Alexander	Healthwatch Hackney*	first	Oct 2022	3/3
Randall Anderson	City of London	first	May 2021	1/3
Julie Attenborough	City University	first	Sept 2022	3/3
Sharon Ellis	Queen Mary University	first	Feb 2023	1/1
Dr Paul Kelland	City and Hackney CCG	first	June 2021	4/5
Yvonne Maxwell	Hackney Council	first	October 2021	1/2

* A new Healthwatch governor was appointed to the Council of Governors in October 2019 following a change to the constitution approved at the Annual Members Meeting in September 2019.

Governors who stood down in 2019/20

The following governors stepped down during the year, either through resignation or their terms of office expiring:

Name	Constituency	Current Term	End of Term	Meetings Attended
Nagaraja Akkisetty	Public (Outer)	first	Sept 2021	0/1
Paul Ashton	Public (Hackney)	second	Sept 2019	2/2
John Bootes	Public (City)	third	Sept 2019	2/2
Steve Cummaford	Public (Hackney)	first	Sept 2020	2/2
Chris Mullett	Staff (Non Clinical)	first	Sept 2019	2/2
Jeremy Mayhew	City of London	first	May 2021	0/2

Role of the Council

The Council has a number of statutory responsibilities including:

- Holding the non-executive directors to account for the performance of the Board
- Appointing or removing the Chairman and non-executive directors
- Appointing or removing the Trust's auditors

The Chairman of the Board of Directors is also Chairman of the Council. This establishes an important link between the two bodies and helps governors to fulfil their statutory duties. The Chairman ensures that governor views on key strategic issues are considered at the Board of Directors' meetings as part of the decision-making process.

The Council of Governors and the Board of Directors hold regular joint meetings during the year. Executive directors and non-executive directors regularly attend Council meetings to gain an understanding of governor views and the membership constituencies they represent. In turn Governors have the opportunity to ask Board members questions about areas of concern or if they wish to receive further information.

The Lead Governor holds regular meetings with governors to keep in touch with opinion, to seek views about future agendas and to enhance communication between the Council and the Board.

The Governors held five meetings in 2019/2020 including two joint meetings of the Council and the Board.

Director Attendance

The directors' record of attendance at Council of Governors meetings is shown below.

Non-executive director	Council attendance	Executive director	Council attendance
Sir John Gieve	5/5	Tracey Fletcher	4/5
Dr Shree Datta	0/4	Deblina Dasgupta	4/5
Andrew Hudson	1/3	Dylan Jones	1/5
Cherron Inko-Tariah	1/5	Tom Nettel	2/2
Rommel Pereira	2/4	Frances O'Callaghan*	1/4
Martin Smith	4/5	Iain Patterson*	1/3
Vanni Treves	0/2	Catherine Pelley	4/5
Jude Williams	4/5	Phill Wells	3/5

The Council receives regular reports from the Board on clinical and financial performance, quality standards and reports from the Chair of the Audit Committee. The Chief Executive updates the governors on service developments and collaborative work within the East London Health and Care Partnership.

Register of interests

Governors sign a code of conduct and declare any interests that are relevant once elected or at the time of appointment. A copy of the register may be obtained from the Company Secretary: email address: huh-tr.companysecretary@nhs.net and telephone number: 020 8510 5555.

Committees of the Council

The Council of Governors has responsibility for approving the reappointment or appointment of non-executive directors as recommended by the nomination committee or by a non-executive or chair appointment panel.

Non-executive directors are appointed by the Council for an initial period of three years and subject to satisfactory appraisal appointments may be extended for a further three years. In exceptional circumstances a non-executive director can serve for a further year. The Council may also remove the Chairman or another non-executive director in accordance with the provisions set out in the constitution.

Nomination Committee

The Nomination Committee of the Council of Governors comprises public and staff governors and is chaired by the Trust Chairman. Its purpose is to select non-executive directors and approve non-executive reappointments.

In 2019/20 the committee met on one occasion to discuss the recruitment of two new non-executive directors to replace one vacancy created by the appointment of Sir John Gieve as the Trust Chairman and another vacancy arising from an end of office term.

In May 2019 a recruitment panel comprising the Chairman and five governors interviewed six candidates for the NED roles. The process was supported by Gatenby Sanderson, external search advisors.

On 23 May 2019 the Council of Governors approved the appointment of Andrew Hudson and Rommel Pereira to the Board of Directors.

In February 2020 the Council of Governors approved the reappointment of Jude Williams as a non-executive director for a further six months until 31 October 2020, to retain valuable experience and skills on the Board.

Remuneration Committee

The Remuneration Committee of the Council of Governors comprises public and staff governors and is chaired by the Lead Governor. Its purpose is to recommend salary and related conditions of the non-executive directors and the Chairman. The committee met on one occasion during 2019/2020 to consider non-executive performance and remuneration.

Contacting the Governors

If a member of the public or patient wishes to contact a governor they can do so by email:

huh-tr.members@nhs.net or by telephone: 020 8510 5302

Cost allocation and charging guidance

The Trust has complied with HM Treasury cost allocation and charging guidance, including incorporating action plans and feedback from previous audit recommendations.

Political and charitable donations

The Trust has not made any political or charitable donations this year.

Better payment practice code

During the financial year to 31 March 2020, the Trust paid 93.9% by volume and 90.5% by value of all non-NHS suppliers within 30 days and the Trust paid 85.6% by volume and 81.6% by value of all NHS suppliers within 30 days.

NHS Improvement (NHSI) well-led framework

During the reporting the year the Board carried out a well-led review based on the NHSI well-led framework. The Annual Governance Statement on page xx contains further details on the overall evaluation of the organisation's performance and action plans to improve the governance of quality.

Patient care activities

Our Quality Account describes what the Trust is doing to develop its services and improve patient care. The Quality Account will be published later this year and will be available on our website.

Stakeholder relations

The Trust continues to maintain and develop relationships within the NHS, the local authority, education partners and community and patient representative groups. The Trust works jointly with local commissioners and providers within City and Hackney and continues to work with health and care partners across north east London as part of the East London Health and Care Partnership.

The Trust is also a partner organisation member of the inner north east London (INEL) System Transformation Board. Building on a range of successful collaborations, the Board works proactively to address significant system challenges, and collectively towards addressing the big priorities for the health and social care system.

The Trust is an executive partner of University College London Partners and a member of NHS Quest, a network of high performing NHS foundation trusts.

The Trust has a statutory duty to collaborate with partners in health and social care. We have representation at Hackney HealthWatch meetings and we also attend Health Scrutiny Commission meetings which are held in public. The Trust is also actively engaged in the Health and Wellbeing Board for Hackney and is represented within its formal sub-structures.

Some of our key stakeholders have nominated representatives on the Council of Governors which enables them to receive regular service and performance updates along with elected representatives of members of the public living in local boroughs.

Income disclosures

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the 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. The Trust complies with this requirement as can be seen in the following table:

	£'000
Health care income	348,938
Non-health care income	4,642
Total income	**353,580**

The Trust has included within "health care income": all income from contracts for patient services; Sustainability & Transformation Fund income; and income for the use of the Trust's buildings and facilities where it is from another NHS body engaged in the provision of health care. During the year the Trust received a total of £4.9m funding in relation to Sustainability & Transformation funding.

The Trust has included within "non-health care income": income from private patients; rental income from non-healthcare bodies; income from overseas visitors, and other miscellaneous non-healthcare related income. This income makes an additional contribution towards the cost of providing NHS health care and improving the services that the Trust can provide to its patients.

Disclosure to auditors

As far as the directors are aware, there is no information relevant to the audit which has not been disclosed to the auditors. The directors have taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Tracey Fletcher

Chief Executive

23 June 2020

Remuneration report

For the purposes of this report the disclosure of remuneration to senior managers is limited to executive and non-executive directors of the Trust.

In accordance with the constitution, executive director remuneration is determined by the Nomination and Remuneration Committee of the Board, comprising the Chairman and all non-executive directors. The remuneration of the Chairman and non-executive directors is determined by the Remuneration Committee of the Council of Governors.

Both committees work to common principles and procedures. Remuneration levels are set taking into account the requirements of the role, market rates, the performance of the Trust, benchmarking information (NHS and public sector) and affordability. The committees are authorised to obtain external or other professional advice on any matters within their terms of reference, with due regard to probity and cost. No individual is involved in any decision that affects his or her own remuneration.

The Nomination and Remuneration Committee is responsible for determining and agreeing, on behalf of the Board, the broad policy for the remuneration of very senior managers. It is also responsible for considering the performance of the Chief Executive and executive directors. The Trust does not award performance bonuses.

The committee meets at least annually to review the Board structure, size and composition, to consider succession planning and to identify the required board level skills and knowledge. The committee also meets as part of the appointment process for executive directors and to decide on their remuneration.

During 2019/20 Tom Nettel was appointed as an executive director.

Executive directors are required to give six months' notice to terminate their employment contracts. Non- executive directors are required to provide three months' notice. All directors have permanent contracts. Non-executive directors are appointed for a period of three years in accordance with the Constitution.

The Trust currently carries a provision of £0.309m for early retirements relating to ex-members of staff.

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the workforce. The remuneration of the highest paid director in Homerton University Hospital NHS Foundation Trust in 2019/20 was £185,296 (2018/19 £195,604). This was 5.21times (2018/19 5.80 times) the median remuneration of the workforce, which was £35,561 (2018/19 £34,027).

The remuneration of two executive directors is greater than £150,000.[1] In consideration of benchmarking information compared with peer trusts, the scope of the job roles and their responsibilities and the continued probity of the Remuneration Committee the Trust is satisfied that the remuneration is fair and reasonable.

[1] £150,000 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury as set out in guidance issued by the Cabinet Office. Although the Cabinet Office approvals process does not apply to NHS Foundation Trusts the threshold is used as a benchmark for disclosure.

Audited Analysis of Staff Costs 2019/20				
			2019/20	2018/19
	Permanently Employed	**Other**	**Total**	Total
	£000	**£000**	**£000**	£000
Salaries and wages	173,879		173,879	162,715
Apprenticeship Levy	850		850	795
Social Security costs	17,714		17,714	17,457
Employer contributions to NHS Pensions Agency	29,258		29,258	18,787
Pension Cost - Other	36		36	14
Termination Benefits				41
Agency staff		16,167	16,167	13,527
	221,737	**16,167**	**237,904**	**213,336**

The following table provides information on the remuneration of senior managers in the Trust in 2019/2020.

Audited Remuneration of Senior Managers 2019/20						
Name and title	**Salary**	**Taxable Benefits**	**Performance Pay and bonuses**	**Long term performance pay and bonus**	**All Pension -related Benefits**	**Total**
	(bands of £5,000)	**(to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
Executive Director	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Fletcher T – Chief Executive	185-190	-	-	-	27.5-30.0	**210.0-215.0**
Jones D - Chief Operating Officer	135-140	-	-	-	32.5-35.0	**170.0-175.0**
Wells P – Director of Finance	135-140	-	-	-	30.0-32.5	**165.0-170.0**
Pelley C – Chief Nurse and Director of Governance	115-120	-	-	-	132.5.-135.0	**250.0-255.0**
Dasgupta D – Medical Director	175-180	-	-	-	30.0-32.5	**205.0-210.0**
Patterson I – Interim Director of Workforce[1]	65-70				35.0-37.5	**100.0-105.0**

Nettel, T – Director of Workforce and Organisational Development[1]	45-50	-	-	-	45.0-47.5	**95.0-100.0**
O'Callaghan F – [4] Director of Strategic Implementation and Partnerships	95-100	-	-	-	-	**95.0-100.0**
Gieve Sir J – Chairman	40-45	-	-	-	-	**40-45**
Treves V – [2] Non-executive Director	5-10	-	-	-	-	**5-10**
Williams J – Non-executive Director	10-15	-	-	-	-	**10-15**
Pereira R – [3] Non-executive Director	10-15	-	-	-	-	**10-15**
Smith M – [6] Non-executive Director	10-15	-	-	-	-	**10-15**
Datta S – [5] Non-executive Director	5-10	-	-	-	-	**5-10**
Hudson A – Non-executive Director	5-10					**5-10**
Inko – Tariah C – Non- executive Director	10-15	-	-	-	-	**10-15**

[1] The post of Director of Workforce was covered on an interim basis by Iain Patterson until 4 November when Tom Nettel was appointed on a permanent basis.

[2]The late Vanni Treves held a non-executive director role until 31 August 2019 at the end of his term of office.

[3] Rommel Pereira joined the Trust as a non-executive director on the 1 June 2019.

[4] Frances O'Callaghan, Director of Strategic implementation and Partnerships resigned on 14 February 2020.

[5] Dr Shree Datta resigned as a non-executive director on 13 December 2019.

[6] Andrew Hudson joined the Trust as a non-executive director on the 1 August 2019.

In 2019/20 the Trust paid £212 (2018/19 - £96) as expenses to executive and non-executive directors and there were no payments to governors (2018/19 - nil). The Trust is well served by its governors and volunteers who are not paid for their services.

The element of the Medical Director's salary that related to their clinical role in 2019/20 was approximately £38k.

The following table provides information on the remuneration of senior managers in the Trust in 2018/19.

Audited Remuneration of Senior Managers 2018/19						
Name and title	**Salary**	**Taxable Benefits**	**Performance Pay and bonuses**	**Long term performance pay and bonus**	**All Pension-related Benefits**	**Total**
	(bands of £5,000)	**(to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
Executive Director	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Fletcher T – Chief Executive	180-185	-	-	-	77.5-80.0	**260-265**
Jones D - Chief Operating Officer	130-135	-	-	-	65.0-67.5	**195-200**
Wells P – Director of Finance	60-65	-	-	-	-	**75-80**
Wilson J – Director of Finance	75-80	-	-	-	-	**75-80**
Pelley C – Chief Nurse and Director of Governance	95-100	-	-	-	-	**95-100**
Adam S – Chief Nurse and Director of Governance	15-20	-	-	-	-	**15-20**
Dasgupta D – Medical Director	145-150	-	-	-	-	**145-150**
Gill M – Interim Medical Director	40-45	-	-	-	-	**40-45**
Kuper M – Medical Director	0-5	-	-	-	-	**0-5**
Waldron D - Director of Organisation Transformation	80-85	-	-	-	25.0-27.5	**105-110**
Patterson I – Interim Director of Workforce	20-25					**20-25**
Melville-Ross T - Chairman	40-45	-	-	-	-	**40-45**
Gieve Sir J – Non-executive Director	10-15	-	-	-	-	**10-15**
Treves V – Non-executive Director	10-15	-	-	-	-	**10-15**
Williams J – Non-executive Director	10-15	-	-	-	-	**10-15**
Weitzman P – Non-executive Director	5-10	-	-	-	-	**5-10**
Osborne S – Non-executive Director	5-10	-	-	-	-	**5-10**
Smith M – Non-executive Director	10-15	-	-	-	-	**10-15**
Datta S – Non-executive Director	5-10	-	-	-	-	**5-10**
Inko-Tariah C – Non-executive Director	5-10	-	-	-	-	**5-10**

Pensions

Normal retirement age is dependent upon NHS Pension scheme, for the 1995 scheme normal retirement age is 60, for the 2008 scheme normal retirement age is 65. One of the Trust's directors during 2019/20 is a member of the 1995 scheme and their normal retirement age is 60. There are no additional benefits receivable in the event of early retirement and no rights under more than one pension scheme arising for the directors.

There were no payments in the year in respect of "golden hellos", compensation for loss of office, or benefits in kind for any of the senior managers. As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown below relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV amounts, and from 2004/05 the other pension amounts, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional pensionable service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The CETV at 31 March 2019 is discounted by the HM treasury discount rate. A common market valuation factor is then applied to the difference between this and the CETV as at 31 March 2020 to calculate the real increase in CETV. If a director or senior manager started during the year, the opening pension or cash equivalent transfer value (CETV) values will not normally be available and therefore the opening value or increase in year will be set to nil.

Audited Pension Benefits of Senior Managers

Name and title	Real increase in pension at Pension Age	Real increase in pension lump sum at Pension Age	Total accrued pension at pension age at 31 March 2020	Lump Sum at pension age related to accrued pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000
Fletcher T - Chief Executive	0.0-2.5	0	55-60	125-130	1,054	997	57
Jones D – Chief Operating Officer	2.5-5.0	0	30-35	55-60	425	382	43
Wells P – Director of Finance	2.5-5.0	0	0-5	0	36	11	25
Pelley C- Chief Nurse and Director of Governance	5.0-7.5	17.5-20	45-50	145-150	1,031	852	179
Dasgupta D – Medical Director	2.5-5.0	0.0-2.5	60-65	160-165	1,353	1,231	122
Nettel T - Director of Workforce and Organisational Development	2.5-5.0	0-2.5	20-25	35-40	269	233	36
Patterson I - Director of Workforce	0.0-2.5	95-97.5	40-45	95-100	795	729	66
O'Callaghan F - Director of Strategic Implementation and Partnerships	0	0	40-45	115-120	824	812	12

Nomination and Remuneration Committee – Chairman's report

The Nomination and Remuneration Committee met in October 2019 to consider executive director performance and remuneration. The meeting was chaired by Sir John Gieve also present were Andrew Hudson, Cherron Inko-Tariah, Rommel Pereira, Martin Smith and Jude Williams. The meeting was also part attended by the Chief Executive and fully attended by the Company Secretary.

The Committee considered the internal and external salary and workforce context as well as current director salaries and benchmarking information. Following discussion, the Committee agreed to increase executive director salaries taking into account individual performance, national pay awards and comparative benchmarking salary data. The components of senior management remuneration are confirmed in the table below.

Components of Senior Management Remuneration

Component	Purpose	Operation	Opportunity	Performance Measures	Recovery
Salary	The Trust has 3 strategic priorities: Quality Integration Growth Executive directors are set annual performance objectives aligned to these priorities and lead on the delivery of divisional business plans structured around the same priorities.	Executive directors are on spot salaries, which are agreed upon appointment. Salaries are reviewed annually by the remuneration committee which considers the market rate for the position, any alterations to scope and the performance of the individual as assessed in their PDR*. A remuneration benchmarking report, based on a benchmark of similar trusts, is prepared for the Remuneration Committee.	Executive directors are paid a flat salary that is not linked to performance outcomes. Based on performance and benchmarking decisions are made by members of the Remuneration Committee in respect of the potential for pay awards.	Executive directors along with all staff are assessed against both what they achieve (objectives) and how they achieve it (values and behaviours) as part of their annual PDR.	There are no provisions for withholding payments.
Pension	Executive directors are eligible to join the NHS pension scheme which is linked to the director's salary.	NHS pension rules and contribution rates apply	As above	N/A	Where dismissals are made due to misrepresentation in obtaining office, there are provisions for recovering employer pension contributions .

*PDR = performance development review

Executive directors are not on Agenda for Change terms and conditions. The Trust's approach to remuneration for executive directors is set out in the terms of reference of the Trust's Remuneration Committee.

Medical staff within the Trust are on standard medical terms and conditions. Non-medical staff are employed on Agenda for Change terms and conditions and pay increments are based on performance in line with the framework described above.

Employees were not consulted as part of the preparation of the current Nomination and Remuneration Committee Terms of Reference which cover executive directors' remuneration.

Policy on payment for loss of office

Payments for loss of office are made in line with the Trust's change management policy.

Tracey Fletcher

Chief Executive

23 June 2020

Staff report

The number of staff directly employed by the Trust increased by 46.01 full-time equivalent (FTE) from 3611.95 FTE in 2018/19 to 3657.96 FTE in 2019/20. Excluded from these figures are pre and postgraduate health care practitioners who were placed with us for training, bank and agency employees, staff holding honorary contracts and catering and domestic personnel.

In respect of the staff groups the Trust employs, this is presented below:

Average number of whole time equivalent (WTE) employees	**2018/19**	**2019/20**
Medical and dental	**525**	**564**
Ambulance staff	**0**	**2**
Administration and estates	**701**	**773**
Healthcare assistants and other support staff	**756**	**731**
Nursing, midwifery and health visiting staff	**1,372**	**1401**
Nursing, midwifery and health visiting learners	**0**	**0**
Scientific, therapeutic and technical staff	**564**	**688**
Other	**175**	**18**
Total average numbers	**4,093**	**4177**

Of these staff, 70% work primarily in an acute setting, 21% primarily in a community setting and 9% in corporate functions.

Gender and Disability Analysis

Gender	**2018/19**	**%**	**2019/20**	**%**
Male	832	21%	874	22%
Female	3105	79%	3133	78%
Total	**3,937**		**4,007**	
Recorded Disability	152	4%	171	4%

In total, 78% of our staff are female which is typical of NHS organisations. This proportion has decreased by 1% since last year.

At the end of the year there were seven male and five female members of the Board of Directors.

In the recent staff survey, 14.1% of staff declared they had a long-standing illness, health problem or disability. This represents a higher number than the recoded disability data. Supporting staff with their health and well-being is a key priority for the Trust.

Owing to the coronavirus outbreak the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) suspended enforcement of the gender pay gap deadlines for this reporting year (2019/20). To date, the Trust has not submitted gender pay gap data.

Staff performance indicators

Performance against workforce indicators overall remains consistent, with the Board and Divisional Management Teams receiving monthly performance information.

Vacancy rates have increased over the last financial year from 7.50% at March 2019 to 8.76% at March 2020 although this is against a background of increasing budgeted FTE. The staff turnover rate has decreased over the last financial year by 1.15 percentage points.

Staff support and wellbeing

Employee health and wellbeing is a commitment that the Homerton makes to employees throughout the employment lifecycle. This starts with health clearance at the pre-employment stage, ensuring staff are fit to undertake their appointed role and they will not be putting themselves or others at risk. This is followed by an on-going commitment from the organisation to ensure that the employee's health and wellbeing is not negatively impacted by the work or work environment. These are essential components for good employee relations and the provision of safe patient care.

The Trust's occupational health (OH) service team has worked closely against a targeted action plan and has delivered some significant improvements. Firstly, close working with our recruitment team has led to an improved turnaround time for pre-employment health screening checks. Secondly, OH has performed well against key performance indicators (KPIs) for management referrals. In March alone, 88% of referrals resulted in staff being able to remain at work, with appropriate support. Similarly, early indications in relation to the Trust's Employee Assistance Programme (EAP), implemented in January 2018, show that its therapy service has begun to have positive impact on employees. Following therapy intervention 53.8% of employees returned to work.

The Trust's sickness absence rate averaged 3.24% for the 2019/20 financial year. This is above our target of 3% and is largely attributable to a number of long-term absences. The sickness management policy is widely used to ensure staff receive appropriate support and attendance is managed in the interests of service delivery.

The OH team regularly reviews core employee health metrics, including reason for referral and referrals by staff group and division. Mental health and musculoskeletal concerns have been identified as the most common reasons for referrals. Further work is ongoing in these areas, including plans to deliver stress awareness workshops and an enhanced physiotherapy service. The OH service is subject to audit and remains SEQOHS accredited.

Influenza Programme

During 2019/20 NHS England set a Commissioning for Quality and Innovation (CQUIN) scheme to improve the uptake of frontline healthcare workers receiving the influenza vaccine to above 80%. This year's campaign saw a total of 2778(70.4%) frontline healthcare workers at Homerton receiving the vaccine; a slight decrease of 0.5% in comparison with the 2018/19 campaign.

The Trust awaits direction in respect of the 20/21 campaign however it has committed to learn from the 19/20 campaign and seek improvement in order to achieve national targets.

Staff involvement and engagement

The Trust has a range of mechanisms to support the involvement of staff and staff representatives in the planning and development of services. The monthly 'Team Brief' system, involving presentations from the Chief Executive and other senior leaders is used to cascade key messages across the Trust on a monthly basis. This is complemented with a printed quarterly staff magazine (HomertonLife), an electronic weekly newsletter (HomertonLite) and weekly managers' briefing. In addition, quality improvement and learning opportunities are shared with staff through a monthly electronic bulletin (QTC).

The Trust intranet continues to act as the primary information source for staff and it is kept up to date with news items and feature articles on developments across the Trust. This is supplemented by daily updates on the Trust Twitter feed and Facebook account. The Trust's website and intranet have been subject to review during the year to ensure they are informative, relevant and easy to use.

The Joint Staff Consultative Committee and the Local Negotiating Committee (for doctors) are well established and meet regularly throughout the year. At year end, all elected staff governor positions were filled and their participation in Council of Governors' meetings supported.

Staff survey

In broad terms our 2019 staff survey tells us that our staff are proud of the care that they provide to our patients and they positively rate the safety culture, managers and engagement. However, ratings for morale, health and well-being, bullying and harassment as well as diversity and inclusion, do not score as highly and these are areas we are seeking improvement.

The 2019 Staff Survey ran between September and November 2019 and was based on a whole Trust sample of 3,871 eligible staff. The Trust achieved a 56% response rate with 2,142 colleagues completing the survey which asked 90 core questions. This is an increase on last year's 52.4% the average response rate for similar trusts was 45.6% and the best 76%.

For the purposes of benchmarking, Homerton is categorised as a combined acute and community trust, of which there are 48 in total.

In terms of our benchmarked group the Trust was above the average for the following themes:

- Immediate managers
- Quality of appraisals (= best)
- Quality of care
- Safe environment – violence
- Safety culture

- Staff engagement

Our top five scores were:

2019	Top 5 scores (compared to average)	2018 Score	Average Score
49%	Q19e. Appraisal/performance review: organisational values definitely discussed	50%	38%
69%	Q22c. Feedback from patients/service users is used to make informed decisions within directorate/department	69%	59%
52%	Q9b. Communication between senior management and staff is effective	50%	41%
44%	Q9d. Senior managers act on staff feedback	42%	33%
78%	Q21d, If friend/relative needed treatment would be happy with standard of care provided by organisation	76%	69%

The Trust was below the average for the following themes:

- Equality, diversity and inclusion
- Health and wellbeing
- Morale
- Safe environment – bullying and harassment

Our bottom five scores were:

2019	Bottom 5 scores (compared to average)	2018 Score	Average Score
82%	Q19a. Had appraisal/KSF review in last 12 months	82%	88%
65%	Q28b Disability: organisation made adequate adjustment(s) to enable me to carry out work	89%	73%
48%	Q23b. I am unlikely to look for a job at a new organisation in the next 12 months	N/A	54%
77%	Q14. Organisation acts fairly: career progression	77%	85%
66%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	68%	72%

Homerton's overall results when benchmarked against other trusts are:

	2019/20		2018/19		2017/18	
	Trust	Benchmark Average	Trust	Benchmark Average	Trust	Benchmark Average
Equality, Diversity and Inclusion	8.5	9.2	8.4	9.2	8.5	9.2
Health and Well Being	5.6	6.0	5.7	5.9	5.9	6.0
Immediate Managers	6.9	6.2	6.9	6.8	6.9	6.8
Morale	5.9	6.2	6.0	6.2		
Quality of Appraisals	6.2	5.5	6.2	5.4	6.3	5.3
Quality of Care	7.8	7.5	7.8	7.4	7.8	7.5
Safe Environment – Bullying & Harassment	7.8	8.2	7.8	8.1	7.9	8.1
Safe Environment – Bullying Culture	9.5	9.5	9.5	9.5	9.5	9.5
Safety Culture	7.0	6.8	6.9	6.7	6.9	6.7
Staff Engagement	7.1	7.1	7.2	7.0	7.2	7.0

Equality and diversity

Given the diversity of the population of Hackney well as the profile of staff employed by Homerton, the Trust is committed to do all it can to ensure it operates as an employer in the most inclusive manner possible. In doing this the Trust will be able to enhance its ability to deliver high quality health outcomes for patients and provide a positive employment experience for staff.

The Trust's lead for equality and diversity is the Director of Workforce and Organisational Development. The latest Equalities Report, performance against the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the Gender Pay Gap (GPG) and our equality objectives are available on the Trust's website. All publication duties have been met.

Diversity data
The below table confirms the Trust's diversity data. In total 52.6% of staff at the Trust identify as from Black, Asian and minority Ethnic (BAME) backgrounds.

Representation of BAME staff at a senior level remains a priority for the Trust and the Board has become more reflective of the wider organisation.

Ethnicity	2018/19	%	2019/20	%
White	1743	44.3%	1809	45%
Mixed	139	3.5%	142	4%
Black or Black British	1113	28.3%	1123	28%
Asian or Asian British	619	15.7%	630	16%
Other Specified	189	4.8%	213	5%
Not Stated	64	1.6%	90	2%
Undefined	70	1.8%	0	0%
Total	3,937		4,007	

To meet our equality objectives a Diversity, Equality and Inclusion Strategy has been developed and sets out what the Trust will do to support the cultural transformation outlined in the NHS England Long Term Plan and also to support the Trust's diversity aspirations.

The Refreshed People Plan

Following careful review of the Staff Survey results, the Equality and Diversity data above and the Workforce Race Equality and Disability Standards a refreshed people plan for Homerton was agreed by the Trust Board in early 2020. This was developed with the intention of delivering meaningful, measurable and sustainable improvements, at pace, in our people's experience at the Trust.

i. What is the Plan's Aim?

In line with the Interim People Plan aim to make the NHS the best place to work, the suggested and draft aim of the plan is to make the Homerton University Hospital NHS Foundation Trust the best place to work in the NHS by 2023.

This is the aim because there is wide-ranging and substantial evidence of the direct link between our people's experience and the experience and care that patients receive.

ii. Underpinning Principles

- The most effective plans for improving people's experience at work, at scale and at pace is to ensure that the plans are under ongoing review and discussion by a range of staff and management representatives.
- The plans need to be flexible enough to be iterated on an ongoing basis following these discussions however this will be balanced with the need for sufficient clarity and certainty to allow for effective delivery at pace.
- The plans must deliver real and measurable change.
- Therefore the plans should also be regularly monitored monthly and quarterly using a range of Key Performance Indicators while recognising that meaningful improvement is likely to be seen over an annual basis.

- Finally it is essential that there is ongoing communication to all HUH people of a clear ongoing narrative of the plan, what it means for each person at HUH and how progress is being made. This will also assist in addressing the challenge of the 'hiatus' in focussed work in this area.

iii. Governance, Development and Oversight

A first critical element will be to establish a structure of governance and regular meetings with senior leaders and staff representatives to oversee and support delivery as well as help ongoing development and iteration of the plan.

The structure will be as follows:

- Working group chaired by Chief Executive with staff representatives from unions and staff networks as well as senior leadership
- Reporting to renamed and refocussed People and Culture Committee chaired by Chief Operating Officer.
- Reporting to Trust Management Board once a month and Board of Director's
- Trust Management Board focussing on Quality and Assurance will be renamed and refocussed to People, Quality and Assurance with People the first standing item on the agenda.
- This will be underpinned by a planned renaming and refocussing of the Workforce and Organisational Development division to the People and Culture division (reinforcing in the shift in language and focus in the governance set out above) with a refocus across roles in the division to delivering effective services to our clients but to also in parallel deliver services, developments and policies that support delivery of the Plan's overall aims.

Key Performance Indicators are also being developed and agreed through this governance as and are likely to be as follows:

- By 2023:
- CQC Well Led Rating: Outstanding
- Chosen NHS Staff Survey measures: Best of NHS Acute and Community Hospital Comparator Group
- Workforce KPIs (vacancies, turnover, appraisal): Performance in Upper Quartile nationally
- Chosen Staff Survey measures:
- WRES, Gender Pay Gap and WDES
- Equality, diversity and Inclusion
- Safe Environment – bullying and harassment
- Morale
- Turnover Rate – e.g. 12% or below
- Vacancy Rate – e.g. 8.5% or below

- Appraisal Rate – e.g. 95% or above; validated by Staff Survey results re quality of appraisal and reported appraisals by staff

These measures will be reviewed on a quarterly and annual basis through this governance structure and will be supported by more regular pulse surveys of people's experience across the Trust.

Delivery of the People Plan

The plans and projects that will deliver the improvement in our people's experience (at scale and at pace) will be made of three key elements.

- Creating a Values-led Organisation for all our People
- Equality and Inclusion for our People
- Strategy and Communication

i. Creating a Values-led Organisation for all our People

The first will focus on continuing to embed the Trust's values throughout the organisation and at every stage of our people's life at the Trust. Best practice and research shows that such work unites people across the organisation behind a common set of values and empowers and energises collective leadership and delivery of behaviours by all our people all of the time. Our values will be the foundation upon all other projects, communication and strategy will be based.

In practice the key projects will be:

- Embed values at every stage of the 'employee lifecycle' including:
    - Appraisal – first area of priority
    - Recruitment (building on work done in previous years)
    - Induction
    - Leadership
    - Education and Development
- Relaunch 'Living Our Values' document
    - In addition develop HUH Leadership Compact led by TMB (quick win – see example) To be supported by HUH Leadership and Management Development Programmes
- Launch employee and team recognition and reward for living values
    - Launch annual staff awards – awards based on living values (quick win if funding can be identified)
    - Alignment with NHS People Plan's Improve NHS Leadership Culture

ii. Equality and Inclusion for our People

The second key area of work will focus on the Trust's most significant area of concern for the experience of our people, the perceptions of inequality and the real inequality that is evident in some of our processes and approaches (as is the case with the significant majority of Trusts across London).

There will be a focus on projects that will deliver measurable improvements in the equity and inclusiveness of our processes and approaches to leadership and management. These are intended to deliver specific improvements to

These will be developed, overseen and where appropriate led and championed by staff network chairs and members.

In practice the key projects will be:

- Focus on race and disability where experience is poorest but also gender and LGBT
- Development and implementation of Just Culture principles:
    - Review of Conduct, Grievance and Bullying policies
    - Introduction of agreed outcomes where appropriate
    - Further leverage informal resolutions and mediation
- Empower and Staff Networks
    - Establish effective funding/resourcing for networks (including release)
    - Define role of Staff Network chairs and members – consider development of Ambassador role to work locally with the divisions
    - role to oversee and influence change including monitoring of all projects i.e. pre-action checklist, recruitment principles, diverse recruitment panels, improving performance management
- Establish Fair Recruitment Principles signed off by TMB, Unions and Networks to ensure fair and transparent recruitment processes
- Continue implementation of diverse recruitment panels
- Review impact of Pre Formal Action Checklist and further enhance
- Improve performance management capability and discussions
- Develop a Talent Management plan for 2021
- (All aligns with the NHS People Plan objective – making the NHS the best place to work)

iii. Strategy, Communication and Supporting Local Improvements

The third and final key area of work will focus on three important areas – the first will be continuous communication with staff throughout the organisation using staff stories and video to publicise improvements in our people's experience over the next twelve months.

A second linked area of work would be to integrate this work within an overall 'Homerton Story' aligned to a refreshed Trust Strategy with a focus on improving our people's experience and the evolution of the organisation, its people and its services to support the future integrated, population healthcare of Hackney and North East London.

The intention and ambition is that the above communication and strategic narrative will inspire, encourage and support the third area of focus; local action. This will be supported in practice by the Improvement team and underpinned by Quality Improvement methodologies, to develop local, effective solutions to improving Homerton people's experience. There are already a number of good examples of locally-led improvement projects that have delivered measurable improvements in people's experience. Where these demonstrate opportunities for improving experience at scale these will be considered and supported where appropriate.

Trade Union facility time

In accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to disclose it meets the criteria of having at least one trade union representative and at least 49 full time equivalent employees during any seven of the 12 month period of the annual report.

The following disclosure is provided under Schedule 2 of the above Regulations and follows the guidance provided by the Cabinet Office.

Number of employees who were relevant TU officials during the relevant period	FTE Equivalent
35	33.73 WTE
Percentage of time spent on Facility Time	
Percentage Time	Number of Employees
0%	0
1 – 50%	35
51 – 99%	0
100%	0
Percentage of Pay Bill Spent on Facility Time	
Total cost of facility time	£101,246
Total pay bill	£180,435,096
Percentage of the total pay bill spent on facility time (total cost of facility time / total pay bill x 100)	0.056%
Paid Trade Union Activities	
Time spent on Trade Union Activities as percentage of total paid facility time hours calculated as: Total hours spend on paid trade union activities by relevant union officials / total facility time hours	59%

Education and related activities

Core mandatory training

The Trust ended the year with an overall compliance rate of 89% against all core mandatory training requirements. The Trust achieved 85% compliance in Information Governance for the second year running. All but one of the 12 subject areas achieved improved compliance of 80% or above, compared to eight subjects reaching the same levels in March 2019. Moving and Handling dipped below 80% in March 2020 due to a combination of the impact of Covid-19 pandemic response and trainer resource; however Adult Basic Life Support and Paediatric Life Support both achieved steady improvements throughout the year, achieving over 80% compliance by the end of March 2020.

The Trust achieved over 80% compliance in WRAP training (Workshop to Raise Awareness about PREVENT), part of the Government's approach to tackling radicalisation introduced during 2018, which was an increase in 10 percentage points from March 2019.

Leadership development

The Trust continued with its successful leadership programmes in 2019/20. A total of 35 staff took advantage of these opportunities and they provided positive feedback.

The Quality Improvement Team continued to support the leadership cohort in developing purposeful work-based QI projects. Unfortunately, because of the impact of Covid-19, the leadership presentations and QI poster display arranged for mid-March 2020 had to be cancelled. We intend to celebrate this cohort’s success as soon as it is possible to do so.

Our REACH leadership programme aimed at BAME staff is in its third year, and continues to be popular with staff across all pay bands in the Trust.

Apprenticeships and work experience

Homerton offers apprenticeship opportunities for all our entry level job vacancies, and higher apprenticeships are available to staff as part of their personal development planning.

Current support for managers includes: a streamlined apprenticeship recruitment process with a step by step guide for managers, and facilitated effective communication between managers and apprenticeship training providers.

Future activity will include an information pack for managers and apprentices, to outline expectations and useful information to help address issues.

Local publicity has seen an increase in staff enquiring about suitable apprenticeships which can be facilitated whilst in their current role, including:

- Business Administration, Level 3
- Team Leader / Supervisor, Level 3
- Operations / departmental manager, Level 5
- Nursing Associate Level 5

The Trust works closely with HEE and our north east London partnership organisations in the joint procurement of apprenticeships, to share experiences, and improve apprenticeship implementation.

We have seen growth in our work experience programme in partnership with local schools and colleges from April 2019 until March 2020. We have hosted a number of career awareness sessions for students from local colleges to introduce them to the variety of NHS health care roles.

Workforce education and development

The Trust continues to provide programmes of workforce education and training to support all staff in the delivery of safe, effective care and a positive patient experience.

Training programmes are regularly reviewed and refreshed following feedback from staff, and further to the Customer Care programme which we introduced last year, this was rolled out to all outpatient staff in 2019; we also continued with the *Conducting Difficult Conversations* workshop, delivered by ACAS, and targeted to specific managers.

We have continued to deliver the Care Certificate Programme to all non-registered staff in patient facing roles, resilience workshops for preceptorship nurses, and maths and English skills alongside interview preparation training for our healthcare support workers who have ambitions to train in the new Nursing Associate role.

We continue to work with our NHS and education partners in north east London to deliver the Nursing Associate Apprenticeship, and have met our ambition of starting a minimum of 10 support workers on this two-year apprenticeship programme in 2019/20.

We continue to fully utilise our budget allocation from HEE in responding to the education priorities of our workforce, including both clinical and non-clinical programmes such as, chaperone training, mental health and wellbeing, new-born life support, leg ulcer management, the diabetic foot, and pharmacy practice programmes.

Many of these are bespoke training programmes, designed for groups of staff and are delivered onsite.

Medical education

In 2019/20 the Trust continued to demonstrate its commitment to the delivery of undergraduate and postgraduate medical education. The results from the national GMC survey of doctors in training were positive. Feedback from the Barts and the London School of Medicine and Dentistry Quality Visit was also very positive. The Trust has increased the numbers of medical students on placements and continued to accommodate physicians' associate students on placements. Initial feedback from students is good.

Homerton has delivered regional teaching days for several postgraduate specialties, including core medical training. Medical Education were also successful in securing funding from HEE to deliver a communications course 'Engaging with Millennials' and funding for exam resources. Three Grand Rounds took place during the course of the year and were well received. During the summer the trust accommodated 30 City and Hackney sixth form students for medical work experience. Trainees delivered a day on applications to medical school and interview skills.

The Simulation Centre was again successful in securing bids and delivering numerous courses, many in collaboration with other centres across the region and pan London. Among these were Paediatric Cardiology in collaboration with GOSH and Advanced Debriefing skills in collaboration with UCLH and Barts Health. The simulation team continue to deliver Resuscitative and Interventional Procedures in Simulation (RIPS), a multi-professional for emergency medicine trainees and senior Emergency Department and Resuscitation nurses.

In situ simulation is now embedded across the Trust and is having a profound impact on improving the environment for patients and staff. The 9th Homerton Simulation Conference; 'Wellbeing and Frugal Innovation in Simulation and Healthcare' was held and received good feedback.

The Newcomb Library team continues to support the education, learning, research and evidence-based practice of Homerton staff and students on placement. The services supplied provide the evidence base to departments across the Trust to make decisions on treatment options, patient care and safety, commissioning and policy, as well as to undertake research and drive innovation.

Staff Policies

Raising concerns (whistleblowing)

We encourage staff to raise concerns with senior managers about patient safety, criminal offences, breaches of legal obligations, miscarriages of justice, or the deliberate concealment of information. Our Raising Concerns at Work policy guides this process. Our Freedom to Speak Up Guardians offer confidential advice to support staff to raise issues with senior management. We continue to raise the profile of this service so that staff are aware of its benefits.

Counter fraud, anti-bribery and corruption

The Trust has counter fraud, corruption and bribery policies for dealing with suspected fraud, bribery and other illegal acts involving dishonesty or damage to property. Staff can contact nominated officers in confidence if they suspect a fraudulent act. The nominated officers are the Director of Finance and the local counter fraud specialist, provided by TIAA.

Other policies

During the financial year policies were in place and were applied to ensure that full and fair consideration was given to employment applications made by disabled persons. The Trust's Recruitment and Selection Policy outlines the process to be followed to demonstrate that the organisation has considered the particular aptitudes and abilities of disabled people.

During the reporting year, policies were also in place for continuing the employment of and arranging appropriate training, career development and promotion of disabled employees. The Trust policy for Professional Education, Learning and Development outlines the arrangements in place to support education, training and workforce development. The Trust is committed to the development of a learning culture and values the contribution made by each individual member of staff. To this end all managers apply this policy in an unbiased and consistent manner.

Consultancy expenditure

The 2019/20 expenditure on consultancy was £0.5m (2018/19 £1.2m) and this included the cost of consultancy work around organisational development and support, advice on the development of the clinical services surgical review and additional specialist procurement support.

Exit Packages

Exit Packages awarded in 2019/20 were as follows:

	Reason	**Redundancy**	**PILON**	**Other**	**A/L**	**Total**
1	Agreed Termination	£0	£0	£1,337	£0	£1,337
2	Agreed Termination	£0	£155,878	£0	£0	£155,878
3	Compulsory Redundancy	£3,938	£0	£0	£0	£3,938
Totals		**£3,938**	**£155,878**	**£1,337**	**£0**	**£161,153**

Salary and pension entitlements of senior managers

Tax arrangements of public sector appointees

The tables below summarise the Trust's appointees who fall within the definition of PES (2017)11 published by HM Treasury.

- All off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2020, of which:	1
Number that have existed for less than one year at time of reporting	nil
Number that have existed for between one and two years at time of reporting	nil
Number that have existed for between two and three years at time of reporting	1
Number that have existed for between three and four years at time of reporting	nil
Number that have existed for four or more years at time of reporting	nil

For the one existing engagement the Trust has undertaken a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

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

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, of which:	1
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency / assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

- For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on- payroll engagements.	8

Disclosures set out in the NHS Foundation Trust Code of Governance

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

For the year ending 31 March 2020 the Trust complied with all the provisions of the Code as set out in NHSI's Annual Reporting Manual 2019/20.

Throughout this Annual Report the Trust describes how it has met the Code's requirements. The table below provides a summary of where information can be found on the issues the Trust is required to disclose.

Code Reference	Annual Report Section	Page
A.1.1	Board of Directors and Council of Governors	12
A.1.2	Directors Report and Board Committees	12
A.5.3	Council of Governors	21
Additional requirement	Council of Governors	23&25
B.1.1	Board Composition	12
B.1.4	Board Composition and Directors' Evaluation	12
Additional requirement	Board Composition	12
B.2.10	Nomination Committee	25
Additional requirement	Governor Nomination Committee	25
B.3.1	Sir John Gieve's biography	12
B.5.6	Foundation Trust Membership	21
Additional requirement	Not applicable	-
B.6.1/B.6.2	Directors' Evaluation and Well-led Framework	21&61
C.1.1	Statement of Accounting Officer's Responsibilities	53
C.2.1	Annual Governance Statement	55
C.2.2	Audit Committee	17
C.3.5	Not applicable – Accepted by the Council	-
C.3.9	Audit Committee	17
D.1.3	Remuneration Report	29
E.1.4	Contacting the Board/Contacting the Governors	16&26
E.1.5	Council of Governors	24
E.1.6	Foundation Trust Membership	21
Additional requirement	Membership Strategy	22
Additional requirement	Register of Directors'/Governors' Interests	12&25

NHS Improvement's Single Oversight Framework

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

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

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

Homerton was in segment 3 at the end of the reporting year, with no formal interventions introduced by NHSI under the legal authority as Monitor. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	**Metric**	**2019/20 Q4 score**	**2018/19 Q4 score**
Financial sustainability	Capital Service Cover	1	1
	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from financial plan	1	1
	Agency spend	4	3
Overall scoring		**3**	**1**

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Homerton University Hospital NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Homerton University Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Homerton University Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

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

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

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

Tracey Fletcher

Chief Executive

23 June 2020

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 Homerton University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Throughout the reporting year the Trust has ensured that its risk management system receives the appropriate leadership and management. The Chief Nurse and Director of Governance is the executive lead for risk management and the Director of Finance has lead responsibility for managing financial risk. All executive directors, operational directors and heads of service have a key role to play in developing a strong risk management approach in all aspects of the Trust's activities, both clinical and non-clinical.

The Board of Directors has overall accountability for the Trust's risk management strategy and has established a Risk Committee to provide assurance to the Board that the Trust has effective risk management processes. The Risk Committee has been in operation since 2005 and is chaired by a non-executive director (NED). Meetings are held on a quarterly basis.

The Risk Committee:

a) ensures that the Trust Risk Register is fit for purpose and has an appropriate structure is in place for the regular scrutiny and monitoring of risks;

b) is kept informed about all aspects of risk management through a variety of reports from sub-committees and working groups on clinical and other organisational risks such as health and safety and estates;

c) receives scrutiny reports from both internal and external sources including the Care Quality Commission;

d) receives annual compliance reports from the Improving Patient Safety Committee, Information Governance Committee, Improving Clinical Effectiveness Committee, Improving Patient Experience Committee and the Resilience Committee (for emergency planning and business continuity);

e) supports the development of risk management systems and helps to promote a culture in which risk management is seen as an integral component of all aspects of healthcare delivery.

The Board Assurance Framework (BAF) is the mechanism which is used to record the Trust's strategic objectives and manage the associated risks that threaten their achievement. The BAF is reviewed and updated by the executive directors and is formally reviewed by the Risk Committee and Board of Directors to ensure that appropriate controls are in place and mitigating action is being taken against the key risks.

Early in the reporting year the BAF was reviewed by the Executive Team and a new format was introduced to provide assurance to the Board on the effectiveness of the risk controls identified for the principal risks associated with the Trust's strategic objectives. Using a three line assurance model, the BAF confirms:

- The assurance reporting line
- First line assurance – at service level
- Second line assurance – within the Trust
- Third line assurance – outside the Trust (independent)
- The level of assurance (high, medium or low)
- Assurance gaps and planned actions

All executive directors take responsibility for risk identification, management and mitigation within their designated areas of work. Operational and other corporate risks are reviewed by the Board as part of its regular monitoring of performance through reports received, or in the context of specific issues that arise.

There are internal processes to ensure that incidents which fit the national criteria for serious incidents are reported on the Department of Health and Social Care's Strategic Executive Information System (STEIS). The Trust's Improving Patient Safety Committee has oversight of serious incidents and receives a monthly report on serious incidents declared and reports completed that month. The Board is provided with a monthly report on serious incidents.

The corporate induction programme ensures that all new staff receive information on the Trust's risk management systems and processes. This includes the comprehensive induction of all junior doctors with regard to key policies, standards and practice prior to commencement in clinical areas. The mandatory training programme ensures that essential training is delivered to staff members, which includes risk management processes such as health and safety, manual handling, resuscitation, infection control, safeguarding patients, blood transfusion and information governance.

In addition, specialist risk training is identified by managers for individual job roles and agreed with staff through personal development plans. Board members receive training in risk management awareness and an overview of the risk systems.

The Trust is committed to continuous improvement and learning; from incidents and complaints, outcomes from audits and the experiences of patients, other service users and staff.

The divisional Quality and Patient Safety Managers report regularly via the Head of Quality and Patient Safety to the Chief Nurse and Director of Governance.

Best practice is highlighted and shared across divisions through the divisional leads, the Improving Patient Safety Committee, the Improving Patient Experience Committee, the Improving Clinical Effectiveness Committee and their respective sub-committees. We seek to learn from both internal and external sources of good practice.

During the reporting year we have enhanced our serious incident process which has strengthened the handling of clinical incidents within the divisions. In addition we continue to maximise our use of our risk management software system (Datix) with the aim of simplifying the reporting of incidents and to widen our understanding of particular themes and trends which have been identified.

The risk and control framework

The Risk Management Policy is reviewed by the Risk Committee and approved by the Board of Directors. It describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process and the organisation's risk appetite.

The policy was revised in 2018 to include a greater level of detail on the processes for risk assessment, risk approval, risk review and on identifying actions to mitigate risk. The intention was to provide a comprehensive guide to staff on how risks are escalated from the front line to the board. The policy is available to all staff via the Trust's intranet.

As set out in the Risk Management Policy, associate medical directors, divisional operations directors, senior nurses, and other relevant senior managers are responsible for the management of risk within the workplace. Together they foster a culture of risk awareness throughout their divisions and ensure that risk assessments for all work-based activity are conducted. The updated policy includes guidance on the risk assessment matrix used to evaluate risks for inclusion in the Trust's risk registers. The Head of Quality and Patient Safety is responsible for the maintenance of the Trust's risk register. Risk registers are also held within the divisions and they are subject to regular scrutiny.

The Risk Management Policy confirms which risks need to be escalated to the next management level and describes the risk escalation route. Risks are classified as low, moderate, major and catastrophic, based on a consequence and likelihood matrix approved by the Board. While the Board recognises that risk is inherent in the provision of healthcare and its services, the Trust has a low risk appetite for risks that could affect patient safety.

Incident reporting is openly encouraged through staff training and the Trust's positive risk management culture. Our aim is to involve all patients and families in the serious incident process so that they are aware of the risks identified, and in particular those that impact on public stakeholders.

During the year the Trust's BAF and risk management was subject to internal audit. The review acknowledged the ongoing work, led by the newly appointed Risk Committee chair and Director of Governance to strengthen the risk management arrangements at the Trust. Specifically the Risk Committee has considered the role of the BAF and the risk register and the role of the Board in reviewing risk, risk appetite and tolerance levels.

The internal audit opinion was that the Board could take reasonable assurance that controls were in place to manage risk that were suitably designed and consistently applied.

In the reporting year the internal auditors presented the results of an assurance map exercise which was presented at the October 2019 Audit Committee. The purpose of the exercise was to build on the Board Assurance Framework and to map out the different sources of assurance for key process areas within the Trust.

The Assurance Map provided external assurance of the Trust's risk control framework.

Quality governance arrangements

The quality governance arrangements within the Trust are organised through the divisional structure with each division headed by an operational and clinical lead, and with a governance structure in place that supports the achievement of all quality priorities. The divisions review quality governance and performance information on a regular basis, including incidents and serious incidents; patient experience feedback including Friends and Family Test; survey reports; complaints; Patient Advice and Liaison Service (PALS) enquiries; litigation; clinical audit data and NICE compliance. Divisional performance is also monitored and reviewed each month against a range of performance measures including quality and safety at divisional performance review meetings.

The Trust Management Board (Quality and Operational Assurance), chaired by the Chief Executive, meets monthly and reviews and monitors quality issues for the whole Trust. The Risk Committee, the Improving Quality Board, the Improving Patient Safety Committee, the Improving Patient Experience and the Clinical Effectiveness Committee also have an important governance role in the oversight of quality.

The above committees and their supporting sub groups are used as conduits to disseminate information from the wards, departments and divisions to the Board and vice versa. This approach supports the process for enabling that improvement action is delivered at the point of care and it also provides a route for escalation of concerns and mitigating actions to the Trust Board.

In addition two non-executive directors are assigned to each division to gain an understanding of their priorities and issues and to establish closer working links with the Board of Directors.

Performance assessment

The Board is provided with an integrated monthly performance report to evaluate the Trust's performance. The report is designed around the CQC's five key lines of enquiry and provides metrics and commentary to update the Board on progress against the Trust's key performance indicators.

The Board of Directors receives performance information each month in relation to:

- performance against national targets, including infection control, A&E waiting times, cancer access and referral to treatment (RTT) standards. Improvement plans are also included if there are concerns in relation to any particular targets
- key performance indicators related to patient safety and clinical effectiveness, such as patient safety thermometer results, numbers of falls and pressure ulcers, delayed transfers of care and standardised hospital mortality ratios
- exception report from the maternity services dashboard
- patient experience data, including Friends and Family Test, PALs and complaints data
- key workforce metrics, such as agency spend, vacancy rates, turnover and sickness absence
- key financial performance data, including income and expenditure and a summary of cost improvement programme (CIP) performance
- progress reports on the Trust's financial plan

The Council of Governors holds the Board of Directors to account for its overall performance. The Council receives quality, performance and risk reports throughout the year. Meetings are held on a regular basis and members of the public are able to raise issues directly with board directors at these meetings and at the annual members meeting.

The year-end key performance indicators are confirmed on page 11 of the annual report.

CQC Registration

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

In April 2018, the CQC inspected four core inpatient services at the main hospital site which included; emergency and urgent care, medical care (including older peoples care), surgery and maternity services. Overall, the CQC rated Homerton University Hospital as 'good'. Urgent and emergency services and medical care (including care of the older person) were rated as 'outstanding' overall.

In May 2018 the CQC conducted a well-led inspection which resulted in an overall rating of 'good' for this domain.

In 2017 the CQC inspected the Trust's community health services. A 'good' rating was received across all domains.

In January 2020 the CQC inspected a selection of services on our acute site, including maternity, end of life care and elderly care services. No significant concerns were raised with the Chief Executive following the visit and we await the final report.

In February 2020, the CQC made an unannounced inspection visit at the Mary Seacole Nursing Home. The nursing home has been rated 'good' overall and each of the five domains have also been rated as 'good'.

The CQC did not inspect our community services or carry out a well-led inspection during the reporting year.

The Risk Committee receives regular CQC updates and reviews the CQC Insight reports to identify areas of deteriorating performance.

Major risks

A Board Assurance Framework (BAF) detailing the principal risks to the achievement of the Trust's strategic objectives was in place for the financial year.

The key risks to the achievement of the strategic objectives include:

- There is a failure in the standards of safety in the Trust and patients are not protected from avoidable harm
- Difficulties in recruiting and retaining staff thereby placing at risk the ability to provide compliant and optimal rotas
- Failure to adhere to best practice or the latest research which is not compliant with the best evidence that could lead to less effective service provision
- Failure to implement recommendations and learning from national audits, external reviews including Getting it Right First Time (GIRFT) methodology
- There is a failure to deliver national, and relevant local access standards relating to elective care, cancer and emergency care
- There is a failure to maintain waiting times and deliver national and local standards for services provided within community settings and patients homes
- Lack of compliance with the Data Security and Protection Toolkit and the new Cyber Security Standard
- There is a failure to improve the staff engagement concerns, particularly those identified within the staff survey and the workforce race equality standard (WRES)
- The Trust is set control and efficiency targets which cannot be achieved, with the resultant loss of Provider Sustainability Funding and medium term financial stability
- Failure to develop an integrated care and health system in City and Hackney which improves service provision and care for the local population

The most significant clinical risk for the Trust is the ability to recruit and retain medical and nursing staff to ensure the delivery of safe, harm free care for patients. The Trust continues to monitor the number of clinical post vacancies and it will remain a major focus in 2020/21.

The financial pressures within the health economy and the risks associated with the delivery of cost improvement efficiencies will continue to challenge the Trust in the coming year and may impact on the Trust's achievement of its control total and other financial targets. There is a greater degree of uncertainty given the coronavirus outbreak and the new financial arrangements which have been made for provider trusts.

The Trust has comprehensive plans in place to mitigate the above risks which are monitored y by the Executive Team and reviewed by the Trust Board and the Risk Committee on a regular basis. The Trust recognises its risk management approach will not totally eliminate risk, but it will provide the organisation with a means to identify, prioritise and manage the risks.

Workforce Safeguards

During the reporting year the Board approved a refreshed People and Culture Plan 2020-2023, which is aligned to the overarching aims of the interim NHS People Plan. One of the key aims is to prioritise urgent action on nursing shortages. A new governance structure was established to oversee and support delivery of People and Culture Plan.

The Board receives twice yearly reports on the Trust's staffing levels. The reports include information to demonstrate how the Trust complies with the 'Developing Workforce Safeguards' recommendations.

The Board receives an assessment of staffing levels based on agreed tools and quality metrics in line with National Quality Board guidance. The Trust uses care hours per patient day (CHPPD) information to assess the number of care hours provided on the wards. This assessment is benchmarked against all trusts to consider the Trust's performance.

During the year the Board has reviewed the impact of recruitment and retention initiatives and actions on the overall nursing and midwifery staffing levels. Positive action has led to some improvement in nursing and midwifery vacancy and turnover rates. The Trust continues to work to ensure safe staffing in all clinical areas.

Foundation trust governance requirements

The Board sets the vision, values and strategic direction of the Trust and is collectively responsible for its performance. The Council of Governors receives regular updates on clinical and financial performance and service delivery. The governors meet jointly with the non-executive directors (NEDs) twice a year and the NEDs are available to answer questions in formal and informal settings to enable the governors to discharge their duties.

The Board is supported by four committees and two executive led committees with a remit to monitor the effectiveness of risk management, quality, performance, financial sustainability, internal control and assurance arrangements. The clinical governance arrangements within the divisions have been reviewed during the year. The Board of Directors receives regular assurance reports from its sub committees and has considered the effectiveness of the existing committee structure during the year.

Well-led framework

In 2018 the Trust received a 'good' rating following the CQC's well-led inspection. As mentioned above, the CQC did not carry out a well-led review as part of their 2020 inspection visit.

During the reporting year we completed a well-led self-assessment in line with the NHSI well-led framework guidance. The participants were Board directors, Trust Management Board members, executive director direct reports and members of the Audit and Risk Committee.

Participants were asked to consider the framework's eight key lines of enquiry and:

- Award a priority rating for each key line of enquiry (High, Medium or Low)
- Explain the assessment rating using the well-led framework and descriptions of good practice
- Confirm the evidence in place to support the assessment judgement
- Flag up the areas for action/discussion with the Board

The results of the assessment revealed a consensus opinion in relation to:

a) Visibility of leadership
b) Experienced and knowledgeable Board members
c) Understanding of need to deliver high quality sustainable care
d) A strong culture of engagement by the leadership with frontline staff in both clinical and non-clinical areas
e) Good governance and accountability throughout the organisation, especially in relation to patient quality and safety
f) There was a comprehensive Board performance report modelled on CQC reporting
g) The Board received information of sufficient quality to manage the Trust effectively
h) There was close engagement with NHS partners and other stakeholders both locally and across a wider region
i) Good evidence of a learning culture and continuous improvement and good use of benchmarking
j) A very open culture of incident reporting and effective risk management framework

The areas identified for further action were considered by the Board and will inform our governance action plans and the discussion with the external facilitator of our next independent well-led assessment which is due in 2020/21.

Together with CQC rating achieved, the Board received assurance of the organisation's well-led capability.

The Board made a self-declaration in June 2019 that it was compliant with the conditions of the NHS provider licence and with no significant risks identified in relation to the corporate governance statement.

Other control measures

The 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.

Control measures are in place to ensure that the Trust is compliant with equality, diversity and human rights legislation. An equality impact assessment is completed for all new and revised policies, which is considered by the relevant committee and the Trust's Policy Group. The Workforce Committee is responsible for progressing actions to advance equality in the Trust and meet the standards set out in the NHS Equality Delivery Systems (EDS2).

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.

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

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

The Trust has established processes in place to ensure that resources are used economically, efficiently and effectively. In addition to the financial review of resources and the quarterly monitoring returns to NHS Improvement (NHSI), all budget holders are provided with monthly financial information for the purposes of monitoring and control. The Board also receives financial performance reports on a monthly basis.

Internal audit reports consider value for money and KPMG is required as part of their annual audit to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion it has not.

The Trust has an internal performance management review process which provides evidence of divisional performance and the actions being taken to ensure resources are being used effectively and efficiently. In addition productivity and efficiency opportunities are identified as part of the annual business planning process.

The Trust has a comprehensive Quality, Innovation, Productivity and Prevention (QIPP) Programme Board in place to identify and deliver efficiencies against the Trust target for savings which is chaired by the Director of Finance. The Board of Directors and Council of Governors receive regular updates on progress and the risks associated with the Trust's cost improvement plans.

Information governance

The Trust's information governance (IG) work is led by the Medical Director, as the Caldicott Guardian and the Chief Operating Officer as the Senior Information Risk Officer. The IG Manager is the Trust's designated Data Protection Officer. The Information Governance Committee is responsible for monitoring and controlling risks relating to data security and has oversight of the IG risk register. The Information Governance Committee reports to the Risk Committee on a quarterly basis, which in turn reports to the Board.

All Information Governance security related incidents were reported to NHS Digital during 2019/20. Of these IG incidents, a total of 12 were also reported to the Information Commissioner. These incidents were all successful phishing attacks which were risk assessed in line with Data Security and Protection Toolkit incident reporting guidance. No other IG breaches were reported to the Information Commissioner in the last 12 months.

Data quality and governance

The Trust continues to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services. The Board understands that accurate and timely data is essential to provide robust intelligence and to facilitate sound clinical and strategic decision making.

To assure the Board that appropriate controls are in place to ensure the accuracy of data the Trust has established a Data Quality Committee chaired by the Chief Operating Officer which meets on a quarterly basis. The role of the committee is to provide assurance that robust processes for creating and managing accurate information within the organisation are in place and ensure that information that leaves the organisation is of the highest quality.

The Data Quality Committee reports to the Trust Management Board. The Chief Operating Officer is the Trust's Senior Information Risk Officer and member of the Information Governance Committee which reports to the Risk Committee. The Head of Information Services is also a member of the information Governance Committee.

Through the use of data quality indicators for both acute and community services the committee monitors data quality and promotes data quality improvement and awareness within the Trust.

The steps taken by the Trust to maintain and improve the quality of data are:

- Developed new data quality indicators
- Provided staff with additional training and developmental support (required or identified) to maintain skills, knowledge and data management
- Implemented a formal internal rolling programme of audit
- Maintained close working relationships with clinical services.
- Continued to use benchmarking data to enable the Trust to identify areas of opportunity i.e. where the Trust is benchmarked as being a negative outlier.
- Developed an internal programme of quality improvement to ensure the availability of clinical information is enhanced, thus ensuring clinical coders have easy and quick access to all relevant clinical information
- Investment in clinical information systems and electronic patient records
- Engaged an external auditor to undertake a comprehensive independent review of the Trust's clinical coding.

Data quality assurance

The Trust's Data Quality function maintains regular monitoring of key quality indicators (contractual, safety, and clinical). Deep-dive audits are periodically conducted within specific areas with reports produced on current status and key recommendations. Regular daily, weekly and monthly processes are in place to monitor key areas such as the recording of patient demographics, the timely production of discharge summaries, and the correct recording and coding of clinical events.

External assurance is also provided by the CSU in relation to activity data as part of the monthly data challenge process.

An annual independent clinical coding audit is undertaken as part of the Data Protections and Security Toolkit submission to ensure that clinical data submitted to Secondary Uses Services aligns with clinical documentation. Finally, an annual data quality audit is undertaken by the Trust's internal auditors and is reported to the Audit Committee. The outcome of these audits is generally positive.

Covid-19

The emergence of Covid-19 in the latter part of the reporting year did not have a negative impact on the Trust's system of internal control and we were able to adapt our governance arrangements in response to the coronavirus outbreak. Although we were unable to meet in public in March 2020, virtual weekly board meetings were introduced in the new reporting year to update non-executive directors on Covid-19 activity. Weekly briefings were also circulated to governors.

In summary:

a) The Trust's governance structure enabled a prompt and agile response to the significant change in circumstances
b) The Trust was able to maintain control over its decision making
c) The Trust's business continuity plans were found to be robust
d) There was no adverse impact on the control environment or internal audit's opinion

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 result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/clinical governance/quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In addition, I gain assurance from the following third party sources:

- reports from the internal and external auditors and the local counter fraud specialist
- patient and staff surveys
- Care Quality Commission review reports

The Trust's regular reporting to NHS Improvement provides additional assurance with regard to compliance with our licence conditions.

The key considerations of my review of the effectiveness of the system of internal control can be summarised as follows:

- The Board has been actively involved in reviewing the Trust's risk management processes and the Board Assurance Framework. The Board has played a key role in reviewing risks to the delivery of performance objectives through monitoring and discussion of the Integrated Board Report.

- The Risk Committee has overseen the effectiveness of all the Trust's risk management arrangements, the on-going development of the risk register and all key clinical and non-clinical risks highlighted by other committees.
- The Audit Committee has overseen the system of internal control, especially with regard to corporate risk and counter fraud, and it has actively engaged in the oversight of the Trust's key financial challenges.
- Internal Audit has reviewed and reported on financial controls and financial reporting, cost improvement plans, clinical audit and risk management, based on an audit plan approved by the Audit Committee. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.
- Internal Audit provided consistent support and advice with regard to the system of internal control. The head of internal audit opinion did not, based on the work they undertook during the year, highlight any significant control issues. The opinion was the Trust had an adequate and effective framework for risk management, governance and internal control. Some weaknesses were identified in the application of some internal controls and management actions to address these weaknesses were agreed and are progressing.

Conclusion

The Trust has a robust system of internal control that supports its aims and objectives, while safeguarding patients and the public funds. We have taken steps to mitigate and resolve issues in-year and we continue to work towards successful assurance outcomes. No significant internal control issues have been identified.

Tracey Fletcher

Chief Executive

23 June 2020

Annual Accounts

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

Homerton University Hospital NHS Foundation Trust Annual Accounts 2019/20

CONTENTS **Page**

Foreword to the Accounts

Homerton University Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2020 have been prepared by Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the NHS Act 2006.

Signed:……..……..

Tracey Fletcher
Chief Executive

23 Jun 2020

Independent auditor's report

to the Council of Governors of Homerton University Hospital NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Homerton University Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019-20 and the Department of Health and Social Care Group Accounting Manual 2019-20.

Basis for opinion

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

Overview	
Materiality: financial statements as a whole	£6m (2019:£6m) 1.8% (2019: 1.8%) of Trust forecast revenue

Risks of material misstatement		vs 2019
Recurring risks	Valuation of land and buildings	◀▶
	Revenue recognition – NHS income	◀▶
	Fraudulent expenditure recognition – accruals	◀▶

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

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters (unchanged from 2019), in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion . These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Valuation of land and buildings (£142.5 million; 2019: £126.7m) *Refer to page 9 (accounting policy) and page 23 (financial disclosures)*	**Subjective valuation** Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with a modern equivalent asset. When considering the cost to build a replacement asset the Trust may consider whether the asset would be realistically built to the same specification or in the same location. The Trust engaged a professional valuer to carry out a full valuation of its land and buildings as at 31 March 2020. . When considering the valuation of land and buildings, the Trust will consider whether there has been an impairment to any of those assets. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. **Disclosure Quality** There is a risk that uncertainties expressed by the Trust's valuer around the impact of the Covid-19 pandemic on market-based values of land and buildings will be inappropriately disclosed.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to the valuer for consistency with the requirements of the Department of Health and Social Care Group Accounting Manual. We inspected the instructions provided to the valuer to verify that they are appropriate to produce a reliable valuation in line with the requirements of the RICS Red Book. — **Substantive analytical procedure:** We carried out a substantive analytical procedure to review the depreciation charge at an individual asset category level. — **Methodology choice:** We used our own valuation specialist to assess the methodology used in preparing the valuation, including the choice of indices used to determine the valuation. — **Test of detail:** We evaluated the accuracy of the floor area data submitted to the external valuer for the preparation of the valuation by re-performing measurements of a sample of the Trust's properties. — **Our sector experience:** We challenged the Trust's assumptions used to prepare the valuation by comparing to our own expectations based on knowledge of the Trust and industry norms; We also considered the impact of Covid-19 on the valuation as at 31 March 2020. — **Accounting analysis:** We assessed the accounting treatment of the adjustments made for the changes in valuation of the Trust's land and buildings following the valuation. — **Accounting analysis:** We critically assessed the Trust's approach to impairment by developing our own expectation. — We used industry standard indices to assess any material change to the valuation between the valuation date (1 April 2019) and the year end (31 March 2020). — **Assessing transparency:** We considered the adequacy of the disclosures about the key judgements and degree of estimation involved in concluding whether there has been any material movement in the value of land and buildings since 31 March 2019. — Specifically we considered the adequacy of disclosures made around the uncertainty caused by the Covid-19 pandemic on market data used to underpin the valuer's assumptions, and management's consideration of these factors when arriving at the year-end valuation figures. **Our findings** — We found the disclosures to be proportionate and the valuation of land and buildings to be balanced (2019: optimistic).

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

	The risk	Our response
Operating income from patient care activities (NHS only) and PSF Funding (£299.7million and £7.2million; 2019: £271.6m and £16.4m) *Refer to page 8 (accounting policy) and page 18 (financial disclosures)*	**Subjective estimate** Of the Trust's reported total income, £299.3 million (2018-19: £268.5m) came from commissioners (Clinical Commissioning Groups (CCG) and NHS England). Income is contracted based on expected levels of activity and standard tariff prices for procedures, however the actual income for the year is based on the actual levels of activity completed during the year. Other performance based income is received from NHS Improvement (via local CCGs). This results in estimates being required at the year end. Income from NHS England and CCGs is captured through the Agreement of Balances exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes. The Trust recognised £7.2million of income from the Provider and Sustainability Fund. Receipt of this income is contingent on achievement of quarterly financial targets agreed with NHS Improvement.	Our procedures included: **Tests of detail:** — For the Trust's three largest commissioners we inspected documentation to confirm that contracts had been agreed for the delivery of services; — We inspected supporting documentation for variances over £300,000 arising from the Agreement of Balances exercise to critically assess the Trust's accounting for disputed income; — We tested that invoices had been issued in line with the contracts signed for the three largest commissioners; — We critically assessed the level of prudence applied in accruing for income at the end of the year where balances have not been agreed with commissioners, including the accrual made for partially completed spells; — We inspected a sample of items posted at the end of the financial year to assess whether they had been recorded within the correct period; and — We inspected the external confirmation received from NHS Improvement of the Trust's entitlement to Provider Sustainability Funding for 2019-20. **Our findings** — We found the resulting estimates of income from patient care activities to be balanced (2019: balanced).

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

	The risk	Our response
Fraudulent expenditure recognition - accruals (£23.8million; 2019: £16.5m) *Refer to page 9 (accounting policy) and page 27 (financial disclosures).*	**Effects of irregularities** As most public bodies are net spending bodies the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end. The Trust agreed a target for its financial performance with NHS Improvement for 2018-19, achievement of which entitled it to Provider Sustainability Funding. There may therefore be an incentive to defer expenditure or recognise commitments at a reduced value in order to achieve the control total agreed with NHS Improvement.	Our procedures included: **Historic comparison:** We critically assessed whether there were significant accruals included in the prior year accounts that were not included as part of the 2019-20 accounts and the reason for this. **Tests of detail:** We undertook the following tests of detail: — We inspected transactions incurred around the end of the financial year to critically assess whether they had been included within the correct accounting period; and — We inspected a sample of accruals made at 31 March 2020 for expenditure but not yet invoiced to assess whether the valuation of the accrual was consistent with the value billed after the year end. **Our findings** — We found the resulting estimates of accrued expenditure to be balanced (2019 balanced).

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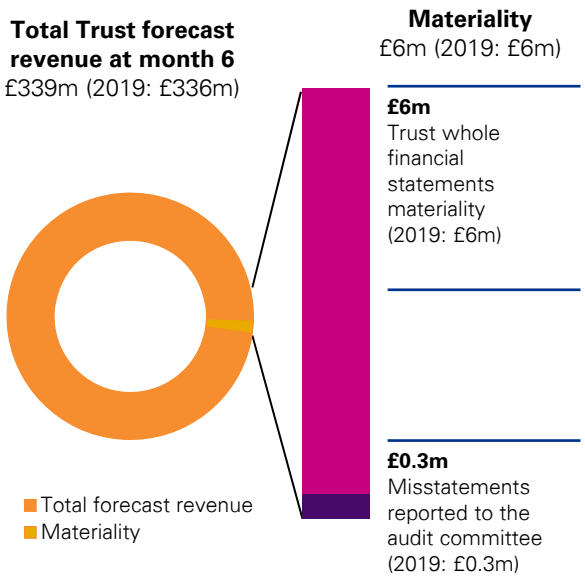
3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £6 million (2019: £6 million), determined with reference to a benchmark of forecast operating income (of which it represents approximately 1.8%) (2019: 1.8%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2019:£0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed in part at the Trust's headquarters in London and in part remotely.



4. We have nothing to report on going concern

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

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

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

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

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

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

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

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

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

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019-20.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019-20, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 53, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

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

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

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

We have nothing to report in these respects.

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

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

We have nothing to report in this respect.

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

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

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

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

We did not identify any significant risks as during our risk assessment.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Richard Hewes
for and on behalf of KPMG LLP

Chartered Accountants
15 Canada Square
London
E14 5GL
24 June 2020

Homerton University Hospital NHS Foundation Trust Annual Accounts 2019/20

Statement of Comprehensive Income for the year ended 31 March 2020

	NOTE	**2019/20 £000**	2018/19 £000
Revenue			
Operating income from Patient Care Activities	3	**321,226**	292,948
Other operating income	3	**32,354**	42,561
Operating expenses	4	**(342,165)**	(314,559)
Operating surplus from continuing operations		**11,415**	20,950
Finance costs:			
Finance income	6	**390**	243
Finance expenses	7	**(179)**	(190)
Public dividend capital dividends payable	19	**(4,435)**	(4,205)
Net finance costs		**(4,224)**	(4,152)
Other gains / (losses)	9	**-**	**-**
Surplus / (deficit) for the year		**7,191**	16,798
Other comprehensive income			
Revaluations	SOCITE	**8,227**	7,942
Total comprehensive income / (expense) for the period		**15,418**	24,740

Surplus adjusted for Impairments		
Retained surplus for the year	**7,191**	16,798
Add back ; Impairment	**1,079**	**-**
Retained Surplus for the Year before Impairments	**8,270**	16,798

Statement of Financial Position as at 31 March 2020

	NOTE	**For the year ending 31 March 2020 £000**	For the year ending 31 March 2019 £000
Non-current assets			
Intangible assets	10	**5,106**	6,085
Property, plant and equipment	11	**154,228**	143,889
Trade and other receivables		**50**	50
Total non-current assets		**159,385**	150,024
Current assets			
Inventories	12	**3,428**	2,986
Trade and other receivables	13	**32,642**	35,044
Cash and cash equivalents	14	**67,596**	47,641
Total current assets		**103,666**	85,671
Total assets		**263,051**	235,695
Current liabilities			
Trade and other payables	15	**(41,462)**	(30,059)
Borrowings	15	**(400)**	(374)
Provisions	15	**(6,623)**	(6,289)
Tax payable	15	**(8,008)**	(7,427)
Other liabilities	15	**(5,662)**	(6,180)
Total current liabilities		**(62,155)**	(50,329)
Net current assets		**41,511**	35,342
Total assets less current liabilities		**200,896**	185,366
Non-current liabilities			
Borrowings	15	**(5,196)**	(5,418)
Provisions	15	**(861)**	(898)
Total non current liabilities		**(6,057)**	(6,316)
Total assets employed		**194,839**	179,050
Financed by taxpayers' equity			
Public dividend capital	19	**92,726**	92,355
Retained earnings	SOCITE	**48,718**	41,527
Revaluation reserve	SOCITE	**53,395**	45,168
Total taxpayers' equity		**194,839**	179,050

Statement of Changes in Taxpayers' Equity (SOCITE) can be found on page 5

The financial statements on pages 3 to 34 were approved by the Board and signed on its behalf by:

Signed:……..

Tracey Fletcher (Chief Executive)

23 June 2020

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

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**92,355**	**41,527**	**45,168**	**179,050**
Changes in taxpayers' equity for 2019-20				
Retained surplus for the year	-	7,191	-	7,191
Revaluations of Property, Plant and Equipment	-	-	8,227	8,227
Transfers between Reserves	-		-	-
New PDC received	371	-	-	371
Taxpayers' and others' equity at 31 March 2020	**92,726**	**48,718**	**53,395**	**194,839**

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**91,703**	**24,729**	**37,226**	**153,658**
Changes in taxpayers' equity for 2018-19				
Retained surplus for the year	-	16,798	-	16,798
Revaluations of Property, Plant and Equipment	-	-	7,942	7,942
Transfers between Reserves	-	-	-	-
New PDC received	652	-	-	652
Taxpayers' and others' equity at 31 March 2019	**92,355**	**41,527**	**45,168**	**179,050**

Statement of Cash Flows for the year ended 31 March 2020

	NOTE	2019/20 £000	2018/19 £000
Net Cash flows from / (used in) operating activities	20	**34,574**	38,024
Cash flows from investing activities			
Interest received		**390**	243
Purchase of intangible assets		**(695)**	(2,450)
Purchase of property, plant and equipment		**(10,336)**	(10,684)
Proceeds from disposal of plant, property and equipment		**-**	-
Net cash flows from / (used in) investing activities		**(10,641)**	(12,891)
Net cash inflow before financing		**23,933**	25,133
Cash flows from financing activities			
Public dividend capital received	19	**371**	652
Loans repaid to the Department of Health		**(292)**	(292)
Movement in Other Loans		**98**	87
Interest paid		**(180)**	(193)
Public dividend capital dividends paid		**(3,975)**	(4,029)
Net cash flows from / (used in) financing activities		**(3,978)**	(3,775)
Increase / (decrease) in cash and cash equivalents		**19,955**	21,358
Cash and cash equivalents brought forward as at 1st April		**47,641**	**26,283**
Cash and cash equivalents carried forward at 31 March		**67,596**	47,641

Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on them, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

1.1 Going Concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents

1.2 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.

1.3 Basis of Consolidation

The Trust is the corporate trustee to Homerton University Hospital NHS Foundation Trust Charitable Fund, however the Charity's results have not been consolidated with those of the Trust in 2019/20 on the grounds of materiality. The Charity's accounts for 2019/20 will be published in September and can be found at www.homertonhope.org.

1.4 Critical accounting judgements and key sources of estimation of uncertainty

In the application of the Trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.4.1 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and have the most significant effect on the amounts recognised in the financial statements:

● Depreciation rates applied to property, plant and equipment and valuation methodologies and external indices applied to the valuation conducted by Gerald Eve LLP (note 14 to the accounts).

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

● Income and expenditure accruals

Other sources of estimation uncertainty are the following:

● Provision for injury benefit claims, early retirements, impairments of receivables, and others (notes 16 & 20 to the accounts)

● Estimates for partially completed patient episodes.

1.5 Transfer of functions

As public sector bodies are deemed to operate under common control, business reconfigurations within the DH group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies , the GAM requires the application of 'absorption accounting'. Absorption accounting requires that entities account for their transaction in the period which they took place. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Income and is disclosed separately from operating costs.

1.6 Pooled budgets

The Trust has not entered into any pooled budget arrangements.

1.7 Operating segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used

1. Accounting Policies (Continued)

1.8 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the 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. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

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

Revenue from research contracts

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 it receives notification from the Department of Work and Pension's Compensation Recovery unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF)

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

1.9 Other forms of income

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 grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1. Accounting Policies (Continued)

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 for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.10. Expenditure on Employee Benefits

1.10.1 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, including non-consolidated performance pay earned but not yet paid. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.10.2 Pension costs

NHS Pension Scheme

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

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

1.11 Expenditure on other goods and services

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

1.11.1 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.12 Corporation tax

The Trust is not liable to to pay corporation tax.

1.13 Property, Plant and Equipment

1.13.1 Recognition

Property, Plant and Equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of 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.

1. Accounting Policies (Continued)

1.13.2 Measurement

Valuation

All property, plant and equipment is 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definition of investment properties or assets held for 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; and
● Specialised buildings - depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternate basis where this would meet the location requirements.

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 economic 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 held at current value, are depreciated over their remaining Useful Economic Lives (UEL) as assessed by the NHS Foundation Trust's professional valuers in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have infinite life and is not depreciated. Leaseholds are depreciated over the primary lease term. Plant and Equipment initially held at current cost, is depreciated over the estimated UEL.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated. Assets in the course of construction are not depreciated until the asset is brought into use.

The following UELs apply to each individual asset category based on standard asset lives adjusted for local use and expected technology changes:

• Land - Land is not depreciated because it is considered to have an infinite life
• Buildings excluding dwellings - 15 to 75 years
• Plant and Machinery - 5 to 30 years
• Transport Equipment - 5 to 15 years
• Furniture and Fittings - 5 to 30 years
• Information Technology - 5 to 15 years

Material valuation uncertainty due to Novel Coronavirus (COVID – 19)

The valuation exercise was carried out in January 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries. Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement. Our valuation is therefore reported as being subject to 'material valuation uncertainty' as set out in VPS 3 and VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID19 might have on the real estate market, we recommend that you keep the valuation under frequent review.

For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the declaration has been included to ensure transparency of the fact that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case. The material uncertainty clause is to serve as a precaution and does not invalidate the valuation.

1. Accounting Policies (Continued)

Revaluation gains and losses
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is charged to the revaluation reserve to the extent that there is a balance on the reserve for that asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of Other Comprehensive Income.

It is impracticable to disclose the extent of the possible effects of an assumption on another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of the Trust's land, property, plant and equipment could require a material adjustment to the carrying amount of the asset recorded in note 9.1.

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

1.13.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.13.4 Donated and grant funded assets

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

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

1.14 Investment properties

Investment properties are measured at fair value, changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.15 Intangible Assets

1.15.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it's probable that the future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

(i) Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• the way in which intangible assets will generate probable future economic or service delivery benefits e.g. the presence of a market for its output or, where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical or other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

(ii) Software
Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset. Costs associated with maintaining software are recognised as an expense when incurred.

Capitalised computer software is amortised over the expected useful economic life or 5 years, whichever is the shorter.

1. Accounting Policies (Continued)

1.15.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in the development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.16 Depreciation

Freehold land, assets under construction or development, investment properties, stockpiled goods and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over the estimated useful lives. 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.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the Trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

1.17 Donated Assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.18 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1. Accounting Policies (Continued)

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

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

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

1.20 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

1.21 Cash and 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.

1.22 Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1.23 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms. All other provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A short term rate of 0.51 % (2018-19: -0.76%) for expected cash flows up to and including 5 years.
- A medium term rate of **0.55**% (2018-19: -1.14%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of 1.99% (2018-19: -1.99%) for expected cash flows exceeding 10 years.

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

Year 1 - 1.90%

Year 2 - 2.00%

Into perpetuity - 2.00%

1. Accounting Policies (Continued)

1.24 Clinical Negligence costs

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

1.25 Non-clinical risk pooling

which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.26 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, none have been disclosed.
Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.27 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classiification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.17.

Financial assets are classified into the following categories: financial assets at amortised costs, financial assets at fair value through profit and loss, and financial assets at fair value through other comprehensive income. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.27.1 Financial assets and financial liabilities at amortised cost

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

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

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.

1. Accounting Policies (Continued)

1.27.2 Financial assets and financial liabilities at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assests and where the cash flows are solely payments of principal and interest.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income:

1.27.3 Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

The Trust has irrevocably elected to measure the following equity instruments at fair value through income and expenditure:

1.27.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.27.5 Derecognition

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

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

1.28 Public Dividend Capital (PDC) and PDC dividend

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.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

1. Accounting Policies (Continued)

1.29 Foreign exchange

The functional and presentational currency of the trust is sterling.

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

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

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

1.30 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.31 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.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Gifts

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

1.33 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / (loss) corresponding to the net assets/ liabilities transferred is recognised within income / expenses, For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net (loss) / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

1. Accounting Policies (Continued)

1.34. Early adoption of standards, amendments and interpretations

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

1.35. Standards, amendments and interpretations in issue but not yet effective or adopted

1.35.1. IFRS 16 Leases

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

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

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April

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

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable.

1.35.2. IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.35.3. IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2. Segmental Analysis

All activities of the Trust are considered to be one segment, Healthcare. There are no individual reportable segments on which to make disclosures. Income and expenditure is not reported on a segmental basis to the Trust Board and as such the Trust is managed as a single segment.

3. Operating income from continuing operations

All income from patient care activities relates to contract income recognised in line with accounting policy 1.8

3.1 Income from Patient Care activities (by nature)	**2019/20 £000**	2018/19 £000
Elective income	**31,298**	29,827
Non-elective income	**45,227**	40,699
Outpatient income	**45,929**	44,522
A&E income	**17,411**	15,181
Non PbR activity income	**115,456**	112,947
Community income	**55,117**	45,280
Private and Overseas patient income	**1,122**	917
Other non-protected clinical income	**764**	3,575
Additional pension contribution central funding*	**8,902**	-
Other clinical income		
	321,226	292,948
Other operating income		
Research and development	**1,176**	1,024
Education and training	**12,928**	13,419
Non-patient care services to other bodies	**7,505**	8,131
Provider sustainability fund (PSF)	**7,225**	16,411
Other income	**3,520**	3,576
Total Other Operating Income	**32,354**	42,561
Total Operating Income	**353,580**	335,509

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.2 Overseas Patient Income

Income from Overseas Patients is £0.092m in 2019/20 (2018/19 - £0.097m). Cash payments received in year relating to Overseas Patients totalled £0.206m (2018/19 - £0.082m) and amounts added to the provision for impairment of receivables were £0m (2018/19 - £0.1m). Receivables relating to Overseas Patients of £m were written off in the year (2018/19 - £0.217m)

3.3 Income from Patient Care activities (by source)	**2019/20 £000**	2018/19 £000
NHS England	52,577	42,740
Clinical commissioning groups	246,718	225,740
NHS Foundation Trusts	158	126
NHS Trusts	260	295
Local authorities	19,627	19,555
Department of Health and Social Care	-	2,690
Non NHS: private patients	1,122	917
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	92	97
Injury cost recovery scheme	672	788
Total income	**321,226**	**292,948**

NHS Injury Scheme is subject to a nationally prescribed provision for doubtful debts of 21.79% (2018/19 21.89%) to reflect rates of collection

3.4 Income from services designated as commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	310,438	288,456
Income from services not designated as commissioner requested services	43,142	47,053
Operating income from continuing operations	**353,580**	335,509

4. Operating Expenses

4.1 Operating Expenses by type	**2019/20**	2018/19
	£000	£000
Purchase of healthcare from NHS bodies	5,618	5,270
Purchase of healthcare from non-NHS bodies	1,477	1,406
Directors' costs	1,069	1,125
Non executive directors' costs	125	124
Other Staff costs	235,464	211,228
Supplies and services - clinical (excluding drug costs)	22,504	23,095
Supplies and services - general	9,376	8,683
Establishment	4,348	3,487
Patient Transport	1,970	1,718
Premises	19,294	17,620
Increase in bad debt provision	-	63
Drugs costs	15,656	16,119
Depreciation on property, plant and equipment	7,603	6,703
Amortisation of intangible assets	1,674	1,394
Impairments	1,079	-
Audit fees - statutory audit	96	73
Audit related assurance services	12	16
Audit fees - internal audit	80	150
Consultancy	519	1,196
NHSLA insurance premium	11,032	11,734
Other	3,169	3,355
Total	**342,165**	314,559

4.2. Operating Leases		
	2019/20	2018/19
	£000	£000
4.2.1 Operating lease expense		
Rental of Plant and Machinery	**195**	137
Total	**195**	137

4.2.2 Operating lease commitments		
	2019/20	2018/19
Future minimum lease payments due:	**£000**	£000
- not later than one year;	**170**	220
- later than one year and not later than five years;	**215**	401
- later than five years.	**-**	-
Total	**385**	621

Leases in respect of plant and machinery relate to a CT scanner and other smaller items of medical equipment.

4.3 Other auditor remuneration		
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	96	73
2. Audit-related assurance services	12	16
Total	**108**	89

In 2019/20 audit fees for statutory audit, and audit related assurance services (Quality Accounts), excluding VAT, were £67,825 and £10,000 respectively (2018/19 - £60,825 and £13,000). The 2019/20 audit fees for statutory audit include £12,500 (excluding VAT) of statutory audit fees from 2018/19. The limitation on auditors' liability is £2m.

5. Staff costs and staff numbers

5.1 Staff costs

	2019/20 Total	2018/19 Total
	£000	£000
Salaries and wages	**154,109**	144,829
Social Security costs	**17,714**	17,457
Employer contributions to NHS Pensions Agency	**20,356**	18,787
Employer contributions to NHS Pensions Agency paid by NHSE on provider's behalf (6.3%)	**8,902**	-
Pension Cost - Other	**36**	14
Termination Benefits	**-**	41
Bank Staff	**20,620**	18,681
Agency staff	**16,167**	13,527
	237,904	213,336

The staff costs above are shown in Operating Expenses (note 7.1) as Directors' costs and Other Staff Costs.

5.2 Average number of persons employed

	Permanently Employed Number	**Other Number**	**2019/20 Total Number**	2018/19 Total Number
Medical and dental	480	84	**564**	525
Ambulance staff	2	-	**2**	-
Healthcare assistants and other support staff	615	116	**731**	756
Nursing, midwifery and health visiting staff	1,231	170	**1,401**	1,372
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	650	38	**688**	564
Administration and estates	652	121	**773**	701
Other	4	14	**18**	175
Total	3,634	543	4,177	4,093

5.3 Employee benefits

There are nil individual employee benefit costs for 2019/20 (2018/19 Nil).

5.4 Retirements due to ill-health

	2019/20 Number	**2019/20 £000**	2018/19 Number	2018/19 £000
Early retirements agreed on the grounds of ill-health	**1**	**84**	**1**	**15**

The costs of early retirements due to ill-health are not included in Operating Expenses as the liability is met by the NHS Pensions Agency.

5.5 Staff exit packages

	Number of compulsory redundancies	**Cost of compulsory redundancies £s**	**Number of other departures agreed**	**Cost of other departures agreed £s**	**Total number of exit packages by cost band**	**Total cost of exit packages by cost band £s**
<£10,000	1	4	15	53	16	57
£10,000 - £25,000	-	-	6	104	6	104
£25,001 - £50,000	-	-	-	-	-	-
Totals	**1**	**4**	**21**	**157**	**22**	**161**

Redundancy and other departure costs have been

5.6 Analysis of Other Departures

	Agreements Number	**Total Value of agreements £000's**
Contractual payments in lieu of notice	20	156
Total	**20**	**156**

6. Finance income	2019/20 £000	2018/19 £000
Interest on loans and receivables and bank current accounts	**390**	243
Total	**390**	243

7. Finance expenses - finance liabilities	2019/20 £000	2018/19 £000
Interest on Loans from the Independent Trust Financing Facility	**179**	190
	179	190

8. The Late Payment of Commercial Debts (Interest) Act 1998

There are no amounts included within Other Interest Payable arising from claims made under this legislation.

9. Other gains / (losses)

There are no other gains / (losses)	**-**	**-**

10. Intangible Assets

All Intangible fixed assets relate to software licences.

10.1 Intangible Assets 2019/2020	Software	Assets Under Construction	Total
	£000	£000	£000
Gross cost at 1 April 2019	10,470	1,034	11,504
Additions - purchased	-	695	695
Reclassifications	1,708	(1,708)	-
Disposals		-	-
Gross cost at 31 March 2020	**12,178**	**21**	**12,199**
Amortisation at 1 April 2019	5,419	-	5,419
Provided during the year	1,674	-	1,674
Disposals	-	-	-
Amortisation at 31 March 2020	7,093	-	7,093
Net book value			
- Purchased at 31 March 2019	5,051	1,034	6,085
- Purchased at 31 March 2020	**5,085**	**21**	**5,106**

10.2 Intangible Assets 2018/2019			
	£'000	£'000	£'000
Gross cost at 1 April 2018	8,483	78	8,561
Additions - purchased	-	2,450	2,450
Reclassifications	1,988	(1,494)	494
Disposals	-	-	-
Gross cost at 31 March 2019	**10,471**	**1,034**	**11,505**
Amortisation at 1 April 2018	4,026	-	4,026
Provided during the year	1,394	-	1,394
Disposals	-	-	-
Amortisation at 31 March 2019	**5,420**	**-**	**5,420**
Net book value			
- Purchased at 31 March 2018	4,457	78	4,535
- Purchased at 31 March 2019	**5,051**	**1,034**	**6,085**

11. Property, Plant and Equipment

11.1. Property, plant and equipment as at 31 March 2020

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2019	26,550	131,280	16	37,134	118	8,740	1,839	**205,676**
Additions - purchased	-	-	10,794	-	-	-	-	**10,794**
Revaluations	(2,610)	(24,397)		-		-	(7)	**(27,014)**
Reclassifications	-	4,193	(10,688)	5,153		1,284	58	**-**
Disposals								**-**
Cost or valuation at 31 March 2020	**23,940**	**111,076**	**123**	**42,287**	**118**	**10,024**	**1,890**	**189,456**
Depreciation at 1 April 2019	-	31,161	-	22,884	100	6,044	1,600	**61,789**
Provided during the year	-	3,273	-	3,204	5	1,067	54	**7,603**
Revaluations	-	(35,235)	-	-	-	-	(7)	**(35,242)**
Impairments - Charged to SOCIE	220	800	-	58	-	-	1	**1,079**
Depreciation at 31 March 2020	**220**	**-**	**-**	**26,146**	**105**	**7,111**	**1,648**	**35,230**
Net book value								
- Purchased at 1 April 2019	26,550	100,119	16	14,250	18	2,696	240	**143,889**
- Donated at 1 April 2019	-	-	-	-	-	-	-	**-**
Total at 1 April 2019	**26,550**	**100,119**	**16**	**14,250**	**18**	**2,696**	**240**	**143,889**
Net book value								
- Purchased at 31 March 2020	23,720	111,076	123	16,141	13	2,913	243	**154,228**
- Donated at 31 March 2020	-	-	-	-	-	-	-	**-**
Total at 31 March 2020	**23,720**	**111,076**	**123**	**16,141**	**13**	**2,913**	**242**	**154,228**

11. Property, Plant and Equipment

11.2. Property, plant and equipment as at 31 March 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	22,340	123,476	2,414	31,510	118	7,999	1,839	**189,697**
Transfers by absorption								
Additions - purchased	-	-	8,533	-	-	-	-	**8,533**
Revaluations	4,210	3,732	-	-	-	-	-	**7,942**
Impairments - Charged to SOCIE	-	-	-	-	-	-	-	**-**
Reclassifications	-	4,072	(10,931)	5,624	-	741	-	**(494)**
Disposals	-	-	-	-	-	-	-	**-**
Cost or valuation at 31 March 2019	**26,550**	**131,280**	**16**	**37,134**	**118**	**8,740**	**1,839**	**205,676**
Depreciation at 1 April 2018	-	28,289	-	20,128	95	5,025	1,549	**55,086**
Provided during the year	-	2,872	-	2,756	5	1,019	51	**6,703**
Disposals	-	-	-	-	-	-	-	**-**
Depreciation at 31 March 2019	**-**	**31,161**	**-**	**22,884**	**100**	**6,044**	**1,600**	**61,789**
Net book value								
- Purchased at 1 April 2018	22,340	94,308	2,414	11,203	7	2,974	290	**133,536**
- Donated at 1 April 2018	-	879	-	180	16	-	-	**1,075**
Total at 1 April 2018	**22,340**	**95,187**	**2,414**	**11,383**	**23**	**2,974**	**290**	**134,611**
Net book value								
- Purchased at 31 March 2019	26,550	100,119	16	14,251	18	2,696	240	**143,889**
- Donated at 31 March 2019	-	-	-	-	-	-	-	**-**
Total at 31 March 2019	**26,550**	**100,119**	**16**	**14,251**	**18**	**2,696**	**239**	**143,889**

11.3 Assets held at market value

At 31 March 2020 the Trust held land assets at market value for existing use of £23,940,000 (31 March 2019, £26,550,000).

11.4 Valuation of land & buildings

The buildings have been valued as at 31 March 2020 using a Modern Equivalent Asset basis of valuation, as discounted for wear and tear.

Land has been revalued at 31 March 2020 at market value for existing use.

Both desktop valuations were carried out by Gerald Eve LLP whose address is 72 Welbeck Street, London. W1G 0AY.

Buildings have estimated useful economic lives ranging up to 73 years (2017/18 - 73 years).

11.5 Assets held under finance leases and hire purchase contracts at 31 March 2020

The Trust did not hold any finance leases or hire purchase contracts during 2019/20.

11.6 Fixed Asset Investments

There were nil fixed asset investments held at 31 March 2020 (31 March 2019 - Nil).

12. Inventories

12.1. Inventories	**2019/20**	**2018/19**
	£000	£000
Drugs	**1,637**	1,342
Consumables	**1,738**	1,591
Energy	**54**	54
Total	**3,428**	2,986

12.2 Inventories recognised in expenses	**2019/20**	**2018/19**
	£000	£000
Total Inventories recognised as an expense in the year	**13,730**	15,182

13. Trade and other receivables

	31 March 2020	31 March 2019
13.1 Amounts falling due within one year:	**£000**	£000
Contract Receivables *	**33,280**	18,966
Trade Receivables *	**(3,065)**	15,386
Allowance for impaired contract receivables	**(3,618)**	(3,687)
Prepayments	**2,572**	1,831
Accrued income	**-**	-
PDC Dividend Receivable	**-**	140
Other receivables	**3,473**	2,408
Total	**32,642**	35,044
Of which receivables from NHS and DHSC group bodies:	**20,727**	28,538

* Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

13.2 Allowances for credit losses -2019/20

	Contract receivables and contract assets £000
Allowances at 1 April 2019 - brought forward	3,687
New allowances arising	-
Utilisation of allowances (write offs)	(69)
Reversals of allowances	-
Allowances as at 31 March 2020	**3,618**

Allowances for Credit Losses by age - 2019/20	**31 March 2020 £000**
Up to three months old	781
In three to six months old	254
Over six months old	2,652
Total	**3,687**

13.3 Age analysis of unimpaired contract receivables:

	31 March 2020	31 March 2019
	£000	£000
Up to three months old	**21,473**	10,064
In three to six months old	**178**	3,143
Over six months old	**9,627**	4,456
Total	**31,278**	17,663

14. Cash and cash equivalents movements

	31 March 2020 £000	31 March 2019 £000
Balance as at 1 April	**47,641**	26,283
Net change in year	**19,955**	21,358
Balance at 31 March	**67,596**	47,641
Of which:		
Commercial banks and cash in hand	**54**	76
Cash with the Government Banking Service	**67,542**	47,509
Other current investments	**-**	56
Total cash and cash equivalents in the Statement of Cash Flows	**67,596**	47,641

15. Liabilities

15.1 (i) Current liabilities: Amounts falling due within one year	31 March 2020 £000	31 March 2019 £000
NHS payables	**5,628**	5,067
Non-NHS payables	**10,100**	7,741
Trade payables - Capital	**880**	422
PDC Dividend Payable	**320**	-
Other payables	**717**	350
Accruals	**23,817**	16,479
Trade and other payables	**41,462**	30,059
Borrowings	**400**	374
Provisions	**6,623**	6,289
Tax payable	**8,008**	7,427
Deferred income	**5,662**	6,180
Total amounts falling due within one year	**62,155**	50,329

Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 17.1. IFRS 9 is applied without restatement therefore comparatives have not been restated.

15.1 (ii) Non Current Liabilities: Payables due after more than one year	31 March 2020 £000	31 March 2019 £000
Provisions	**861**	898
Borrowings	**5,196**	5,418
	6,057	6,316
15.1 (iii) Total payables	**68,212**	56,645

16 Loans - payment of principal falling due:

	31 March 2020	31 March 2019
	£000	£000
Within one year	**400**	374
Between one and two years	**363**	346
Between two and five years	**1,089**	1,039
After five years	**3,745**	4,033
Total	**5,597**	5,792

Of which:

	31 March 2020	31 March 2019
	£000	£000
Wholly repayable within five years	**1,852**	1,759
Wholly or partially repayable after five years by instalments	**3,745**	4,033
Total	**5,597**	5,792

17. Provisions for liabilities and charges

	Pensions - Early departure costs	Pensions - Injury benefits	Redundancy	Clinician pension tax reimbursement	Other	**31 March 2020 Total**	31 March 2019 Total
	£000	£000	£000	£000	£000	**£000**	£000
At 1 April 2019	324	629	15	-	6,219	**7,187**	7,620
Change in discount rate	1	3				**4**	3
Arising during the year	6	8		258	519	**791**	5,282
Utilised during the year - accruals	(5)	(9)				**(14)**	-
Utilised during the year - cash	(17)	(24)				**(41)**	(4,180)
Reversed unutilised					(443)	**(443)**	(1,539)
Unwinding of discount	-		-	-	-	**-**	-
At 31 March 2020	**309**	**607**	**15**	**258**	**6,295**	**7,484**	7,187
Expected timing of cash flows							
Not later than one year	21	34	15	258	6,295	**6,623**	6,289
Llater than one year and not later than five years	88	137				**225**	220
Later than five years	200	436				**636**	678
Total	**309**	**607**	**15**	**258**	**6,295**	**7,484**	7,187

Pension related provisions as at 31 March 2020 consist of £0.607m in relation to Injury Benefits and £0.309m relating to Early Retirement benefits payable to former employees of the Trust. These benefits are calculated and paid to the individuals concerned by the NHS Pensions Agency (NHSPA) and the provision represents the future liability of the Trust based on expected lifetime calculations discounted appropriately.

The Clinical Pension Tax provision totals £0.258m and is based on the estimated liability arising in the next year relating to pension liability from consultants working additional PAs. Redundancy provisions of £0.015m are based on the likely obligation of the Trust towards a small number of staff who are at risk of redundancy in the next year due to the outsoucing of certain back office administrative functions to an external provider.

The most significant elements of the other provisions figure are the following: £0.9m in respect of potential data challenges from commissioners relating to clinical contract income, £1.1m relating to the estimated value of untaken annual leave owed to Trust employees as at 31 March 2020, £0.391m in relation to VAT review by HMRC where the trust may be liable, £0.133m in relation to potential employment tribunal claims and £3.6m in relation to provision for future credit notes.

18. Clinical Negligence Liability

The amount provided by the NHSLA in respect of clinical negligence liabilities of the trust as at 31 March 2020 is £251,113,403 (2018/19 - £207,791,496).

19. Movement in Public Dividend Capital

	2018/19	2017/18
	£000	£000
Public Dividend Capital as at 1 April	**92,355**	91,703
New PDC received	**371**	652
Public Dividend Capital as at 31 March	**92,726**	92,355

The dividend payment for the year was £4.435m (2018/19 £4.205m). Further details on how the dividend was calculated are set out in note 1.27.

20. Notes to the cash flow statement

20.1 Reconciliation of operating (deficit) / surplus to net cash inflow from operating activities:

	2019/20 £000	2018/19 £000
Total operating surplus	**11,415**	20,950
Depreciation and amortisation	**9,277**	8,097
Impairment	**1,079**	-
(Increase) in inventories	**(442)**	(400)
Decrease / (Increase) in receivables	**2,262**	6,899
Increase / (decrease) in payables	**11,205**	3,300
(Decrease) Increase in other liabilities	**(518)**	(389)
Other movements	**296**	(434)
Net cash inflow from operating activities	**34,574**	38,024

20.2 Reconciliation of net cash flow to movement in net funds:

	2019/20 £000	2018/19 £000
Increase in cash in the year	**19,955**	21,358
Cash inflow from debt repaid and finance lease capital payments	**194**	205
Increase in net funds resulting from cash flows	**20,149**	21,563
Net funds at 1 April 2019	**41,888**	20,325
Net funds at 31 March 2020	**62,037**	41,888

20.3 Analysis of changes in net debt

	At 1 April 2019 £000	Cash changes in year £000	Non-cash changes in year £000	At 31 March 2020 £000	At 31 March 2019 £000
GBS cash at bank	47,509	20,033		**67,542**	47,509
Commercial cash at bank and in hand	76	(22)		**54**	76
Debt due after one year	(5,418)	222		**(5,196)**	(5,418)
Debt due within one year	(374)	(26)		**(400)**	(374)
Current investments	56	(56)		**-**	56
Total	**41,849**	**20,151**	**-**	**62,000**	41,849

21. Contractual Capital Commitments

There were £0.5m of commitments under capital expenditure contracts as at 31 March 2020 (31 March 2019 - £0.7m).

22. Contingent Liabilities

	2019/20 £000	2018/19 £000
Liabilities to Third Parties Scheme (LTPS) Members contribution	**17**	35
	17	35

23. Related Party Transactions

There were nil related party transactions with Executive and non-Executive Directors during the financial year (2018/19 nil).

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year Homerton University Hospital NHS Foundation Trust has had a significant number of material transactions with Government Departments and their agencies. The largest of these entities are listed below:

Name	Relationship
East London NHS Foundation Trust	NHS Foundation Trust
Barts Health	NHS Trust
Health Education England	Special Health Authority
NHS England - core	Commissioner
NHS England - London Regional Office	Commissioner
NHS England - London Specialised Commissioning Hub	Commissioner
NHS City And Hackney CCG	Commissioner
NHS Waltham Forest CCG	Commissioner
NHS Newham CCG	Commissioner
NHS Tower Hamlets CCG	Commissioner
NHS Islington CCG	Commissioner
NHS Hammersmith and Fulham CCG	Commissioner
NHS Havering CCG	Commissioner
NHS Redbridge CCG	Commissioner
NHS Barking And Dagenham CCG	Commissioner
NHS Enfield CCG	Commissioner
NHS Haringey CCG	Commissioner
NHS Resolution	Other NHS Whole of Government Accounts Body - Insurer
NHS Property Services	Other NHS Whole of Government Accounts Body
Community Health Partnerships	Other NHS Whole of Government Accounts Body
Department of Health and Social Care	Other NHS Whole of Government Accounts Body
HM Revenue & Customs - VAT	Central Government WGA Body
NHS Pension Scheme	Central Government WGA Body
HM Revenue & Customs - NI Fund & PAYE	Central Government WGA Body
London Borough of Hackney	Central Government WGA Body - Local Authority

The Trust has also received revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund. The Charity is registered with the Charity Commission (Charity Number 1061659) and has its own Trustees drawn from the NHS Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) and these documents are available on request from the Trust.

24. Private Finance Initiative Transactions

The Foundation Trust has no PFI schemes.

25. Financial Instruments

IAS 32 (Financial Instruments: Disclosure and Presentation), IAS 39 (Financial Instrument Recognition and Measurement) and IFRS 7 (Financial Instruments: Disclosures) require disclosure of the role that financial instruments have played during the period in creating or changing the risks an entity faces in undertaking its activities.

The Trust does not have any complex financial instruments and does not hold or issue financial instruments for speculative trading purposes. In light of the continuing service provider relationship the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by non NHS business entities.

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 Audit Committee manages the Trust's funding requirements and financial risks in line with the Board approved treasury policies and procedures and their delegated authorities.

The Trust's financial instruments comprise loans, provisions, cash at bank and in hand and various items, such as trade receivables and trade payables, that arise directly from its operations. The main purpose of these financial instruments is to fund the Trust's operations.

25.1 Financial Instruments - Assets

	At 31 March 2020 £000	At 31 March 2019 £000
Floating rate	**67,596**	47,641
Non-interest bearing	**29,058**	32,760
Total	**96,654**	80,401

Financial assets consist of cash and cash equivalents and trade and other receivables excluding provisions less prepayments and PDC receivable.

25.2 Financial Instruments - Liabilities

	At 31 March 2020 £000	At 31 March 2019 £000
Fixed rate	**5,596**	5,792
Non-interest bearing	**40,712**	37,136
Total	**46,308**	42,928

Financial liabilities consist of current and non-current liabilities less deferred income, payments received on account, tax and PDC payable.

25.3 Analysis of Financial Instruments

	At 31 March 2020 £000	At 31 March 2019 £000
25.3 (i) Financial assets (Book and fair value)		
Cash	**67,596**	47,585
Receivables within one year	**29,058**	32,760
Other current investments		56
Total	**96,654**	80,401
25.3 (ii) Financial liabilities (Book and fair value)		
Payables within one year	**39,851**	36,238
Provisions over 1 year	**861**	898
Loans	**5,596**	5,792
Total	**46,308**	42,928

Notes

a) Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by HM Treasury's discount rate of 3.7% in real terms (2018/19 - 3.7%).

26. Third Party Assets

The Trust held £16,171 of patients' monies at 31 March 2020 (31 March 2019 - £1,171). This amount has been excluded from the cash at bank and in hand figure reported in the accounts.

27. Intra-Government and Other Balances

27.1 Receivable and Payable balances	Receivables: amounts falling due within one year At 31 March 2020 £000	Payables: amounts falling due within one year At 31 March 2020 £000
English NHS Foundation Trusts	**3,011**	**2,178**
English NHS Trusts	**1,376**	**2,870**
Department of Health	**-**	**-**
Public Health England	**-**	**59**
Health Education England	**8**	**-**
NHS England & Clinical Commissioning Groups	**16,041**	**1,555**
Other NHS Whole of Government Accounts bodies	**27**	**3,402**
Other Whole of Government Accounts bodies	**7,324**	**11,391**
Total	**27,787**	**21,455**

27.2 Income and expenditure values for the year	Income Year Ended 31 March 2020 £000	Expenditure Year Ended 31 March 2020 £000
English NHS Foundation Trusts	**4,232**	**2,302**
English NHS Trusts	**882**	**6,925**
Department of Health	**-**	**-**
Public Health England	**2**	**60**
Health Education England	**12,928**	**-**
NHS England & Clinical Commissioning Groups	**299,955**	**379**
Other NHS Whole of Government Accounts bodies	**55**	**16,199**
Other Whole of Government Accounts bodies	**19,634**	**51,327**
Total	**337,688**	**77,192**

28. Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
		£000		£000
LOSSES:				
1. Losses of cash due to:				
Other Losses - Pharmacy Expired / Damaged Stock	10	6	19	42
2. Fruitless payments and constructive losses	-	-	-	-
3. Bad debts and claims abandoned	57	122	66	217
4. Damage to buildings, property etc.(including stores losses)	-	-	-	-
TOTAL LOSSES *	**67**	**128**	**85**	**259**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	5	40	5	59
6. Extra contractual to contractors	-	-	-	-
7. Ex gratia payments in respect of:				
Loss of personal effects	2	-	3	0
Personal Injury with Advice	-	-	5	15
Other	12	4	8	2
8. Special Severance payments	-	-	-	-
9. Extra statutory and regulatory	-	-	-	-
TOTAL SPECIAL PAYMENTS *	**19**	**44**	**21**	**76**
TOTAL LOSSES AND SPECIAL PAYMENTS *	**86**	**172**	**106**	**335**

* Losses and Special Payments have been calculated on an accruals basis but exclude provisions for future losses.

Our Values

PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton
University Hospital
NHS Foundation Trust

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