

The Hillingdon Hospitals NHS Foundation Trust
Annual Report and Accounts
2019/2020

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Overview of Performance

Statement on overview of performance from the Chair and Chief Executive

In July 2018, the Care Quality Commission rated the Trust as 'Requires Improvement'. Since then we have risen to the challenge. With the benefit of fresh leadership, we have focussed the attention of our team to work with drive and determination to improve care for our patients.

A new Executive team was put in place during the time that covers this annual report and into Q1 2020/1. That team's focus for the future is clear; to move the Trust to 'Good' and then to 'Outstanding' - with the Trust focusing on quality, people, performance and value for money.

As part of our responsibility to provide improvements in care for our patients, we have introduced several initiatives to ensure that our work delivers on quality and safety, and we continue to work with NHSI and partners to drive such improvements. Our staff are fundamental to delivering improvements; one example of this is that we introduced a Ward and Department Accreditation Programme in 2019. This encourages best practice to be shared, whilst raising awareness and giving support for the Trust's staff, ensuring they have the right knowledge and tools to demonstrate evidence of continuous quality improvement.

The Board takes seriously our responsibilities to ensure that the NHS's values, human rights, respect, equality and celebrating diversity are embedded in everything we do. Covid 19 has highlighted that we have much to do, particularly for our BAME staff.

We are aware that the hospital suffers from a poor estate, with both Hillingdon Hospital and Mount Vernon needing substantial investment, and we are working with NHS England and Improvement to address this. The Trust board is focused on the future needs of the people we serve, and we have identified the need for investment, but also the need to work with partners to develop a longer-term plan.

Due to the unprecedented demand on our services, our financial position has weakened during the course of the year and unfortunately, we fell short of our efficiency savings. We are taking steps to address this and to put the Trust on a firmer financial footing.

In the future we will be more ambitious about working in partnership to improve care of our patients, enabling people to take a more active role in their own health journey. As a result, we want to continue to build strong working relationships with our local politicians, commissioners, local authorities, community groups, the Metropolitan Police and others, with THHT being central to our local community.

We would like to thank the significant contribution of Hillingdon Hospitals Charity; their help enables us to improve our hospitals and support staff. During this year funding received has allowed us to purchase new equipment, refurbish day rooms and help with additional training.

We would also like to thank both the League of Friends and the Council of Governors who continue to support the Trust to help us meet the needs of patients and the community, whilst providing support and challenge to the Board.

In addition to Mount Vernon hospital, we know there will always be the need for a hospital to serve the people of Hillingdon and we are committed to ensuring that it is fit for the future, whilst delivering the right care, in the right place, at the right time and demonstrating value for money.

At the beginning of 2020 our Trust, like the rest of the country, faced an unprecedented test - that of Covid 19. We had to change the way we worked and how we provided services for our local community, at speed. As the Prime Minister, one of our local MPs, the Rt Hon Boris Johnson MP, said when commenting on 'lock down', "by adopting those measures we prevented this country from being engulfed by what could have been a catastrophe in which the reasonable worst case scenario was half a million fatalities."

Our staff responded impressively quickly and, during the first phase of the Covid 19 response, over 170 innovations were introduced across the Trust, examples of this work follow on pages 12-14.

So when we say that Hillingdon Hospitals NHS Foundation Trust has come through a difficult year, it is an understatement. We have been humbled by the way our staff have responded. We would like to thank all our staff for their commitment and dedication to supporting the needs of our patients.

We continue to have the opportunity to work with so many talented people who are committed to improving the health of the community and people we serve. Their dedication and hard work in the exceptionally challenging environment in which we operate must be commended.

Sir Amyas Morse

Trust Chair
The Hillingdon Hospitals NHS Foundation Trust

Sarah Tedford

Chief Executive
The Hillingdon Hospitals NHS Foundation Trust

24 June 2020

PERFORMANCE REPORT

Purpose, Activities and History of the Trust

The purpose of this overview is to provide sufficient information for the reader to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

The Performance section of the report provides detail on how the Trust met its performance obligations across the financial year.

The Hillingdon Hospitals NHS Foundation Trust was established on 1st April 2011, when Monitor authorised the organisation as an NHS Foundation Trust. The Trust provides health services at two hospitals in North West London: Hillingdon and Mount Vernon.

Hillingdon Hospital is the only acute hospital in the London Borough of Hillingdon and offers a wide range of services including accident and emergency, inpatient care, day surgery, outpatient clinics and maternity services. The Trust's services at Mount Vernon Hospital include routine day surgery, delivered at a modern treatment centre, a minor injuries unit and outpatient clinics. The Trust hosts several other organisations that provide health services at Mount Vernon including East & North Hertfordshire NHS Trust's Cancer Centre.

The Trust provides clinical services to over half a million patients a year, which includes over 105,000 Emergency attendances, although this has changed significantly at the end of the year due to the COVID-19 pandemic.

As an NHS Foundation Trust, the Trust has a 25-strong Council of Governors and over 4,700 public members. It employs over 3,500 staff, making it one of Hillingdon's largest employers. The Board of Directors, led by Chairman Sir Amyas Morse during 2019-20, comprised of seven non-executive (including the Chairman) and six executive directors (including the Chief Executive). The Trust was rated overall as 'Requires improvement' by the CQC in 2018, whilst safety and Well Led domains for the Hillingdon Hospital site were rated as 'Inadequate'.

Overview of the Trust's Strategy and Business Model

Vision

"To be an outstanding provider of healthcare through leading health and academic partnerships, transforming services to provide best care where needed."

Purpose

"To provide high quality, safe and compassionate care, improving the health and wellbeing of the people that we serve."

The Trust's focus is to improve health outcomes and, in doing so, it will adopt the most efficient approaches to deliver effective care. This involves extending the Trust's reach beyond the footprint of the physical hospitals by working with community-based partners to respond to local needs.

This statement of purpose is informed by the dual nature of the Trust's role. The Trust will continue treating people when they are ill, by providing the best available acute care – as has been the focus to date. Looking forward, the Trust will be more forthright in helping people to stay healthy, so that they don't become ill in the first place – this will mean an increased focus on prevention

The Trust strategy for 2019/20 is summarised in the diagram below:



In 2019/20 the Trust's clinical services strategy was updated, with our clinicians working in partnership with our local stakeholders, ensuring that we had an agreed clinical services strategy to inform the development of our new hospital. In 2020/21 our strategy

will be taken forward within the development of our Strategic Outline Case (SOC) and Outline Business Case (OBC) for our new hospital.

In 2019/20, the Trust had six key objectives, which are illustrated below.



Improvement Strategy

In 2019/20, the Trust made significant progress in embedding our improvement methodology, CARES+. As one of the eight trusts selected in England to be part of the national Vital Signs Programme, NHSI have supported the Trust in delivering significant improvements in patient care, whilst also improving our efficiency

CARES+ is now the Trust's single quality improvement methodology, allowing clear vision and sharing of improvement across all areas. The approach is based on enabling and supporting staff, who deliver care and services, to identify and implement their own improvement plans, with close links to the voice of patients and service users. Management will support, enable and coach, in order to support teams to deliver changes that matter for both staff and patients.

Particular focus in the year was on the Frailty Unit, where multidisciplinary staff worked together to introduce improved processes for patient review and management of the patient pathway, seeing a 23% reduction in patient length of stay, as well as improvements in stock management, ward layout, and improved processes in the outpatient clinic environment. The CARES+ methodology was also used to deliver improvements in quality processes across the Trust's inpatient wards, and to deliver improved patient pathways in Ambulatory care.

Over 240 staff were trained in the basics of the improvement practice, and 13 staff achieved the coveted Practice Coach certification level, demonstrating the development of significant skills in delivering improvement. The practice also implemented the “Report out”, a weekly opportunity for staff to share and celebrate over 70 different improvements projects delivered across the organisation.

At the end of the year, the CARES+ team were deployed as part of the response to the COVID crisis, and were recognized by the Trust for their excellent work in establishing efficient and effective processes to support the organisation in managing the unprecedented situation, particularly in the coordination and control of the Trust response and in the processes for managing staff sickness and welfare and in facilitating communication with patients and their families.

The Hillingdon Improvement Plan (HIP) is now the Trust’s single improvement methodology, allowing clear vision and sharing of improvement across all areas. The approach is based on enabling and supporting staff, who deliver care and services, to identify and implement their own improvement plans, with close links to the voice of patients and service users. Management will support, enable and coach, in order to support teams to deliver changes that matter for both staff and patients.

Key Issues for the Trust

Poor condition of our estate

Backlog maintenance is the amount it would cost the Trust to rectify issues within the fabric and assets of each of its buildings and bring them in line with current legislation.

A degree of backlog maintenance is not unusual and is dependent on the age and condition of a building as well as being affected by the consequences of changes to legislative requirements generally and to meet NHS related requirements such as are set out in the Hospital Technical Memorandum and Hospital Building Notes.

The Trust completed a condition survey in February 2017 of its estate which concluded that the total cost to address the backlog was £211m for the total occupied estate. This number will be compounded by circa £40m over four years if no further investment is made in the estate.

A review undertaken by cost consultants identified that an additional £100m will be required to maintain the existing building services (business as usual) in parallel with the new hospital development over a period of the next seven years.

A six-facet survey conducted in February 2017 highlighted that 81% of the Hillingdon estate and 51% of the Mount Vernon estate was in a condition that was “operational but major repair or replacement will be needed soon”. Therefore, the replacement of the hospital asset remains a key issue.

CQC Inspection

The Trust is governed by a regulatory framework set by the CQC which has a statutory duty to assess the performance of healthcare organisations.

During March to May 2018 the Trust was subject to comprehensive inspection visits from the CQC, the outcome of which was an overall rating of 'Requires Improvement'.

The inspection visits in 2018 were based on the Hillingdon Hospital site and covered the following:

1) Core services reviews:

- An unannounced series of inspections conducted in March 2018 inspected all eight core services provided by the Trust on the Hillingdon Hospital site
- Effective and Responsive domains were rated as 'Requires Improvement'
- Caring was rated as 'Good'
- Of the eight core services, three were rated as 'Good', three as 'Requires Improvement' and two were rated as 'Inadequate'. These ratings resulted in Hillingdon Hospital site receiving an overall rating of 'Inadequate'

2) Use of Resources inspection was conducted by NHS Improvement using CQC methodology and resources in May 2018

3) The Well Led Review was a planned inspection conducted in May 2018

Our Mount Vernon site did not form part of the 2018 inspection and the CQC took into account the previous 2014 'Good' rating of the core services at this site and the findings of the 2018 Hillingdon Hospital inspection which resulted in the Trust receiving an overall rating of 'Requires Improvement' for Well Led and Use of Resources. The Trust has a comprehensive action plan in place to ensure the issues identified in the report are addressed and that we continue on our journey of improving care.

The Trust submitted the CQC's Provider Information Request (PIR) in February 2020, this request precedes a CQC inspection, enabling the CQC to gain a picture of the organisation. A 'Use of Resources' inspection was scheduled for May 2020, however due to the COVID-19 pandemic, the CQC has temporarily suspended all the inspections.

Responding and recovering from the COVID-19 pandemic

The COVID-19 pandemic is the biggest threat to the health of the population in a generation, resulting in a previously unseen level of demand for hospital critical and medical care. The Trust has and will continue to respond to the pandemic in line with national and local guidance. The Trust has worked with colleagues in the North West London Health and Care Partnership (NWL HCP) to enable us to manage the significant increase in caseload of COVID-19 patients and maintain equity of access to care for all patients. This required rapid and significant transformation of services. Elective inpatient and day-case services were largely paused (with the exception of some urgent critical cases including cancer services). Outpatients services were significantly reduced, with the rapid adoption of virtual clinics where at all possible and maintaining urgent services where required.

Plans have been made in line with national and regional guidance, and with the welfare of our staff and patients at their heart.

A large number of actions have been taken to ensure:

- Compliance with national and regional guidance
- Appropriate management of the organisation during a national incident with a gold, silver and bronze command structure in line with the internal incident and pandemic plans
- Effective communication with staff to support effective two-way flow of information
- Reduction in planned care to manage increase in COVID-19 patients
- Maintenance of time critical emergency work (including cancer and urgent surgery and some diagnostics)
- Increased Intensive Care Unit (ICU) capacity in line with national and regional guidance and modelling including compliance with revised national (medical and nursing) staffing ratios
- Availability of increased numbers of general medical beds so sufficient are beds available and staffed in line with modelling
- Creation of risk assessed and distinct areas to care for possible/definite COVID-19 cases and non-COVID-19 cases
- Safe care provided to deteriorating patients
- Consistent and ethical decision making
- Appropriate provision of Personal Protective Equipment (PPE) in line with national guidance
- Staff well being
- Estates management and changes made in a timely manner to facilitate safe patient care
- Governance systems for Quality have been maintained

The Trust maintains a COVID-19 risk register to support the identification, escalation and mitigation of risks associated with the pandemic. The Trust has also developed a specific COVID-19 Board Assurance Framework to provide onward assurance to the Board on management of the risks associated with the COVID-19 pandemic.

As well as responding to the pandemic itself the Trust is closely monitoring all waiting lists and key quality and performance metrics to maintain patient safety and business as usual functions as far as reasonably practicable. The Trust will continue to monitor the impact on non-COVID-19 patient care and will re-commence planned work in as flexible and timely a manner as capacity and quality parameters permit.

In 2020/21 the Trust will continue to assess and mitigate the risks associated with the impact of the COVID-19 pandemic on its strategic objectives via the Boards Assurance Framework and Corporate Risk Register.

Achieving the 95% A&E target leading to a breach of constitutional standards

A key objective for the Trust was to achieve a consistent performance of 90% by the end of March 2020. This was not achieved and as a result the Trust has reviewed its medical model to strengthen the delivery of clinical pathways and has continued to increase the use of pathways to ambulatory emergency care for both surgery and medicine. The demand in the Emergency Department (ED) continued to increase throughout the year until March 2020, when there was a significant drop in activity due to the COVID-19 pandemic.

The Trust is looking to change ways of working across the ED to reduce the overall time patients are in the department. The Trust's Emergency Care Programme Board continued to drive improvement and oversees the delivery of the improvement plan with a key focus on patients in acute beds over seven days and length of stay in the ED, this is in partnership with the Hillingdon Health and Care partners (HHCP).

The Trust continues to work with Hillingdon Clinical Commissioning Group, the London Borough of Hillingdon, Central and North West London NHS Foundation Trust and the Third sector to integrate care and ensure that admissions to hospital are avoided where possible and that discharge is timely.

Inadequate nursing levels due to a combination of vacancies, national shortages, and additional capacity being opened up to meet any surge in demand

The Trust has mitigated the risk of inadequate nursing staffing levels through a twice daily review of staffing undertaken by senior nurses and midwives. The purpose of this review is to ensure each area is appropriately staffed on each shift, in line with the clinical need of the patients. The Trust uses 'SafeCare', a real time electronic solution which supports dynamic assessment of staffing demand and capacity taking into account patient acuity. This system is embedded across all inpatient wards; it facilitates effective use of the nursing resource and safeguards patient safety on a daily basis. After review of all areas, staff are reallocated across the Trust as required in order to meet the clinical demand.

Average shift fill rates and care hours per patient day are also reviewed retrospectively and triangulated against patient centered outcome indicators such as falls, pressure ulcers and complaints.

Both domestic and overseas recruitment continued in 2019/20 with 38 nurses being recruited in January 2020 from outside of Europe. The Trust is supporting these staff members to achieve registration with the Nursing and Midwifery Council.

Domestic recruitment has been managed through a combination of specialty specific recruitment days and general recruitment events. We have continued to support the development on non-qualified staff to train as Nursing Associates and had had considerable success in recruiting both qualified and non-qualified nursing support staff over the year, which has helped to enhance the standard of care and brought new innovation to the organization.

Delivering high quality patient care with medical recruitment challenges and increased patient acuity

The Trust has recognised that its medical staff numbers overnight did not sufficiently support the consistent provision of high quality and timely patient care. Our success in overseas recruitment has enabled us to commence a Trust Clinical Fellow (non-consultant grade) rota operating overnight from the middle of January 2020.

Challenges remain with regard to recruiting adequate substantive staff, especially at consultant level, to our Acute Medical Unit (AMU) and Ambulatory Emergency Care Unit (AECU). To address this, we have refreshed our recruitment strategy, and are reviewing the AMU/AECU model to enable us to improve clinical services and to staff them appropriately. This includes increased input from ED consultants to the AECU.

The Trust is also building on its partnerships with Brunel University and undertaking a workforce review to build a model that incorporates the new medical associate professions as well as extended roles for nurses, pharmacists and allied health professionals.

This partnership approach of being able to develop skilled professionals locally will help the Trust to mitigate the impact of Brexit and the ensuing changes to immigration policy that will affect the Trust's ability to fill vacancies from the EU. The Trust is also seeking to form partnerships with overseas recruitment agencies to recruit from non-EU countries for 'hard to fill' posts.

Complying with the expected standards set out by our regulators which could impact on the Trust achieving a 'good' rating with the CQC

As outlined earlier the CQC inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March/April 2018 and rated the Trust overall as 'Requires Improvement'. The safety and Well Led domains were rated as 'Inadequate'.

The Trust took immediate action and has made significant improvements since the inspection took place. These improvements have been across a wide range of areas including day-to-day operational performance. The Trust produced, and continues to manage, a specific CQC action plan encompassing the core services.

In addition to this, and in order to effectively manage and control all the elements of change required and to ensure the delivery of required improvements, the Trust established a holistic Hillingdon Improvement Plan known as the HIP.

Throughout 2019/20 this has been used to track our progress, not only against the CQC 'must' and 'should do' requirements but other self-identified areas for improvement. This plan has been overseen by a monthly HIP Board chaired by the Chief Executive Officer, with attendees from all Trust divisions, corporate areas and from external Health Care partners including the CQC regional team, Clinical Commissioning Groups (CCG) colleagues, local Healthwatch colleagues and NHS Improvement (NHSI). This engagement has, and continues to provide, external assurance on the Trust's improvement work and offers scrutiny and challenge to the Trust around delivery. The HIP Board reports to the Trust Management Executive, and then to the Quality and Safety Committee which is a sub-committee of the Trust Board.

A programme for improving quality and safety has been put in place comprising of Ward Accreditation and Clinical Service Reviews. These strands of work support the delivery of the HIP in the form of a series of internal inspections to identify areas of good practice and any additional improvement work required. Action plans are developed from these inspections and managed through the divisional management teams and linked into the HIP where appropriate. Using the Trusts chosen improvement methodology 'CARES+' CARES+, groups of staff have been facilitated to identify and implement solutions to address shortfalls identified through the accreditation inspections, to drive improvements and improve consistency in care delivery.

Effectiveness of the financial control system or inability to achieve the financial plan

NHS provider Trusts are set financial targets on an annual basis by NHS Improvement. Trusts are expected to set a financial plan for income and expenditure during the financial year that allows these financial targets to be achieved. As part of this process, Trusts are eligible for additional funding through the achievement of targets during the year. In 2019/20, the Trust failed to achieve financial targets set for it by NHS Improvement, primarily as a result of:

- Under delivery of Cost Improvement Plan (CIP) savings, so that expenditure was higher than planned; and
- As the Trust's actual performance moved away from plan during the financial year, the Trust lost £12.7m in additional funding

The table below shows planned and actual financial performance in 2019/20 and includes 2018/19 information for context.

	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Forecast (£m)	19/20 Actual (£m)
Deficit Excluding PSF/FRF/MRET Funding	(£27.7)	(£23.7)	(£33.8)	(£34.5)
PSF/FRF/MRET Funding	£2.3	£21.1	£8.4	£8.4
Deficit Including PSF/FRF/MRET Funding	(£25.4)	(£2.7)	(£25.4)	(£26.1)

The Trust planned for a deficit of £23.7m in 2019/20 which after the inclusion of £21m of non-recurrent Provider Sustainability Funding (PSF), Financial Recovery Funding (FRF) and Marginal Rate Emergency Tariff (MRET) funding reduced the deficit to an agreed deficit control total of £2.7m.

The Trust ended the year with a deficit of £26.1m including non-recurrent funding or £34.5m excluding £8.4m of non-recurrent funding actually received during the year.

In order to deliver savings wherever possible, Trusts are encouraged to keep their current expenditure under review. The Audit and Risk Committee (ARC) advises the Board on the work of Trust management in respect of ensuring the economic, effective and efficient use of resources and The Finance and Performance Committee (which meets monthly) receives regular reports on achievement against the savings plan.

The following key governance processes have been established within the Trust:

- a Scheme of Delegation and Reservation of Powers approved by the Board sets out the decisions, authorities and duties delegated to officers of the Trust
- Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that an organisation's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness
- robust competitive processes are used for procuring non-staff expenditure items. Procurement of items above £25k involves competitive tendering
- all procurement tendering activities are published within nominated publications and in accordance with Public Contracts Regulations (2015)
- the Trust's Cost Improvement Plan (CIP) Board oversees the identification and delivery of efficiency savings which comprises Divisional and Trust-wide cost-cutting programmes of work

- opportunities have been identified on the basis of the Model Hospital initiative, national and peer benchmarking, and locally developed analysis
- performance is reported via divisional management teams to the weekly Recovery meetings, chaired by the Chief Operating Officer and Director of Finance
- all schemes within the CIP are signed off by Operational, Clinical, Executive and Finance leads
- Quality Impact Assessments (QIAs) are completed for all schemes. QIAs scoring under 10 are signed off by the Medical Director; QIAs scoring above 10 and all cross-cutting schemes are signed off via the Clinical Advisory Panel
- the Programme in 2019/20 resulted in savings of £8.1m. This was delivered through enhanced governance and a focus on efficiency projects

The financial performance in 2019/20 indicated areas where greater budgetary management was possible and development on this will continue in 2020/21.

ARC receives quarterly reports regarding losses, special payments and compensations (with those of high value – over £50K approved by the Board), write-off of bad debts and contingent liabilities. The value of losses and special payments has remained at an immaterial level (0.044% of Trust turnover in 2019/20). In addition to receiving reports from the Transformation Improvement Board (which manages the CIP), the Trust's Finance and Performance Committee reviews the Trust's financial performance, transformation programme and major strategic service change business cases, including the use of information technology to lever change.

The scale of investment required to improve the Trust's fragile estate infrastructure

The Trust is required to comply with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises which covers issues around failure to maintain the estate. To support the Trust in meeting this requirement the condition of key building systems is assessed by a five-yearly survey, and is risk assessed and rated against available capital. The annual capital investment available for the estate is targeted at addressing specific extreme risks, and has enabled risk reduction, however, the available funds are insufficient to keep pace with the scale of backlog maintenance and the Trust continues to have high-risk estates issues on its Risk Register.

The Trust is taking forward plans for a new hospital to be built to replace the existing facility, however, given the time required to take this through formal approval processes, it is imperative to continue to operate in the interim period, protect the integrity of

service delivery and where possible, to enhance the provision within the constraints of the site and healthcare economy. As such, as part of the recent emergency capital loan received from NHSI, £16.5m was awarded to the Trust to address major infrastructure risks and statutory compliance issues. The projected spend has been profiled over two years to ensure safe and effective delivery of maintenance projects.

Significant progress, aided by emergency capital funding has been made on addressing the statutory compliance in the main areas of:

- Ventilation
- Asbestos
- Water
- Electrics
- Heating and hot water
- Lifts

The Estates Department appointed authorised engineers (external expert advisors) in July 2019 in all areas to ensure compliance against statutory requirements with the outcome received in October 2019.

An Estates Risk Register is in place which is regularly monitored through Trust governance processes.

In October 2019, the Director of Estates and Facilities commissioned a further report by an independent authorised engineer highlighting compliance status in accordance with 'Managing Healthcare Fire Safety' (HTM 05-01) and in particular the fire safety requirements of the Regulatory Reform (fire safety) Order.

The report identified areas of failure to the infrastructure and buildings which will require capital intervention to achieve overall fire safety compliance, in the following areas:

- Means of warning and escape
- Internal fire spread including compartmentation
- External fire spread
- Access and facilities for the fire service
- Support systems (e.g. additional dry riser and the upgrade and maintenance of all detection systems)

These findings were shared with the London Fire Brigade in March 2019 and they have since agreed a two-year plan of works to address these issues. The Trust committed £250,000 capital funding in 2019/20 to commence the procurement of essential fire precautionary works, and in addition to this NHS Improvement have been notified that an investment of £15m will be required to address the full fire programme of works with funding expected to be received in 2020/21.

As noted earlier, the operational viability of the Hillingdon Hospital site has been recognised as a significant issue for a number of years, with £211m of backlog

maintenance identified, the second-highest in England (by m²). The Trust's situation was recognised in the Department of Health and Social Care's 'Health Infrastructure Plan'. This was a new, strategic approach to improving hospitals and health infrastructure, published on the 1 October 2019 and which details new hospital projects across the country, to be taken forward in two phases – phase 1 and phase 2.

- Health Infrastructure Plan HIP1 (2020-2025) will include six new hospital projects that are sufficiently developed in order to get the full go ahead now, subject to business case approvals; and
- Health Infrastructure Plan HIP2 (2025-2030) will include 21 schemes for 34 new-build hospitals, with seed funding provided now to kick-start schemes and allow trusts to proceed to the next stage of developing their hospital plans (and related business cases).
- We are one of the HIP2 21 schemes

As one of the HIP 2 schemes in 2019/20 we accessed seed funding to kick-start our redevelopment programme, and we are progressing our hospital redevelopment plans and the related business cases. This included establishing a Hillingdon Hospitals Redevelopment Partnership Board chaired by the Trust chair and with wide ranging membership and engaging specialist consultancy support. The development of the new hospital will continue as a key NHS and Trust priority in 2020/21, and we will have developed our Strategic Outline Case by the summer of 2020, and the Outline Business Case by the spring of 2021, which will detail the preferred option for our new hospital.

Modernising and reconfiguring the Estate and Facilities to meet the needs of our clinical services

The Trust vision is to provide a hospital estate that is fit for purpose, flexible and which enables the delivery of high quality care, whilst maximising efficiency, productivity and environmental sustainability.

As outlined above the Trust has one of the highest backlog maintenance liabilities in England and without significant capital investment the estate will continue to deteriorate. This has been recognised nationally and as a consequence Hillingdon Hospital is one of the schemes greenlighted to receive seed funding to allow the hospital to proceed to the next level of development; with work proceeding during 2020/21 to develop the business case.

A substantial investment is required to develop this and work is now underway to prepare a Strategic Outline Case with a number of development options all of which require the Hillingdon Hospital site to remain operational for the foreseeable future. This has also been recognised in the Health Infrastructure Plan published by the Department of Health and Social Care Health in September 2019.

Solutions are required for the short term, as well as the medium to long term. For the medium to long term, it is assumed that the vision will be delivered through a new hospital build and the Trust will develop plans that will be ready from 2025. In conjunction, with this the Trust will explore whether a supportive business case process could mean that delivery may start sooner, with the new hospital linking in with current plans which look to address the immediate estate risks. Central capital has been provided to address the most immediate estates risks over the next two years and further significant funding will be required to support the new hospital build. Plans for funding are expected to go through governance processes and be submitted to Treasury early in 2020/21.

The development of plans for a new hospital are informed by the priorities in the clinical services strategy and will involve a continued focus on working with partners to ensure proposals meet the needs of the wider system and maximise opportunities to share and co-locate with other health and social care providers to reduce void space (and associated cost) across the system. The SMART city concept, which is focussed on the use of natural resources efficiently to reduce the environmental impact, will be embedded within any future estates plans and the Trust will upgrade and replace its infrastructure to ensure optimum efficiency is achieved, utilising Building Information Modelling to reduce environmental impact of the Trust's business, together with running costs.

Maintaining and running the estate must be affordable and accordingly the estate should be maintained within the financial controls set.

We are committed to ensuring that our estate aligns with the needs of clinical services, it needs to change to ensure that service requirements are met now and in the future.

Going Concern disclosure

In line with paragraphs 4.11 – 4.15 of the DH Group Accounting Manual (GAM), Department of Health and Social Care (DHSC) group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. This has not happened in the case of the Trust, and services are expected to continue for the foreseeable future.

The Trust's financial statements (which form part of the Trust's annual report) have therefore been prepared on the going concern basis.

Given the Trust's financial position, consideration has been given to the Trust's broader financial sustainability for the 'foreseeable future' (which is determined as a period of 12 months following the approval of the financial statements – to 30 June 2021); as well as the circumstances in which the Trust (and all other NHS providers) are currently operating. Based on this review, we note the following:

- The recurrent financial position of the Trust is in deficit. The reported deficit for 2019/20 was £26.2m (2018/19: deficit of £25.9m). While the Trust's 2020/21 operational plan currently forecasts a breakeven position, this is after receipt of £20.3m of non-recurrent funding, so the underlying position is for a £20.3m deficit

- The Trust has £111.2m of DHSC loans on the balance sheet. In April 2020, DHSC announced changes to the cash regime, which means that in September 2020, the Trust will receive £95.0m in Public Dividend Capital (PDC) to repay the majority of these loans; this PDC will be added to the balance sheet. This will reduce the exposure of the Trust to future loan payments, but the revenue position of the Trust will deteriorate by approximately £2.0m per year due to the additional PDC dividends payable
- The trust has £7m of loan principal falling due during 2020/21 which it is forecasting to pay. This will have a significant impact on cash balances
- As with all other NHS provider organisations, the Trust is currently being funded on a block contract arrangement for the period up to July 2020, as the DHSC provides certainty in cash flows for all NHS organisations during the COVID-19 pandemic. National planning and contracting rounds for 2020/21 have been frozen until further notice
- NHS Improvement issued a letter to all NHS providers on 27 May stating that future cash flows would be at levels similar to those previously provided. However, the letter does not provide a guarantee to underwrite any underlying deficits arising during the period up to 30 June 2021.

Given that the mechanism the DHSC is using for agreeing cash support is on a month-to-month basis, the continued provision of revenue funding for the period up to 30 June 2021 is uncommitted. These conditions constitute a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern.

However, as stated above, for the purposes of the financial statements, in line with the existing financial reporting framework, the Trust is considered by management to be a going concern.

SUMMARY OF OTHER PERFORMANCE 2019/2020

Managing our resources well

In a financially challenging year we delivered in excess of £8.1m of savings. We aim to build on this in 2020/21, and further strengthened our Transformation Team through the appointment of a Chief Transformation Officer. The Transformation Team, with aligned processes, personnel, aims and objectives and working under the direction of the Chief Transformation Officer will provide the programme support required to deliver an ambitious 2020-21 trust-wide transformation agenda.

Achieving greater efficiencies

Highlights included:

- Improved patient care and efficiency with a reduction in length of stay for emergency admissions 4.7 days (2018-19) to 4.1 days (2019-20), which enabled the closure of a ward delivering a saving of over £1m
- Improved processes and engagement with procurement delivered in-year £1.8m in non-pay savings
- Improved control and reporting across all staff groups and an overseas recruitment drive for medics and nurses, delivered £4.3 m in pay savings including £1.5 m in medical pay savings
- Improved patient care and efficiency with a Rapid Improvement Event, resulted in improved ways of working with our Frailty Team on Lister Ward delivering improvements in patient care and making us financially more efficient and we delivered a 23% reduction in length of stay

Improving our digital services

In 2019/20, we continued to increase our digital capabilities with the aim of improving the digital infrastructure and the digital offer to our staff and patients. The key achievements during the course of the year were:

- Deploying video consultation technology, supporting remote corporate meetings and transforming the way we deliver outpatient care to patients
- Achieved Cyber Essentials Plus accreditation, improving our organisational cyber-readiness and protecting patient data and systems
- Electronic observations, ED, eTriage and Sepsis alerting for adults was rolled out across the Trust and completed in December 2019. An average 55,000 electronic observations and 2000 sepsis screens are undertaken per month, enhancing patient safety and reducing serious incidents (SI's) in relation to National Early Warning Scores (NEWS)
- ED Transformation, through development of digital dashboards supporting patient flow and use of mobile doctors coding functionality to improve the quality of discharge information
- Clinical Handover was implemented for doctors with 70% doctors and 90% of nurses using the system. Rollout has significantly enhanced patient safety for our inpatients and improving multidisciplinary communication between staff
- Outpatient Transformation – will include integration with the national eRS service to enable electronic receipt and vetting of referrals available in the Hillingdon Care Record (HCR), supporting remote clinical outpatient virtual clinics, completing the summary care record for patients to compliment the outpatient

letters, inpatient and Emergency Department Discharge summaries, GP record and diagnostic information for a patient

- The Trust has also worked closely through shared leadership arrangements for digital services to evaluate market options for an electronic patient record to support its future aspirations for clinical and operational transformation to enable new models of care

Complaints and PALS

During 2019/20 1371 PALS concerns were recorded compared to 1552 in 2018/19, and the Trust received 359 complaints compared to 302 in 2018/19.

Themes featuring across both feedback pathways included:

- Appointments
- Communication
- Clinical care

Staff attitude was an issues raised frequently in complaints, as was experiences during discharge.

Since October 2019 the Complaints Management Unit has been recording divisional actions arising from a complaint investigation on the GiveMeData system. A report is produced for each divisional governance meeting, with management teams. expected to review the complaints they received and implement any identified actions.

Going forward, actions to support improved timeliness of complaint responses, and dissemination of learning, have been identified for 2020/21. These include:

- New divisional structure implemented for 2020/21, with an identified Governance Lead for each division who will be instrumental in driving the completion of timely, high quality complaints investigations
- Complaints reports to be a standing item at divisional governance meetings
- Strengthen systems in place to progress actions arising from complaints
- Develop and implement robust system to capture compliments received at ward or department level

Securing external recognition

The past year has brought a great deal of success and some noteworthy honours for a number of teams at the Trust. Starting in May 2019, our Facilities Catering Team was awarded a 'Food for Life Served Here' Bronze Award by the Soil Association for the freshness 'environmental friendliness', sustainability and ethical sourcing of all our food, which also promotes healthy eating and champions local food producers. The Trust Facilities Team enjoyed a double success in the HEFMA National Awards, scooping

both the 'Team of the Year' Award (Beds Maintenance) and runner up (Facilities Catering) in the same category, in May 2019. HEFMA is the national body representing Estates and Facilities departments across the NHS.

Our People and Organisational Development Team won two National Healthcare People Management Association HR Excellence Awards in June. The department won the Social Partnership Forum Award, given for partnership working between employers and trade unions, for its collaborative development of our People Strategy. Further success followed when the team also won the Capsticks Award for Innovation in HR for collaborative international recruitment for physician associates.

Our Children and Young People with Diabetes Team won a Quality in Care Diabetes award at the Sanofi Pharmaceuticals/ Diabetes UK awards for its project, which made clinics an inclusive and collaborative experience for 9-11-year-olds with Type 1 diabetes.

In January 2020, our Bed Maintenance and Bio-Medical Equipment Maintenance Teams were re-accredited with the coveted ISO 9001 for quality management.

Maintaining and upgrading our buildings

Over the past year the Trust has invested more than £5 million in improving and maintaining its electrics, specialist ventilation and heating, plus major surveys on water pipework in Maternity and in the main building at Hillingdon Hospital were commissioned. Improvements were also made to wards on the Mount Vernon Hospital site and to the HR and Estates Department buildings at the Hillingdon Hospital. In addition to this £470k was spent on roads and car parks resurfacing works, asbestos removal, door controls, medical gas controls and safety improvements.

Strengthening partnerships

The Trust is working in partnership with Central and North West London NHS Foundation Trust, Health for All (H4All), a partnership of Third sector organisations, the Hillingdon CCG, and the Hillingdon, Primary Care Confederation in continuing to develop Hillingdon's Integrated Care Partnership, Hillingdon Health and Care Partners (HHCP). HHCP's aim is improved join up of care around the patient in order to support patients to stay in their own homes for longer, to enable earlier identification and treatment of any deterioration in health for patients with long term conditions and multiple co-morbidities, and to reduce the requirement for hospital admission. During 2019/20, to support delivery of this, the HHCP implemented a detailed plan.

The Trust has continued to work in partnership with Central and North West London NHS Foundation Trust and Brunel University London within the Brunel Partners Academic Centre for Health Sciences (BPACHS). This partnership of academic and clinical organisations aims to revolutionise the way health and social care is delivered in the future. BPACHS is progressing work to address workforce and training, Research and Innovation, Quality Improvement, Outcome based care, and Digital Healthcare.

Improving patient facilities

The multi-phased programme of works for the upgrade of the Emergency Department started in 2018 was completed by March 2020, with improved patients flow, waiting area and consultation spaces. The Trust spent £320k to improve adult daycare, and outpatients' clinics in Tudor and lockdown facilities in the Emergency Department.

To address structural defects of the Peter Pan and Wendy Ward paediatric building, the Paediatric Inpatient Department was relocated in Fleming Ward while its daycare facility was relocated on the ground floor of the podium. Both areas have been designed as modern and upgraded facilities.

A new ward block, adjacent to the Nightingale Centre was started on site in February 2020 and will be completed by the end of 2020, providing up-to-date inpatient facilities.

Works to the female day-care area was undertaken to include a separate male area, as well as improvements in adjacent corridors and WC for a total of £400k during the course of the year.

Funding was received for a new ambulatory care area of 6 chairs, which were delivered at the start of 2019.

A new main boiler was installed to provide much needed resilience to support the existing fragile infrastructure. The boiler was fully commissioned and operational by January 2020.

PERFORMANCE ANALYSIS

Approach to measuring performance

The Trust has an established integrated performance framework in place to monitor and track all the performance standards. There are weekly performance oversight meetings led by the Chief Operating Officer which include detailed operational reviews of constitutional standards covering both emergency and planned care.

To support the divisions, the Director of Operations for Planned and Emergency Care holds weekly Elective Programme, Cancer Patient Tracking and Emergency Recovery meetings.

The monthly divisional reviews at the Trust Management Executive form a core part of the framework led by the Executive Team to ensure there is effective support and controls in place to deliver high quality services to patients. These meetings consider performance on constitutional and Trust agreed performance standards and take a risk based approach to agreed targets and standards and confirm mitigating actions that will take place to reduce the risk of the Trust failing to perform. This element is a key part of the accountability framework.

The weekly and monthly meetings provide reports on performance to the Trust Management Executive meeting which in turn reports to the respective sub committees of the Trust Board, where further scrutiny is applied to ensure continuous improvement of the Trust's delivery on quality and operational performance.

An integrated quality and performance report is presented to sub committees and the Trust Board which covers the five key domains based on the CQC framework:

1. **Safe**, includes infection control, falls, maternity indicators, safety thermometer, Serious Incidents/Never Events, patient safety and mortality standards
2. **Effective**, covers readmissions and Did Not Attends (DNA) as well as monitoring performance on the use of the Electronic Referral Service (ERS).
3. **Caring**, monitors outputs and delivery of Friends and Family surveys, as well as complaints and feedback from the Trust's Patient Advisory and Liaison Service (PALS).
4. **Responsive**, focuses predominantly on the constitutional standards reporting on Emergency Care, Cancer and Referral to Treatment (RTT)
5. **Well Led**, monitors recruitment and retention as well as sickness rates and Performance Development Review (PDR) performance.

The Trust Board receives these key performance indicators in a way that considers the risks associated with achieving performance standards within time defined targets in a "RAG" (red, amber, green) format with commentary on performance and the actions being undertaken or about to be undertaken to mitigate the risk of failing to achieve the target.

Analysis of the Performance of the Trust

The NHS gives patients the right to access services within maximum waiting times. Over 2019/20 the Trust has not consistently met all of the constitutional or local standards it aims to achieve; RTT was at 76.3% against the 92% standard, cancer standards were met in quarters 1,3 and 4 (but were not met in quarter 2). Due to COVID-19 these quality metrics have not been subject to the usual external assurance programme in 2019/20.

Whilst the Trust has continued to monitor all the above standards the focus at the end of March 2020 shifted to safety.

The Emergency Care transit time standard is monitored. The Trust has worked closely with the regulators, system partners and staff towards delivering sustained improvements in this key delivery area. The performance for this standard is being monitored through the A&E Delivery Board which has representation from the whole care system leads, highlighting the dependency of achievement across all the agencies involved in providing emergency care for the residents of Hillingdon and the neighboring boroughs.

The performance table below provides comparative data for each of the performance standards over 2018/19 and 2019/20. The attendances to A&E do not include those to the Urgent Treatment Centre as this is managed by Greenbrook Healthcare.

Attendance table: Comparison 2018/19 and 2019/20

Attendance	2018/2019	2019/2020	variance
Attendances made to our Emergency Department	67653	69661	3.0%
Attendances made to our Minor Injuries Unit	29582	29918	1.1%
Attendances made to our Emergency Department and Minor Injuries Unit	97235	99579	2.4%
Babies born in our Maternity Unit	4458	4175	-6.3%
Attendances made as outpatients	380076	366367	-3.6%
Admissions made for emergency treatment	25257	27594	9.3%
Admissions made for planned operations and day-surgery	27584	26332	-4.5%
Total Contacts	534610	524047	-2.0%

Performance Table: 3-year comparator (2017/18 to 2019/20)

Indicator	Performance In 2017/18	Performance In 2018/19	Performance In 2019/20	Target Achieved
Clostridium difficile (Total)	19	16	24	✓
Clostridium difficile (Lapses of Care)	5	4	NA	NA
All cancers: 31 days for second or subsequent treatment (surgery)	98.7%	99.1%	98.2%	✓
All cancers: 31 days for second or subsequent treatment (anti-cancer drug treatments)	100.0%	100.0%	96.0%	×

All cancers: 62 days for first treatment from urgent GP referral for suspected cancer	85.9%	85.3%	82.4%	×
All cancers: 62 days for first treatment from NHS Cancer Screening Service referral	96.5%	89.7%	75.8%	×
All cancers: 31 days diagnosis to first treatment	98.9%	99.1%	98.2%	✓
Cancer: two week wait from referral to date first seen for all urgent referrals (cancer suspected)	95.1%	94.5%	87.3%	×
Cancer: two week wait from referral to date first seen for symptomatic breast patients (cancer not initially suspected)	95.2%	92.5%	90.8%	×
Maximum time of 18 weeks from point of referral to treatment – patients on an incomplete pathway	91.1%	86.4%	76.3%	×
A&E: Total time in A&E less than 4 hours (Accident & Emergency, Minor Injuries Unit, Urgent Care Centre)	84.5%	82.3%	82.3%	×

Self-certification on compliance with requirements regarding access to healthcare for people with a learning disability

The Trust reports a high level of compliance with requirements regarding access to healthcare for people with a learning disability (LD). The Trust appointed an LD Nurse Specialist in 2019/20 to drive improvements; initial outputs have seen increased direct support for people with LD and their families, increased training and progression of engagement work to inform service developments.

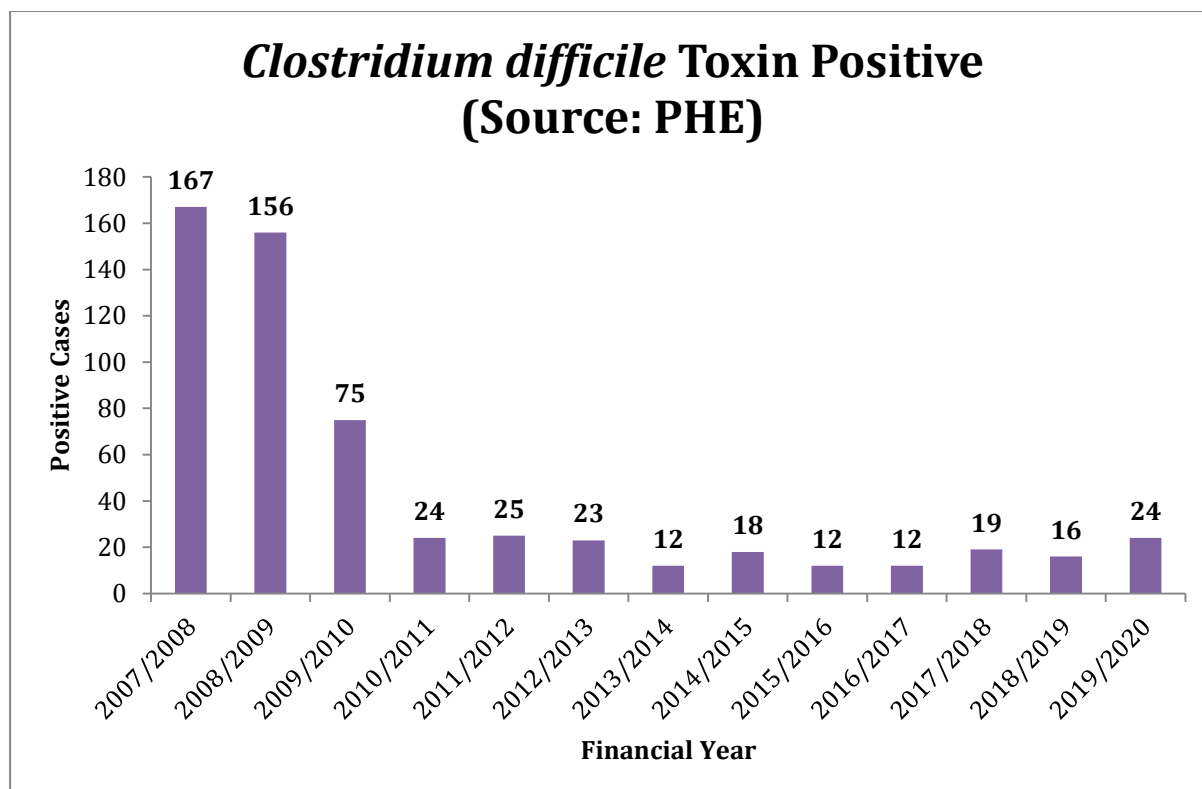
Clostridium difficile

The Trust reported Clostridium difficile infections in line with the NHS Improvement revised objectives set for all NHS organisations in 2019/20. The classification of the C. difficile cases changed in 2019/20 and the table below breaks down the performance for the Trust under each category. Following the new classifications, the Trust reported a total of 30 C. difficile infections in 2019/20. However, when compared to the 2018/19 classification the Trust recorded 24 C. difficile infection in 2019/20.

Criteria	C Diff cases
HOHA - Hospital onset healthcare acquired Specimen sent within 2 days of admission	24
COHA - Community Onset Healthcare Acquired Commenced in community with previous recent admission in the previous 4 weeks.	7
COIA - Community Onset Indeterminate Association Patient admitted to the Trust in the previous 12 weeks but not in the last 4 weeks	3
COCA - Community Onset Community Acquired	21

Although lapses in care were no longer monitored centrally within the NHS in 2019/20 the Trust has continued to learn from cases. In the previous year (2018/19) the Trust reported 16 cases of which four were deemed to be lapses in care against a threshold of seven. Clostridium difficile infection rates remain, however, below the London and national average where an increase has been noted regionally and nationally.

A multidisciplinary Root Cause Analysis (RCA) investigation is undertaken for all Trust-attributed cases of C. difficile, with the consultant in charge of care, the consultant microbiologist, lead nurse infection prevention and control, ward sister and responsible matron forming a panel as part of the process. All RCAs are reviewed by the Director of Infection Prevention and Control and, in turn, presented to the CCG to establish whether there were any lapses in care.



Cancer Performance

The Trust was compliant in three of the quarters of 2019/20 for the cancer standards. However, fluctuation in demand meant the Trust was unable to put on the required capacity consistently through 2019/20. The Trust was expecting to be fully compliant with cancer and diagnostic waiting times in 2020/2021 for each quarter, however this is now unlikely due to the COVID-19 pandemic. Recovery of elective care standards are being planned at an Integrated Care System (ICS) level.

Referral to Treatment (RTT)

The Trust ended the year with a performance of 76.3% against a target of 92% for RTT and has not yet reached the anticipated sustainable position of achieving RTT compliance. The Trust did meet the internal trajectory of 88% for quarter 1, however from July onwards performance deteriorated. This has a direct correlation with the continuous increase in the waiting list size from June (a result of increase in demand) and data corrections in the way we were measuring the wait which was anticipated at the beginning of the work.

The Trust has achieved significant improvement with reduction of 52 week waits which was on a trajectory for zero waits by the end of the year, had Covid-19 not occurred.

Further targeted investment in backlog reduction and recurrent capacity is required to achieve sustainable waiting times performance in the context of this referral growth. The Trust has adopted the IMAS Intensive Support Team demand and capacity (D&C)

modelling tools to identify the scale of investment required in selected specialties with performance challenges. The COVID-19 pandemic has had a very significant impact on the referral to treatment target, and this is not expected to be recovered in 2020/21.

A&E 4-Hour Standard

The Trust ended the year with a performance of 82.37% against a target of 95% for the 4-hour Emergency Care transit time standard. The Trust did meet the internal trajectory for the first quarter of the year. However, the performance deteriorated from July. This has a direct correlation with the rise of type 1 activity (which is activity that has to occur in a department which can deal with the most seriously unwell patients with a full resuscitation suite), which year to date has seen a 6.3% increase from 2018/19.

The Trust has achieved a significant and sustained improvement in London Ambulance Service handover times.

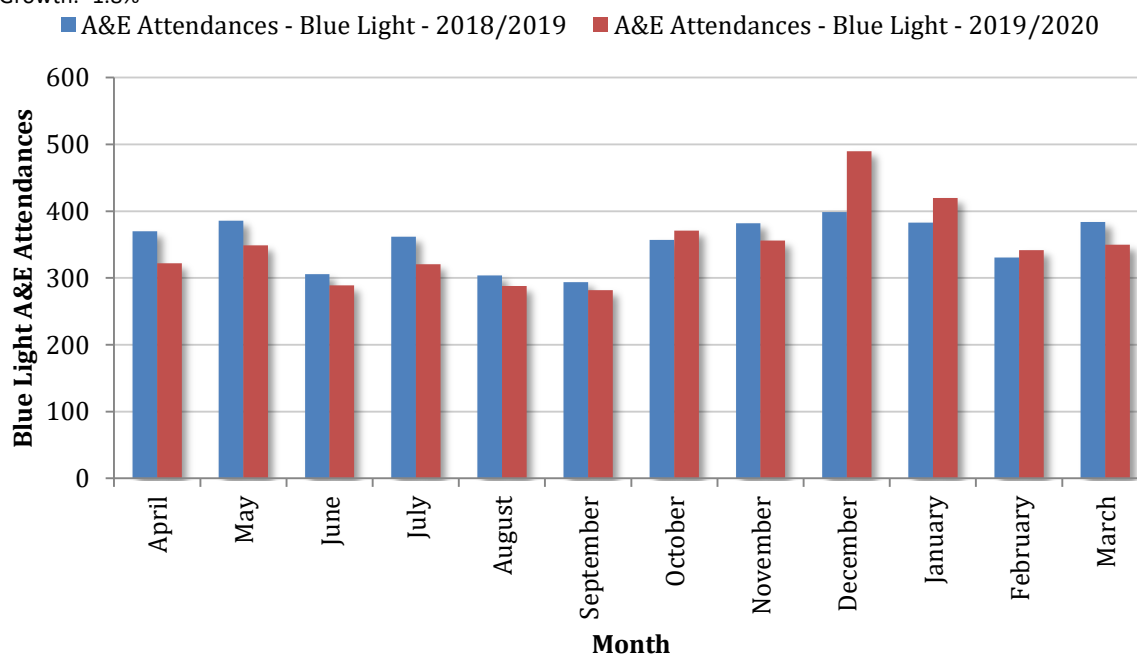
There has also been a sustained improvement in the reduction of the number of patients in hospital longer than 21 days which has reduced from an average of 121 in 2018/19 to an average of 85 in 2019/20.

2018/2019: 4258

2019/2020: 4180

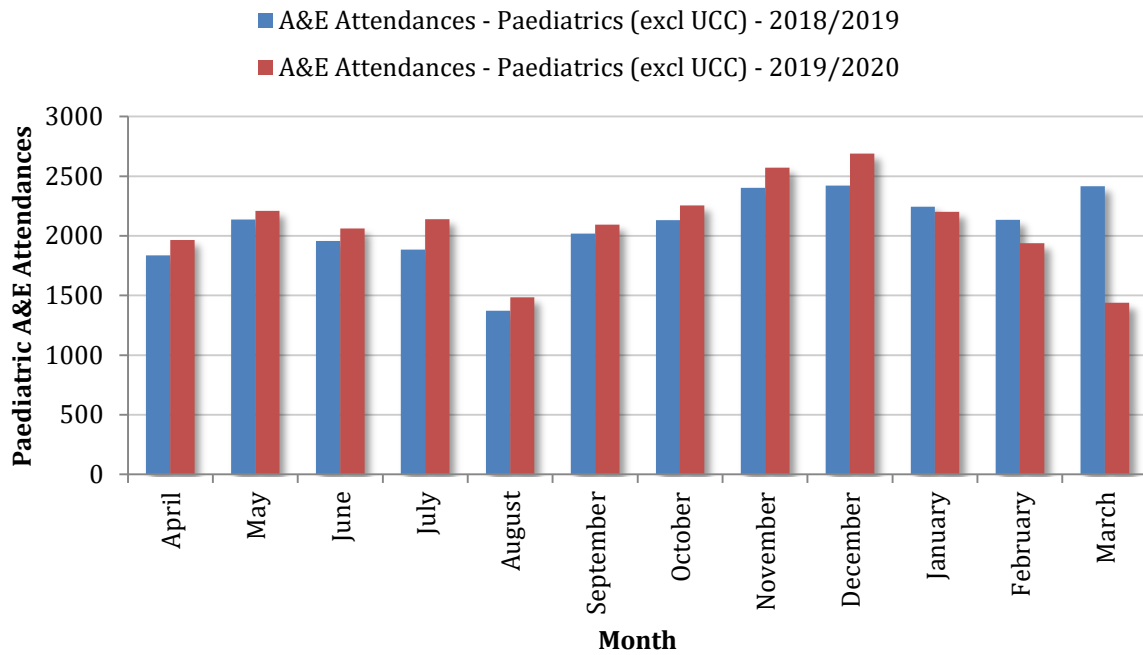
Growth: -1.8%

Blue Light A&E Attendances by Month



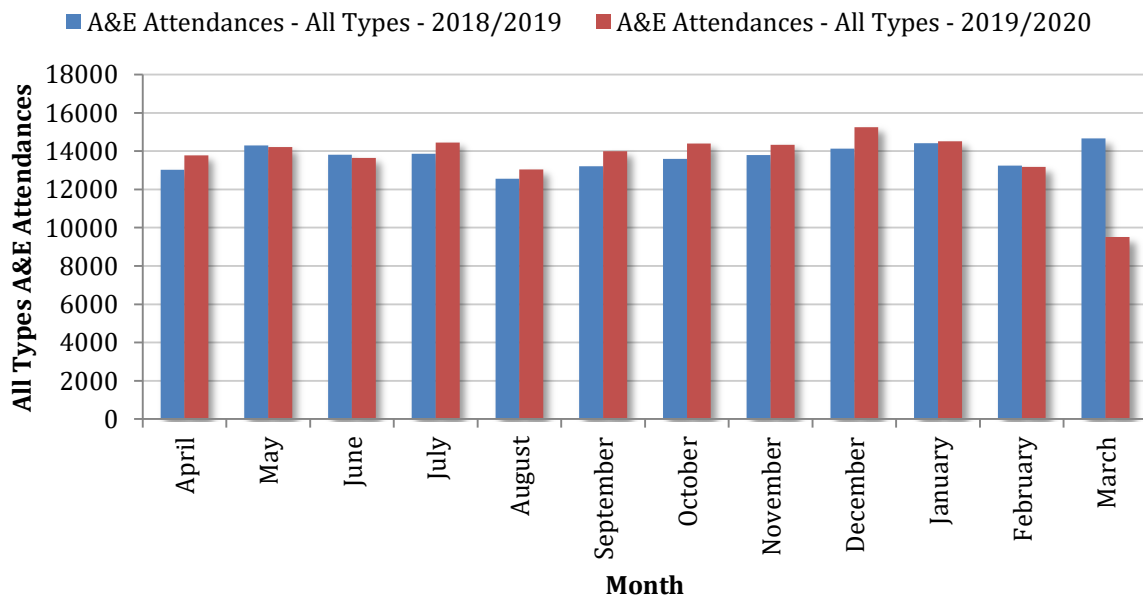
2018/2019: 24959
 2019/2020: 25595
 Growth: 0.4%

A&E Attendances - Paediatrics (excl UCC)



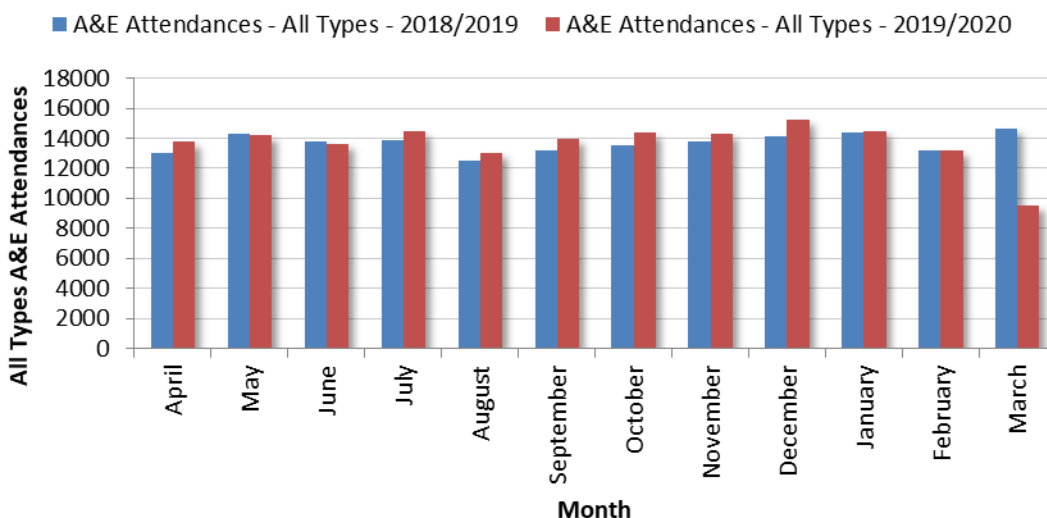
2018/2019: 150071
 2019/2020: 154884
 Growth: 3.2%

All Types (Main A&E, MIU & UCC) Attendances by Month



2018/2019:
150071
2019/2020:
154884
Growth: 3.2%

All Types (Main A&E, MIU & UCC) Attendances by Month



Financial performance

Overall Performance

The Trust continued to face significant financial challenges in 2019/20, and failed to achieve financial targets. The table on page 17 demonstrates the Trust's planned and actual financial performance. The Trust Board agreed a control total (financial target) of a deficit of £2.7m (including non-recurrent funding) at the beginning of the financial year, and this deficit was underpinned by £21.1m additional funding. As such, the planned deficit without non-recurrent funding was £23.8 m.

The table below shows the amount of funding the Trust was eligible for, and lost during the financial year:

	Plan (£m)	Actual (£m)	Amount not received (£m)
Provider Sustainability Funding (PSF)	4.7	1.6	3.1
Financial Recovery Funding (FRF)	14.8	5.2	9.6
Marginal Rate Emergency Tariff (MRET)	1.6	1.6	0
	21.1	8.4	12.7

This funding was only payable in arrears if the Trust achieved its financial plan at the end of each quarter. Funding is weighted in that 65% of PSF and FRF are receivable in the second half of the year.

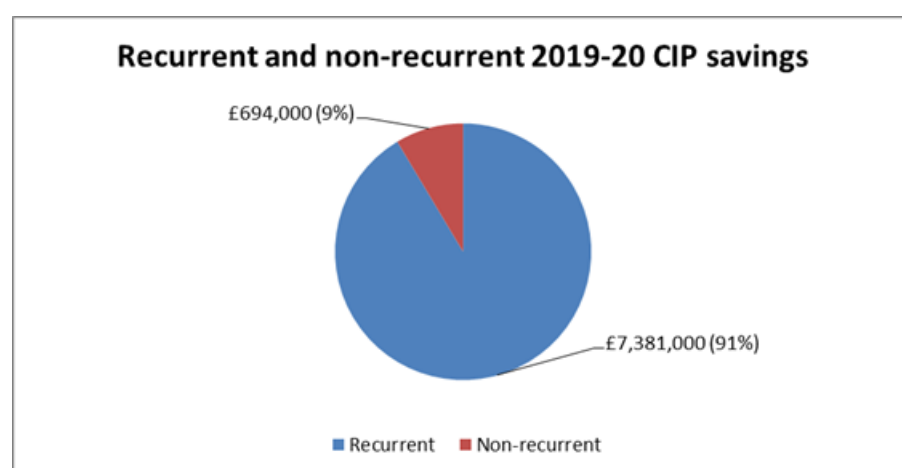
The organisation was required to deliver £11.7m of financial savings to achieve the plan for the year, however, due to the late identification of the savings targets that were planned to deliver largely in the second half of the financial year this was not met in full. The Trust was able to keep to plan and was entitled to receive funding for the first two

quarters of the year, but was unable to achieve the required savings level in the second half of the year and, as a result, was not eligible for the final two quarters of non-recurrent funding. As shown in the table above, the value of this funding was £12.7m.

There were overspends on staffing, particularly on medical and nursing, although agency staffing costs were reduced throughout the year and remained well below the cap set by NHS England & Improvement.

Non-pay was overspent in year due to pressures on utilities (an incinerator breakdown meant that the Trust needed to use additional electricity and gas), and investment required to support the Trust in identifying and delivering its savings plans, designing and implementing a new governance structure, and supporting the identification and management of the Trust's waiting list.

The Trust achieved Cost Improvement savings of £8.1m in year, £7.4m (91%) of which were recurrent savings (see pie chart below).



Income remained within the tolerance levels agreed with commissioners for 2019/20, whilst elective activity (including outpatients) was below plan, the over performance on emergency inpatients, direct access diagnostics and ED activity meant that income levels were stable at the baseline level agreed with commissioners at the beginning of the year.

The table on page 16 in the section entitled 'Effectiveness of the financial control system or inability to achieve the financial plan, demonstrates the Trust's planned and actual financial performance.

Cash flow

The Trust's cash position improved in year, largely as a result of £49.6m net loans provided from the Department of Health and Social Care (DHSC). The Trust received £51.9m loans in year and repaid £2.3m. These loans were received to:

- replace non-recurrent funding not received (£12.7m)

- support the continued supply of services to the Trust through payment of outstanding supplier debt and service interest payments on loans and leases
- support the Trust's capital investment programme, on which the Trust spent £25.5m in 2019/20 (see section below)

The Trust had a cash balance of £9.8m at the end of 2019/20. This resulted from the Trust receiving loans to fund capital expenditure, the invoices for which had not been settled at year end.

Capital Investment

The Trust has received significant levels of capital funding in 2019/20, this has been through a combination of loans, public dividend capital and internally funded. The total capital spend was broken down as follows:

	Plan (£m)
Estates projects (excluding new temporary ward spend)	10.4
New temporary ward spend	11
Medical equipment	1.6
Digital investment in IT	2.5
TOTAL	25.5

The investment in the estate included upgrading the boilers and the incinerator, improving the water systems to reduce the risk of legionella, upgrading wards and environmental improvements including the entrance at Hillingdon Hospital and the Minor Injuries Unit at Mount Vernon Hospital. In addition, we completed the upgrades to the ED and Urgent Treatment Centre on the Hillingdon site.

The medical equipment included a new CT scanner and mammography machine, image intensifiers and monitors for radiology, a fogging machine (ultra violet) for infection control and mobile x-ray machines.

We have invested over £1m in digital infrastructure improvements in preparation for the implementation of a new electronic patient record system in 2020/21.

The money spent on the modular wards will ensure the trust continues to support safe care whilst designing and building a new hospital for the future delivery of healthcare services to the population of Hillingdon.

Looking ahead

The Trust finished the 2019/20 financial year with a deficit of £26.1m including non-recurrent funding (£34.5m without non-recurrent funding), and continues to face finance challenges moving forward. The target savings in order for the Trust to achieve its financial trajectory in 2020/21 are £12.1m (for the year). Savings plans have been developed which will require transformation of the way the Trust delivers healthcare in

the following years. These plans have been developed both in conjunction with Hillingdon Health and Care Partners (HHCP) and North West London Health and Social Care Partnership. The savings programme, including transformation schemes with a value of £7m, is designed to deliver from early in 2020/21.

The Trust has signed up to its financial trajectory of £20.3m deficit. Delivering this would make the Trust eligible for £20.3 m of non-recurrent funding, and enable it to deliver a breakeven outturn position. However, this funding is partly dependent on the North West London Sector meeting its financial plan across all constituent organisations each quarter.

The Trust is re-modelling its medium term financial plan in support of the Business Case for a new hospital. It is modelling its likely transition costs as it maintains the existing aging infrastructure, and the requirements to maintain current facilities to meet compliance standards while service requirements remains high. Operating within a new facility will allow the Trust to transform clinical services in order to provide high care on a sound financial basis.

Environmental Performance

Sustainability and Environmental Performance

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, smart and efficient use of natural resources and building healthy, resilient communities.

Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) and NHS Standards Contracts are met. In addition to this, we recognise the UK Government's commitment to take action on climate change with a target to cut carbon emissions by 100% by 2050 (also referred to as Net Zero).

Supporting the National Ambition

NHS England has launched 'For a Greener NHS' campaign in January 2020 to help address and support the NHS organisations and their staff to tackle climate change and help meet the UK's Climate Change Act ambition of achieving Net Zero. This ambition will help the NHS improve the environment, clean the air, reduce the carbon emissions, reduce the impact on the limited natural resources, improve health & wellbeing and reduce pressure on our NHS services by preventing illness. In preparation for its delivery, the NHS Sustainable Development Unit (SDU) has published a revised Green Plan guidance. The achievement of this ambition of Net Zero by 2050 depends on how quickly the country as a whole succeeds.

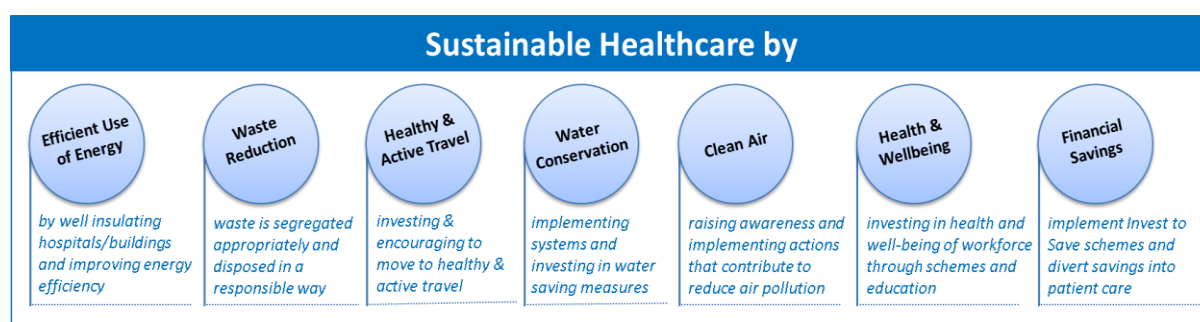
It is our duty to contribute towards achieving Net Zero by 2050 both in our current activities and redevelopment plans.

Sustainable Healthcare

“A sustainable health and care system helps us develop systems that minimise health impacts and help develop preventative approaches”.

Although it is recognised that natural resources are rising in terms of cost, the Trust is committed to making the most of its social, environmental and economic assets to improve health both in the immediate and long term.

This is achieved by delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage. This involves giving particular attention to energy, travel, waste, procurement, water and infrastructure adaptation, as outlined below:



Looking Ahead

The Trust has made a corporate and strategic commitment to sustainability, and appointed a Sustainability Lead to help us drive this agenda. This is a new and exciting journey for all of us, and we are confident that with corporate team support and multi-stakeholder engagement we will be able to identify a multitude of opportunities that will help us achieve results in a very short time. We have successfully managed to move all Trust electricity supplies to 100% green / renewable electricity from 1 April 2020 and in the early months of 2020/21 we will be looking forward to achieving the following:

- operate zero to landfill domestic waste contracts
- Sustainability Lead's role engagement with wider teams (both internal and external stakeholders)
- Implementing initiatives that ensure sustainability is integrated within the organisation
- Implementing energy monitoring initiatives that enable us to proactively manage and deliver energy and carbon savings
- Developing a longer-term Sustainability Plan with specific targets
- Conducting staff and patient travel surveys so that we can further improve our healthy and active travel schemes
- Working on London RE:FIT Programme to implement a range of energy and carbon reduction initiatives

- Integrating sustainability at the out-set in all our redevelopment plans

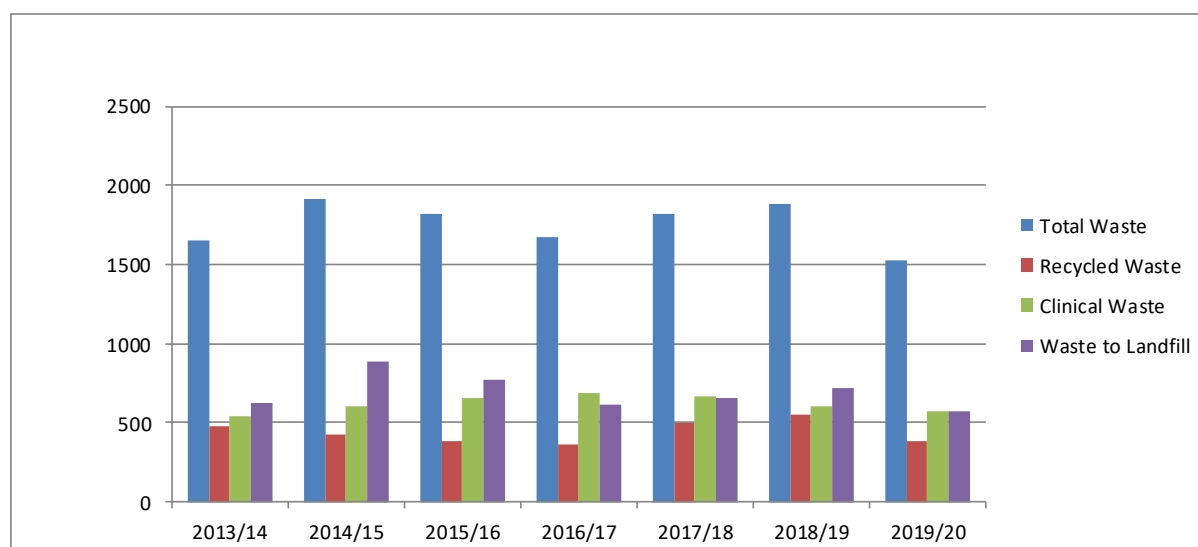
Our goal is to ensure that sustainability is considered in key policy areas, including estates and facilities, car parking management, waste management, transport & travel, business cases, procurement (environmental and social aspects), and suppliers' impact.

Waste reduction and minimisation

The Facilities waste & recycling service provides the safe collection, management and disposal of materials from our sites. The Trust ensures that its waste is segregated, managed, recycled and disposed of effectively in line with the Department of Health publication 'Safe Management of Healthcare Waste' and 'Waste Hierarchy' of the Department for Environment, Food & Rural Affairs. Waste minimisation efforts have been focused on reducing reliability on plastic-based packaging and plastic items and replacing with either cardboard based or biodegradable alternatives. All takeaway food in the Trust restaurants is served in compostable packaging. Food oil is recycled.

Annual Waste	Total Waste generated at Hillingdon and Mount Vernon Hospitals (in tonnes)	Recycled Waste materials Recovered (in tonnes)	Clinical Waste incinerated to produce steam that generated heat and hot water at Hillingdon Hospital (in tonnes)	Waste sent to landfill (in tonnes)
2013/14	1648	483	545	620
2014/15	1915	423	606	886
2015/16	1816	386	659	771
2016/17	1669	365	688	616
2017/18	1821	498	664	659
2018/19	1879	555	604	720
2019/20	1523	381	574	568

Annual waste graph for Hillingdon and Mount Vernon Hospitals



Green travel

The Trust continues to promote green travel for staff and users and the Trust Travel Plan Co-ordinator has undertaken a range of initiatives to encourage green travel in liaison with both the Local Authority and Brunel University. The Santander Cycle Scheme docking station has been a very popular addition to the Hillingdon Hospital site linking it with the university campus and Uxbridge town centre. We have added a further electric charge point and continue to invest in hybrid vehicles in our Trust fleet. Off-site parking is encouraged, and the Trust's large number of off-site parking spaces are fully used by Trust staff.

Our Challenges

Achieving sustainability in hospitals is always a challenge; the following will have an effect on how we deliver our sustainability commitments:

- Growing demand for services and increase in patient activity will add to the energy consumption and waste
- General water consumption and increase in travel related facilities
- Rise in utilities prices; we can only mitigate this through the invest to save schemes to reduce consumption
- The Trust has the second largest backlog of repairs for any hospital in the country presenting huge challenges for energy management resulting in limited/expensive solutions

Response to the potential impact of the UK's exit from the European Union

The Trust made preparations in 2018/19 for the potential impact of the UK's exit from the European Union, including planning for the case of a 'no deal' EU Exit, following recommendations in the Department of Health and Social Care's EU Exit Operational

Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers.

The Trust set up a Local EU Exit Group, to complete an assessment of any risks, covering the following:

- The seven key areas identified nationally.
- Potential increases in demand associated with wider impacts of a 'no deal' exit.
- Locally specific risks resulting from EU Exit.

In terms of governance, the Director of People and Organisational Development was the Trust's EU Exit Senior Responsible Officer, reporting to the Board with effect from January 2019 and the Corporate Risk Register included relevant risks and mitigations in respect of the UK's Exit from the EU and the potential impact was also reflected in other relevant risks.

The Trust has considered material risks, uncertainties and mitigation in relation to EU Exit planning under the following headings:

- Governance and infrastructure
- Medicines and vaccines
- Medical devices and clinical consumable goods (MDCC)
- Supply of non-clinical consumables, goods and services
- Workforce
- Reciprocal healthcare
- Research and clinical trials
- Data sharing, processing and access

A key focus throughout this period has been how we manage the impact of Brexit on our staff and their families, in particular how we can support them to remain and work in the UK and gain settled status. During this transition period, we have also worked to ensure any potential staffing shortages can be proactively addressed.

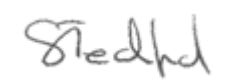
Important events since the end of the financial year affecting the Trust

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £95.4m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

COVID-19 had a significant impact on the Trust towards the end of the financial year. Updates on the Trust's response to this are provided throughout the document and specifically on pages 12 to 14.

Accounting Officer approval of the Performance Report

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2019/20.

A handwritten signature in black ink, appearing to read 'S Tedford', enclosed within a thin black rectangular border.

Sarah Tedford

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

24 June 2020

Accountability Report

Directors' Report

How we are organised

The Trust is run by a Board of Directors which met on eight occasions during 2019/20. The Board, led by the Chair, sets the vision and values of the Trust and works to promote the success of the organisation. It is responsible for the organisation's decision-making and performance to ensure the Trust delivers high quality, safe and efficient services.

The Board of Directors comprises a non-executive chair; up to seven other non-executive directors; and up to seven Executive Directors one of which should be the Chief Executive. During the year, the Board agreed to appoint two additional executive directors who attend the Board but who are non-voting members. The Trust Board Secretary is an Officer of the Board, attends all meetings and ensures provision of effective secretariat and governance services.

The Chief Executive leads the Executive Team and is accountable to the Board for the operational delivery of the Trust's objectives. The Chair leads the Board and ensures its effectiveness. The Chair sets the agenda for Board meetings which includes a patient story, reports from standing committees and integrated quality and performance reports. The Board also regularly invites presentations by other staff to highlight issues of quality, safety and patient experience.

Well Led Framework

The Trust has had regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality. Further details are provided below and in the Annual Governance Statement. No material inconsistencies have been identified between the Annual Governance Statement, Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any subsequent action plans. Work is underway within the Trust to prepare for the next CQC visit which it is anticipated will take place in 2020/21.

In July 2019, the Board received and approved a completed action plan put in place to address recommendations from an external governance review undertaken in 2018/19. This confirmed all actions had been addressed or were significantly in progress the Executive can confirm all were fully completed within the financial year 2019/20 although it is recognised further improvement and strengthening on our governance arrangements and embedding these fully below the Board Sub Committee level will continue in 2020/21.

Topics which have supported us in the Well Led area across the year have included the development of our Board Assurance Framework and the development of our risk management systems and processes, our Quality Improvement Programme, and our strategic planning with the updating of our clinical services strategy and the

development of plans for our new hospital as well as laying the foundations for our divisional re-organisation which is progressing in earnest early in 2020/21.

With the establishment of the current executive team, the Trust commissioned NHSE and NHSI to undertake a review of the planning of the new Hillingdon Hospital, with the finalised Gateway report issued in October 2019. All the recommendations of the review were implemented with the Trust updating its clinical services strategy as part of the development of the Strategic Outline Case for a new hospital, the appointment of a highly experienced Redevelopment Programme Director, and ensuring that the programme governance arrangements were strengthened. These significant improvements have ensured that the programme has now been robustly established, which has been recognised by the DHSC in providing the Trust with £5m of capital funding to support the development of the new hospital.

A significant commitment was made by the Board in carrying out a comprehensive review (conducted by the Good Governance Institute, GGI) of the Board Assurance Framework (BAF), including arrangements for the identification, moderation and escalation of risk. This methodology has been embedded Trust-wide and underpins the Trust's governance structures and operations and is continually reflected upon by the Board Assurance Committees to improve quality.

Board of Directors, 2019/2020

Directors' details, together with their committee membership as at 31 March 2020, are given below. Board members declare their interests at the time of their appointment and annually. The register of directors' interests is published annually on our website on the Board of Directors' pages or can be obtained from the Trust Secretary. 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 our directors meet the "fit and proper person" test.

Company directorships and other declarations of interest or gifts and hospitality were declared by all Board members in year. The full register of declarations is available from the Trust Secretary.

Arrangements for the appointment and termination of appointment of non-executive directors are set out in the Trust's constitution. Non-executive directors are normally appointed for a period of three years and can be re-appointed for a further period of three years. Exceptionally a third term may be agreed.

In compliance with NHS Improvement's Code of Governance, no executive director holds more than one non-executive directorship of an NHS Foundation Trust or other organisation of comparable size and complexity.

Richard Sumray resigned as Chair on 30 April 2019 and Professor Elisabeth Paice was appointed on the same day by the governors as the Interim Chair. Her roles as Senior Independent Director (SID) and Deputy Chair passed to Richard Whittington in an interim capacity with the approval of the Council of Governors. Sir Amyas Morse was appointed as Chair on 1 October 2019 and at that point the Deputy Chair role reverted to Professor Elisabeth Paice and Richard Whittington took up the substantive SID role.

Non-Executive Directors

Sir Amyas Morse: Trust Chair

Chair of the Board of Directors

Chair of the Remuneration Committee and Chair of the Council of Governors

Sir Amyas Morse was appointed on 1 October 2019. Sir Amyas has a distinguished career in finance in both the private and public sector; recently as Comptroller and Auditor General of the National Audit Office (NAO), leaving a much-respected NAO after his 10-year tenure. Sir Amyas has worked for Coopers & Lybrand, reforming as PricewaterhouseCoopers taking on a global role. He became a member of their UK and Global boards. He joined the Ministry of Defence in July 2006 as the Defence Commercial Director, before joining the National Audit Office. Sir Amyas was Chair for the Board of Audit for the United Nations between 2011 and 2017. He currently serves as Finance Committee Chair for the Royal College of Surgeons. Since January 2020 he has also been Chair of London North West University Healthcare NHS Trust.

Professor Elisabeth (Lis) Paice OBE: Non-Executive Director and Deputy Chair

Vice Chair of the Board of Directors

Chair of Quality and Safety Committee, Vice-Chair of Audit and Risk Committee, Member of Finance and Performance Committee.

Lis Paice was appointed 1 February 2014. Lis was Consultant Rheumatologist at the Whittington Hospital for 15 years. She then became Dean Director of London Deanery, overseeing the postgraduate training of doctors. She chaired the North West London Integrated Care Programmes, later taking the lead on patient engagement for the North West London Integration Pioneer. Lis is a qualified coach and works with London Leadership Academy to develop and deliver leadership programmes for staff and patients. She was named 'NHS Mentor of the Year' in 2010 and in 2011 received OBE for services to Medicine. Lis brings clinical knowledge, experience of the wider NHS and integrated care, patient engagement and leadership skills. Her term of office expired on 31 January 2020 and has been further extended to 31 January 2021.

Richard Whittington DL: Non-Executive Director and Senior Independent Director

Chair of Audit and Risk Committee, Member of Quality and Safety Committee

Richard Whittington was appointed 1 October 2014. He is a chartered accountant and was a Senior Partner at KPMG where he was latterly in charge of the Infrastructure Government and Healthcare Audit Group which provided services to the health and public sectors and building and construction companies. He has held a number of non-executive positions and is now Vice President of the Community Foundation of Surrey, a Trustee of Surrey Care Trust, a Trustee of the Gordon Foundation and Chairman of the Governors of Gordon's School Academy Trust Limited. Richard was appointed Interim Senior Independent Director in May 2019 and acted as interim Deputy Chairman from May to October 2019. He became the substantive SID in October 2019. Richard brings senior financial, audit and corporate governance experience to the Board, together with estates and capital investment expertise. He is the link Non-Executive Director to the Estates and Procurement divisions.

Dr Linda Burke: Non-Executive Director

Chair of People Committee, Vice-Chair of Finance and Performance Committee

Linda Burke was appointed as a Non-Executive Director in April 2019 having previously held the role of Associate Non-Executive for the previous two years. Linda is also a Councillor for the London Borough of Ealing and a Governor at Drayton Green Primary School. She has Board experience in health, higher education and not-for-profit, most recently as Executive Director, Education and Quality at the Royal College of Obstetricians and Gynaecologists. Before that Linda was Pro Vice Chancellor for the Faculty of Education and Health at the University of Greenwich. Linda joined the University from the Nursing & Midwifery Council, where she was Head of Revalidation. Linda has been Head of Strategy and Development at NHS London and Associate Dean at St George's Medical School & Kingston University. An Economic & Social History graduate, Linda went on to train as a nurse. Linda has a PhD, Masters in Education and is a qualified coach.

Janet Campbell: Non-Executive Director

Member of the People Committee, member of the Charitable Funds Committee and Board lead for Equality and Diversity

Janet Campbell was appointed 1 August 2019. Janet's professional experience is in Human Resources management and organisational development, working across a range of public and private sector organisations. Since September 2017, she has been an independent HR consultant / interim HR Director, working with senior leadership teams to develop and implement HR strategy, provide interim leadership to the HR function, as well as coach and advise senior executives on a range of people-related matters. Prior to this, she was the HR Director at Ofcom (the UK's communications regulator). Janet has two other non-executive roles, one as the Senior Independent Director on the Board of British Fencing (the governing body for the Olympic sport of fencing) and the other as a Trustee on the Board of the National Youth Jazz Orchestra.

Catherine Jarvis: Non-Executive Director

Chair of Finance and Performance Committee and Vice-Chair of Quality and Safety Committee

Catherine Jarvis was appointed in April 2019. Catherine has extensive experience of the public and not-for-profit sector organisations with a focus on governance, finance and performance. She is a qualified accountant and started her career with the National Audit Office. She is currently also Non-Executive Director and SID with Barnet Enfield and Haringey Mental Health NHS Trust, and Non-Executive Director with Achieving for Children (Community interest Company (CiC) and the Independent Office for Police Conduct. She was previously Vice Chair and Non-Executive Director at First Community Health and Care (CiC). Prior to this Catherine was Strategic Advisor to the CEO of Achievement for All – (a national education charity set up to transform the lives of vulnerable children) and Director for PricewaterhouseCoopers Limited Liability Partnership where she led the Children's Services team delivering services across education, health and social care.

Simon Morris: Non-Executive Director

Chair of the Charitable Funds Committee, Vice-Chair of the People Committee, member of the Audit and Risk Committee

Simon Morris joined the board in May 2019 following a 30-year career in the arena of health and social care. He is a qualified social worker having worked for eight years in local government, the last post being a Commissioning Manager for the London Borough of Hounslow. He then moved to the voluntary sector where he was the Chief Executive Officer (CEO) of one of the top 100 charities in the UK for 15 years. He has a degree in sociology and applied social studies and an MBA from Brunel/Henley. He now holds a number of Non-Executive Director posts in both the commercial and voluntary sector as well as being involved in a start-up using technology to reduce loneliness amongst older people.

Non-Executive Directors who left the Trust during 2019/20

Richard Sumray

Chair (until April 2019)

Richard Sumray was appointed as Chair in November 2014 and resigned from his post in April 2019. Richard has been involved in the NHS for over 30 years as a Non Executive Director and Chair and has held wide ranging roles in Health including Chair of NHS Haringey Primary Care Trust and member of the London Health Commission as well as Chairing the London 2012 Fourm working with the London organising committee of the Olympic Games and was also a member of the Metropolitan Police Authority.

Professor Soraya Dhillon MBE

Non-Executive Director (until December 2019)

Soraya Dhillon was appointed in February 2014 and resigned from her post in December 2019 during the 2019/20 year Soraya sat on the Remuneration; Finance and Performance, the Audit and Risk and Nominations Committees. Soraya holds a PHD in Clinical Pharmacology and has held a number of key senior academic and clinical posts. Soraya was previously the Chairman of Luton and Dunstable Hospital NHS Foundation Trust and a former member of the General Pharmaceutical Council. She is a fellow of the Royal Pharmaceutical Society and was awarded an MBE for contribution to health services in Bedfordshire.

Rima Makarem

Non- Executive Director (until May 2019)

Rima Makarem was appointed as an Interim NED in February 2018 and resigned from her post in May 2019. Rima has had a distinguished career in the healthcare and pharmaceutical industries and holds a wide ranging portfolio of non-executive positions. She also brought a wealth of experience from the private sector having been director of competitive excellence at a global pharmaceutical company which followed roles at management consultancy firms.

Carl Powell

Non-Executive Director (until April 2019)

Carl Powell was appointed on 1st May 2016. Carl is a Fellow of the Royal Institution of Chartered Surveyors, a Certified Valuation Appraiser and a Town Planner. He was formerly Chief Executive of Pell Frischmann Limited (PF) and Conesco International, consulting engineering firms providing financial and management services worldwide. He continues to work with PF and is a NED on several commercial infrastructure

investment companies. Appointed in 2017, he is also a Lay-Chairperson at Kings College Hospital assisting with AAC Consultant appointments. Previous positions include Managing Director of two financial services companies and Director of Planning and Transportation for Westminster City Council. He has also served as a Non-Executive Director at CNWL and East London and City Mental Health Foundation Trust. During his time with the Trust he sat on the Audit and Risk Committee, the Finance and Transformation Committee, the Charitable Funds Committee, the Nominations Committee and Remuneration Committee. He was also the NED link for Cancer and Clinical Specialism Services as well as being the Boards Revalidation Champion.

Executive Directors

Members of the Board

Sarah Tedford – voting

Chief Executive: Executive Director

Sarah Tedford was appointed on 26 November 2018. Sarah came to the Trust from Manchester Royal Infirmary, Manchester University NHS Foundation Trust where she had been appointed Chief Executive in March 2018. She spent the six months prior to this on secondment to NHSI/NHSE as Winter Director London to provide assurance on the systems and processes in place to monitor delivery of the National A&E standard across London. Previously she was Chief Operating Officer at Barking, Havering and Redbridge University Hospitals NHS Trust, helping the Trust to exit 'Special Measures'. Before this she was at Kingston Hospital NHS Foundation Trust as Deputy Chief Executive, a position she acceded to in May 2011. Sarah brings extensive experience of NHS leadership with a focus on strategy, performance and quality and a track record of achievement.

Jason Seez – voting

Deputy Chief Executive Officer and Director of Strategy: Executive Director

Jason Seez was appointed in February 2019. Jason came to the Trust from Barking, Havering and Redbridge University Hospitals NHS Trust where he was Executive Director of Strategy, Transformation and Infrastructure. Jason is an experienced NHS manager and is taking special responsibility for driving the effort to secure a new hospital, transform services, strengthen joint working with Hillingdon Health and Care Partners and London North West University Healthcare NHS Trust and improve our corporate governance.

Dr Catherine Cale – voting

Medical Director: Executive Director

Catherine Cale was appointed in February 2019 on an interim basis and substantively from August 2019. Previously Catherine was the Deputy Regional Medical Director, NHS Improvement (NHSI) London and was GIRFT (*getting it right first time*) Clinical Ambassador in London. Her prior experience includes being the Medical Director of North Middlesex University Hospital and Interim Medical Director at Great Ormond Street Hospital for Children NHS Foundation Trust. Her clinical background is as a Consultant in Paediatric Immunopathology and Immunology. Her areas of strength

include clinical quality improvement and strategic experience, NHSI and GIRFT, experience in an acute setting with demonstrable experience of clinical governance and risk management. She has a strong background in financial management of clinical services partnership/system working. Catherine has responsibility for Patient Safety, and is the Responsible Officer for the Trust.

Jenny Greenshields – voting

Director of Finance Executive Director

Jenny Greenshields was appointed in April 2019 and stepped down at the end of March 2020 as the Director of Finance moving to a secondment role with North West London CCGs from April 2019. Jenny is a member of the Chartered Institute of Public Finance and Accountancy and has over 25 years of experience in NHS Finance. She joined the Trust from Moorfields Eye Hospital NHS Foundation Trust. Previously she has worked in a number of organisations in North West London. She holds an MSC in Economic Evaluation in Healthcare. Jenny was also a lay member of the Board of Trustees of SOAS (University of London). At the Trust Jenny held Board level responsibility for Finance, Procurement services, the Trust's Information Services and Information Technology functions and was the Trust's Senior Information Risk Owner.

Camilla Wiley – voting

Chief Nurse and Director of Infection Prevention and Control - Executive Director

Camilla Wiley was appointed on in October 2019, having previously been the Director of Nursing at the Royal National Orthopedic Hospital and immediately prior to joining the Trust, Hospital Director and a Divisional Operational Director at the Royal Free. Camilla brings a wealth of experience having spent over 30 years in the NHS, including 18 years in Emergency Departments. One of her key priorities is to reinforce basic nursing standards, focusing on professionalism and accountability to ensure our patients receive excellent, appropriate and safe nursing care. Camilla is taking a lead on developing a culture of safety in the Trust.

Tina Benson – voting

Chief Operating Officer (COO) - Executive Director

Tina Benson was appointed on 16 December 2019. Tina is a qualified radiographer who got her first clinical job at Hillingdon Hospital. This was followed by some years at the Royal Free Hospital in a variety of clinical and managerial roles, at London North West Hospitals as a manager and Deputy COO, and then as Deputy COO, Hospital Director, at West Middlesex Hospital and brings extensive experience of operational leadership.

Tahir Ahmed – non voting

Director of Estates and Facilities - Executive Director

Tahir Ahmed joined the Trust on 1 June 2019. Tahir has worked as a Director of Estates and Facilities in a number of London Trust for over 20 years where he managed and delivered numerous large healthcare developments. Tahir is a member of the Royal Institution of Chartered Surveyors and active ambassador of Knowledge Transfer Partnership between academia and the industry. Tahir's central interests lie within complex healthcare construction projects, intelligent buildings and hospital innovation. At the Hillingdon Hospitals, Tahir holds Board level responsibility for Estates, Facilities

and Capital Developments, including the future redevelopment of the hospital estate.

Terry Roberts – Non Voting

Director of HR and Organisational Development - Executive Director

Terry Roberts joined the Trust in 2016 and resigned from his post in February 2019. Prior to joining the Trust Terry was Director of People and Organisational Development at Kingston Hospital Foundation Trust and has held senior HR positions at Bart's Health, Ealing Hospital, St Mary's Hospital and North West London Hospital as well as working at the Department of Health as a National HR Advisor. Terry holds a Master's degree in Human Resources Management and is a fellow of the Chartered Institute of Personnel and Development (FCIPD). He completed the Top Managers programme with the Kings Fund and is a certified Coach and Mediator. Terry is also a Director of Transform Consulting Ltd.

Individuals who held interim/acting Executive Director Non-Voting roles during 2019/20:

Melissa Mellett

Interim Chief Operating Officer (September 2019 – December 2019)

Melissa Mellett has been in the organisation as Director of Operational Performance since 2016 with a primary focus on transforming how the Trust delivers patient flow, protecting and strengthening the elective and cancer programme. Prior to this she worked at Chelsea and Westminster Hospitals in a variety of senior operational roles.

Melissa is driven by improving patient outcomes and to continuing to make Hillingdon Hospitals NHS Foundation Trust a great place to work.

Dean Spencer

Interim Chief Operating Office on secondment from NHSE/I (February 2019 – June 2019)

Dean Spencer joined the trust in February 2019 on secondment from NHS Improvement where he was the Delivery and Improvement Director and the senior relationship lead for NHS Providers in North West London. Prior to that Dean worked for the Trust Development Authority, first as regulator across the north region and then as development director leading the work with Virginia Mason Institute and the NHS. Prior to that Dean was the Director of Planning and Performance at Bradford Teaching Hospitals. Dean has had an extensive career in all sectors of the NHS after originally joining as general management trainee.

Professor Siobhan Gregory

Interim Chief Nurse (from May 2019 – August 2019)

Siobhan joined the Trust as Chief Nurse on secondment from NHSE/I on a part time basis from Feb 2019- October 2019. Siobhan's substantive role is Director of Nursing Quality and Leadership – London with NHSE/I. This role supported Trusts to improve and maintain high quality standards of patient care - ensuring that those with an

inadequate CQC rating improved. Prior to working at NHSI, Siobhan was Chief Nurse at Hounslow and Richmond Community Trust from June 2010- March 2018. Prior to this

Ema Ojiako

Acting Director of People and Organisational Development (from February 2020 – end of May 2020) - Acting

Ema Ojiako joined the Trust in February 2020 as the substantive Deputy Chief People Officer, and acted into the Chief People Officer role pending recruitment of the substantive post holder. Ema is a Fellow of the Chartered Institute of Personnel and Development (FCIPD) and has held senior Human Resources roles in public and private healthcare. Alongside her full time role she is an Employment Tribunals Lay member with HMCTS, and a Trustee on the board of Directors of an international Charity. She also works with the CIPD as a schools Enterprise Advisor supporting senior leaders to enhance their career strategies and employer engagement plans.

Piers Young – Hospital Director – operations (June to September 2019)

Piers Young consulted as a Hospital Director from 3 June to 30 September 2019 and continued to support the organisation's elective programme for a further four months as part of the team from MBI Healthcare Technologies. Piers came with detailed experience in the NHS and at acute provider level. He previously worked as Deputy Chief Operating Officer and also Director of Performance at Barking, Havering & Redbridge University Hospitals NHS Trust, where he was pivotal in the return to reporting and delivery of the RTT constitutional standards as well as sustainably delivering cancer waiting time standards. Piers has held a number of senior operational and transformational roles across non-elective and elective settings, both at a local and national level. He is also a Director with NHS Elect.

Other Directors – in attendance only at Board

Sarah Pinch Chart. PR, FCIPR, MloD.

Interim Director of Communications (until the 28 March 2020) on secondment from Pinch Point Communications – Non Voting

Sarah Pinch started her career as a BBC journalist and director. For the last 20 years she has worked as a director for corporate communications. She has extensive NHS experience, winning the Institute of Directors and Chartered Institute of Public Relations (CIPR) PR Director of the Year award in 2011 for her work with the board at University Hospitals Bristol NHS Foundation Trust. Sarah set up Pinch Point Communications in 2013 and in December 2018 joined the board of The Hillingdon Hospitals NHS Foundation Trust as Interim, part-time, Director of Communications and Engagement, a post she held until February 2020.

Sarah has also advised many organisations in advance of their CQC inspections and responding to the outcomes. She is a Non-Executive Director of the Health and Safety Executive, an Independent Advisor and Chair of the Remuneration Committee for The Welsh Assembly Commission and Chair of The Taylor Bennett Foundation. She is an

elected Fellow and was President for the CIPR in 2015, she is a Freeman of the Company of Communicators and the City of London.

Mike Sims

Trust Secretary (until November 2019)

Michael Wood

Interim Trust Secretary (from November 2019 to 30 April 2020) via Good Governance Institute

Executive Directors who joined the Trust after the end of the financial year 2019/20

David Meikle

Director of Finance – Voting Executive Board Director

David Meikle joined the Trust in January 2020 to provide support to the Director of Finance and became Interim Director Finance in April 2020.

David is a member of the Chartered Institute of Public Finance and Accountancy and has over 25 years of experience as a Finance Director in the NHS. He joined the Trust from NHS Kent and Medway where was Turnaround Director. Previously he has worked in a number of organisations in Kent, Sussex and also in the east of England. David also holds an MBA. He has Board level responsibility for Procurement services, the Trust's Information Services and Information Technology functions and is currently the Trust's Senior Information Risk Owner.

Belinda Norris

Chief Transformation Officer (from May 2020)

Justine McGuinness

Head of Communications and Engagement (from 31 March 2020)

Deborah Lawrenson

Trust Secretary (from May 2020)

Sue Smith

Chief People Officer (from June 2020) Non-Voting Executive Board Director

Statement on the balance, completeness and appropriateness of the membership of the Board

The Board of Directors Nominations Committee is responsible for reviewing the structure, size and composition of the Board and makes recommendations to the Council of Governors on the skills required for any upcoming non-executive director appointments.

As outlined in the biographies of Board members, the Board comprises individuals with senior level experience in the public and private sectors, across a range of disciplines including clinical and patient care; health service leadership; commercial development; business transformation and change management; finance; governance; risk management; and human resources. The Board therefore confirms that the current composition is considered to be appropriate. Taking account of the NHS Foundation Trust Code of Governance published by Monitor, the Board considers the current Chairman and all of the non-executive directors to be 'independent'.

Performance evaluation of the Board and its Committees

The description of each director's experience demonstrates the balance and relevance of skills and expertise of the Board. To help the Board assure itself in this regard it undertakes a collective self-assessment of its performance and governance practices. The Chair appraises the Non-Executives and the Chief Executive. The Chief Executive appraises the executives. The SID appraises the Chair, having taken soundings from the Lead Governor, Chief Executive and fellow Non-Executive Directors. The Council of Governors reviews the appraisals of the Chair and Non-Executives and their objectives for the year ahead.

The Good Governance Institute (GGI) was commissioned in 2019 by the Trust to undertake a Structural Review and Development Programme focusing on the sub-committee and management group structures, to assess how these operate in practice and their fitness for purpose, and to make recommendations for governance improvements as required. The review was conducted in two phases, the first of which was diagnostic in focus, and the second supported improvement and development changes which were put in place during 2019/20. The programme ensured the Trust had robust systems and processes in place to support the well-ordered transition of a number of Board level positions over the course of the year whilst overseeing a significant programme of strategic and operational delivery. Strengthened arrangements were put in place including the following:

- Putting in place a new Board Assurance Framework developed through comprehensive Board engagement
- Aligning the committee structure and discussions at the Board and its sub committees more effectively with our strategic priorities and the Board Assurance Framework
- Putting in place a People Committee
- Updating Terms of Reference for all Board sub committees
- Development of new Terms of Reference for the Capital Review Group and the Trust Management Executive
- Undertaking a structural review of governance arrangements
- Putting in place work plans for the Board and its sub committees

- Putting in place a strengthened governance structure for digital/IT
- Putting in place strengthened arrangements with regard to Risk Management
- Undertaking Board and Committee self-assessments

The Trust will undertake further work in 2020/21 to further embed and strengthen corporate governance arrangements in particular in respect of the governance structure sitting beneath the Board Sub Committees.

Meetings of the Board, its Committees and the Council of Governors 2019/20

The Board

The Board acts as the body which provides assurance that the Trust meets its statutory obligations and that its overall performance (including safety and quality) is of the standard required, either directly or through its Committee structure.

The Board set the strategic vision and direction of the Trust for the year 2019/20, agreeing the annual Operating Plan, the Budget and the Capital Programme early in the year.

In 2019/20 the Board met eight times, seven times in public, with a private session on each occasion to deal with confidential matters. In order to make Board meetings accessible to the public and governors, two Board meetings were held at Mount Vernon Hospital and five at Hillingdon Hospital.

The eighth and final meeting of the year, on 24 March 2020, was held by telephone conference in view of COVID-19 and was, therefore, not open to the public, although the public were invited to submit questions in advance of the meeting. Board papers for the public meeting are published on the Trust website.

The Board also held four seminars and three away-days to develop relationships among the directors, to develop the Board Assurance Framework and discuss the issues facing the Trust in greater depth. Topics covered included our CQC inspection report, our improvement programme, governance improvements, risks and opportunities regarding our estate, and our clinical strategy.

Board Attendance, 2019/20

The following table outlines Board member attendance at Board and Committee meetings during 2019/20 against a total possible number of meetings for which the individual was a member of a Committee or where they are an Expected Executive Director attendee.

Board Member	Board	ARC	QSC	FPC	NC	RC	CFC	PC
Sir Amyas Morse	5/5	-	-	-	1/1	2/2	-	1/3
Professor Lis Paice	8/8	4/6	3/3	7/7	1/1	2/2	3/3	-
Richard Whittington	7/8	6/6	10/12	9/12	1/1	2/2	-	-
Professor Soraya Dhillon	3/6	4/6	8/9				-	-
Dr Linda Burke	8/8	-	1/1	10/1 2	1/1	2/2	-	5/5
Simon Morris	7/8	5/6	1/1	1/1	1/1	2/2	3/3	5/5
Catherine Jarvis	6/8	-	11/12	11/1 2	1/1		-	-
Janet Campbell	7/7	-	-	-	1/1	2/2	2/2	5/5
Sarah Tedford	7/8	4/6	6/12	12/1 2	1/1	1/1	-	5/5
Jason Seez	8/8	5/6	7/12	12/1 2	-	-	-	-
Dr Catherine Cale	6/8	1/1	12/12	-	-	-	-	5/5
Jenny Greenshields	7/8	4/6	3/12	10/1 1	-	-	2/3	-
Camilla Wiley	5/5	1/2	5/6	-	-	-	-	2/2
Tahir Ahmed	4/7	6/6	7/12	12/1 2	-	-	-	-
Terry Roberts	6/6	-	-	-	-	-	1/3	4/4
Tina Benson	2/3	1/2	-	-	-	-	-	-
Siobhan Gregory	1/2	-	2/4	-	-	-	-	1/1
Dean Spencer	1/1	-	-	2/2	-	-	-	-
Melissa Mellett	3/4	-	-	2/4	-	-	-	-
Ema Ojiako	2/2	-	-	-	1/1	-	-	1/1
Piers Young	2/2	-	-	2/4	-	-	-	-

Committees of the Board

The Board has seven Committees, each chaired by a Non-Executive Director. The Terms of Reference of each committee were refreshed during 2019/20 as part of our governance review. The People Committee was a new committee, established in September 2019.

- Audit & Risk Committee (ARC)
- Quality and Safety Committee (QSC)
- Finance and Performance Committee (FPC)
- People Committee (PC)
- Board of Directors Nomination Committee (NC)
- Board of Directors Remuneration Committee (RC)

- Charitable Funds Committee (CFC)

Audit and Risk Committee

The Audit and Risk Committee met on seven occasions during 2019/20, including two special meetings. As at 31 March 2020, the Trust's Audit and Risk Committee was comprised of three non-executive directors. The Committee meetings were attended by the internal and external auditors, the Local Counter Fraud Specialist, the Finance Director and the Chief Nurse, responsible for clinical and corporate governance.

The Committee is responsible for providing an independent and objective review of the Trust's systems of internal control (both financial and non-financial) and the underlying assurance processes in place at the Trust. The Committee is also responsible for ensuring that the Trust has independent and effective internal and external audit functions and overall responsibility for organisation risk management and for reviewing the effectiveness of these. The Committee is responsible for making recommendations to the Council of Governors on the appointment and removal of the external auditor.

The Trust's internal audit service is provided by KPMG. Internal audit provides an independent and objective opinion on risk management, control and governance by measuring and evaluating the effectiveness by which organisational objectives are achieved. Through detailed examination, evaluation and testing of the Trust's systems, internal audit plays a key role in the Trust's assurance processes. The Head of Internal Audit overall opinion for the period 1 April 2019 to 31 March 2020 is that: "Partial Assurance with improvements required" can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The scope and work of the Trust's internal auditors, is set out in a charter approved by the Audit and Risk Committee. The Committee agrees a work plan for internal audit at the start of each financial year, taking account of the risk assessment undertaken by internal audit. The Committee reviews the findings of internal audit's work against this plan at its meetings. The Head of Internal Audit reports to the Committee and the relationship with internal audit is managed by the Director of Finance. The Head of Internal Audit has a right of direct access to Committee members.

Key issues considered by the Committee during the year included: The Committee comprehensively reviewed the Board Assurance Framework (BAF) and the Corporate Risk Register, holding a special meeting in September 2019 specifically to endorse a new BAF methodology framework to be adopted by the Board and its Committees, and embedded Trust-wide. The Committee continued to review and monitor the increasing level of risk in respect of the Trust's deteriorating estate, receiving regular reports (including on fire safety and water quality) from the Director of Estates and independent consultants.

The Committee also received reports from Trust's Local Counter Fraud Specialist and was responsible for reviewing the annual financial statements, with particular focus given to major areas of judgment and changes in accounting policies, discussing with the External Auditor the Trust's status as a going concern, and reviewing the draft

Annual Governance Statement. The Committee also reviewed the assurance in place in respect of data quality, information governance and health and safety. A self-assessment was carried out during the year. The Annual Governance Statement provides a further update on the responsibilities of the committee.

Quality and Safety Committee (QSC)

The QSC met monthly during 2019/20, providing the Board with assurance on three key areas of quality: safety, effectiveness and patient experience. QSC is responsible for ensuring appropriate arrangements are in place for measuring and monitoring quality, challenging assurance and determining what needs to be drawn to the Board's attention. The QSC identifies and escalates potential risks to the quality of services, shares learning from serious incidents and deaths, and ensures that agreed actions are implemented. The Committee reviews compliance and receives assurance on meeting regulatory standards set by the CQC.

The QSC receives reports from the Risk and Compliance Group and the Quality Oversight Group. It reviews the Hillingdon Improvement and CARES+ programmes and the Integrated Quality and Performance Report. Each meeting includes a deep dive into a clinical area, recent examples being the ED, Maternity Services and End of Life. Key issues considered include our response to COVID-19, falls, pressure ulcers, serious incidents, complaints and discharge summaries. A self-assessment was carried out during the year.

Finance & Performance Committee (FPC)

The FPC meets monthly and provides advice, oversight and scrutiny of all aspects of financial strategy and planning and operational performance of the Trust, and on commercial strategy, strategic investments and the development of Trust infrastructure. In relation to operational performance the Committee scrutinises the Trust's performance against operational constitution standards and, where trajectories are not being met, the Committee seeks assurance that clear plans are in place to recover the position. It examines key aspects of financial and operational performance and reviews costing and benchmarking work and provides assurance to the Board on the management of financial and operational risk.

The Committee also reviews the annual capital programme and reports to the Board on major capital investments and programmes including the redevelopment of the Hillingdon Hospital. In addition, the Committee oversees the development and delivery of the digital strategy, including digital, cyber and data security.

People Committee

The People Committee is a new committee, established to oversee issues of workforce, education and development. It meets monthly and has met three times in 2020. It provides advice, oversight and scrutiny of all aspects of recruitment, development, support and retention of the Trust's workforce. Key issues considered have been

responding to the findings of the national staff survey; equality, diversity and inclusion; staff health and wellbeing, recruitment and retention and new ways of working.

Charitable Funds Committee (CFC)

The CFC exists to provide oversight and direction to the Hillingdon Hospital Charitable Trust. The Trustee of the charity is the Trust Board. During 2019/20, the Committee met on three occasions. The committee has looked at the development of the charity to ensure its objectives and work supports the work of the Trust. It has approved the recruitment of a new post Corporate Partnerships Manager to develop relationships with local companies and business to support the hospital both in terms of gifts in kind, particularly at Christmas, but also financial and hosting of corporate social responsibility employee volunteering within the Trust.

The year has been a successful one from a financial perspective. The committee has also discussed plans to develop a capital project to support the maternity ward by building a bereavement suite. The Committee has considered ways in which the charity can support the new build for the hospital in the coming years.

Board of Directors Nominations Committee

The Board of Directors Nominations Committee met twice during 2019/20 and comprises of all non – executive directors and the Chief Executive except where it is dealing with the appointment or removal of the Chief Executive. The committee is Chaired by the Chair of the Trust Board. The Director of People and Organisational Development and the Trust Secretary are in attendance. The committee leads the process for Executive Board appointments, Non-Executive and Executive succession planning and evaluation to ensure the Board has the right skill mix to effectively lead the organisation.

Board of Directors Remuneration Committee

The Board of Directors Remuneration Committee met once during 2019/20 and comprises of all non – executive directors and the Chief Executive. The Committee is chaired by the Chair of the Trust Board. The Director of People and Organisational Development and The Trust Secretary are in attendance. The Committee sets Executive annual objectives, reviews performance and then sets pay based on a thorough appraisal of performance.

Governors' Report

Council of Governors

The role and powers of the Council of Governors statutory duties are set out in the Health and Social Care Acts of 2006 and 2012 and in summary are:

- To hold the non-executive directors to account for the performance of the Board
- Appoint the non-executive directors of the Trust, including the Chair and agree their remuneration
- Approve the appointment of the CEO as recommended to them
- Appoint the Trust's Auditor
- Approve changes to the Constitution
- Receive the Trust's Annual Report
- Approve "significant transactions" and may choose to set out the definition(s) of this in the Trust's constitution

The composition of the Council of Governors is determined by the Trust's Constitution

As of 31 March 2020, there were 24 members of the Council of Governors: 13 elected to represent the public members, seven elected to represent the staff members, and five appointed by partner organisations (Hillingdon Council, Hillingdon CCG, the London Ambulance Service, Hillingdon Healthwatch, with a vacancy in respect of the Trust's Joint Negotiating & Consultative Committee). Governors are normally appointed for a term of three years. By having publically-elected and appointed governors representing the local area, the Trust ensures the public interests of patients and the community are represented. In 2019/20 the Council of Governors met four times in public and held one extraordinary meeting in May 2019 to receive the resignation of the Chair.

Governor	Meetings attended
Graham Bartram (Public)	5/5
Ian Bendall (Public)	4/5
Desmond Brown (Public)	4/5
Ian Burnell (Public)	5/5
Tony Ellis (Public)	5/5
Rosemary Jenkins (Public)	5/5
Robin Launder (Public)	4/5
Ahmet Mustafa (Public)	5/5
Kamran Qureshi (Public)	4/5
Mohan Sharma (Public)	4/5

Rekha Wadhwani (Public)	5/5
Amanda O'Brien (Rest of England)	4/5
Dr Arindam Basu (Staff)	3/5
Jack Creagh (Staff)	5/5
Lubna Hussain (Staff)	4/5
Stephen Ihuanne (Staff)	1/5
Sheila Kehoe (Staff)	4/5
Liz Bunker (Staff)	4/5
Gillian Pearce (Staff)	5/5
Lynn Hill (Appointed)	5/5
Dr Angela Joseph (Appointed)	4/5
Mary O'Connor (Appointed)	4/5
Natasha Wills (Appointed)	4/5

Governors are required to declare any relevant interests which are then entered into the publicly available Register of Governors' Interests. The Register is formally reviewed by the Council of Governors annually and is available from the Trust Secretary. Contact with individual governors can be made by request through the Trust Secretary.

Lead Governor

The Council of Governors elects one of the Public Governors to be the 'Lead Governor'. The main duties of the Lead Governor are to:

- Act as a point of contact for NHSE/I should the Regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.
- Be the conduit for raising with NHSI/E any Governor concerns that the Foundation Trust is at risk of significantly breaching its Licence, having made every attempt to resolve any such concerns locally.
- Chair such parts of meetings of the Council of Governors as cannot be chaired by the Trust Chair or Deputy Chair due to a conflict of interest in relation to the business being discussed.

Tony Ellis was Lead Governor for the whole of 2019/20. In this role, he met with the chair at least monthly throughout the year, agreed the agenda for Council of Governors and the governors' briefings and training sessions and attended bimonthly meetings of staff governors with Chair or Deputy Chair. He maintained close contact with the trust secretary to ensure good communication with governors.

Council of Governors Nominations & Remuneration Committee

The Nominations Committee met three times during 2019/20.

Membership:

- the Chairman of the Trust
- three public governors
- two staff governors and
- the Senior Independent Director (SID)
- the Director of HR and Organisational Development is in attendance
- the Trust Secretary is in attendance

The Council of Governors Nomination & Remuneration Committee leads the process for appointing or terminating the role of the Chairman and all Non-Executive Directors, making recommendations to the full Council of Governors; it is also responsible for recommending their remuneration, appraising their performance and setting their targets.

The Committee's main areas of work during the year were:

- To accept the resignation of the Chair in May 2019 and approve an Interim Chair
- To recruit and appoint a new Trust Chair
- To appoint a new Non-Executive Director
- To recommend to the Council of Governors the Chair and Non-Executive Director appraisals 2018/19 and their objectives for 2019/20
- To make recommendations in respect of remuneration of the Vice Chair.
When considering the appointment or reappointment of Non-Executive Directors, the Council of Governors takes into account the qualifications, skills, and experience required for each position

The Trust's constitution states that the Council of Governors can remove the Chairman or a Non-Executive Director provided that the resolution to remove the individual has the approval of three quarters of the members of the Council. The Council has not invoked this clause during the financial year.

Trust Board liaison with Governors and Members

Council of Governors

The Council of Governors normally meets four times a year. The meetings are held in public, followed where necessary by a private session. At the end of the public session, members of the public are invited to ask questions.

In addition, the Trust held four briefing sessions where governors were updated on important matters allowing governors the opportunity to raise issues of concern with the Chair. In 2019/20, the Trust decided to add a governors' training session after each briefing session. The training covered issues such as quality and safety, risk, finance and the role of the auditors. Each training session was led by an Executive and/or Non-Executive Director. The briefing and training sessions have been well attended and appreciated by Governors.

Staff governors meet with the Deputy Chair and Lead Governor bi-monthly to raise issues put forward by their constituencies. These issues are then discussed with the Chief Executive, and have led, for example, to the establishment of the Trust Health and Wellbeing Board.

Governors are invited to accompany Non-Executives on safety walkabouts to clinical areas of the Trust, so that they may observe the Non-Executives in action and form a view on how they interact with frontline staff.

A new 'Governor Observer' role was established in the refreshed Terms of Reference for the Board committees. Two Governor Observers may serve on each of Audit and Risk, Quality and Safety, Finance and Performance, People, and Charitable Funds Committees. Their role was clarified in a set of principles. Six governors have taken up this opportunity and have attended regularly. In March 2020, the COVID-19 pandemic had resulted in the Board committees being held by teleconference, a special teleconference was also held to bring Governor Observers up to date with the issues that had been discussed.

Attendance by Non-Executive Directors at the meetings of the Council of Governors

Non-Executive Board Member	Council of Governor meetings attended in 2019/20
Professor Soraya Dhillon (previously Non-Executive Director and Deputy Chair)	3/3
Professor Lis Paice (Non-Executive Director and Deputy Chair)	4/5
Richard Whittington (Non-Executive Director and Senior Independent Director)	3/4
Dr Linda Burke (Non-Executive Director)	4/4

Catherine Jervis (Non-Executive Director)	3/3
Simon Morris (Non-Executive Director)	3/3
Janet Campbell (Non-Executive Director)	2/2

Membership

The Foundation Trust membership is divided into two categories: public membership and staff membership.

Public membership

There are four public constituencies, which are collectively known as the Public Constituency. The majority of the public members are drawn from the three public constituencies which cover the electoral wards in Hillingdon borough together with several neighboring electoral wards.

The fourth public constituency covers all other electoral areas in the rest of England. Public membership is open to individuals aged 16 years or over living within the Public Constituency who are not eligible to be a staff member of the Foundation Trust.



Public Membership at 31st March 2020

At 31st March 2020, the Trust had 4703 public members. The table illustrates the number of public members for each constituency compared to the total population. The objective is to achieve a membership broadly equal to the population base.

	31 March 2020	% of membership	Population base	% of area
Hillingdon Central	1,742	37.0%	196,100	39.2%
Hillingdon North	884	18.8%	106,119	21.2%
Hillingdon South	1,917	40.8%	198,503	39.6%
Rest of England	160	3.4%	0	0%
Total	4,703	100.0%	500,722	100%

The Trust complied with the General Data Protection Regulation (GDPR) in May 2018 and wrote to all members to seek their consent to receiving future communication. At the time 99 members asked to be removed from the membership and a further 1611 members did not respond to the email sent to them, they were therefore removed as members. For those members who have chosen to receive communication by post, and did not respond with their communication preferences, the Trust is able to retain them as members.

The Trust is committed to working over the coming year to building back up its membership numbers and in particular recruiting members from the diverse population served by the Trust. This will be linked with our engagement work with our communities on the strategic plans for the build of our new Hospital.

Membership is open to all those eligible to be a member, regardless of gender, race, disability, ethnicity, religion or any other groups covered under the Equality Act 2010. During 2019/20 all trust volunteers were automatically given a membership form to complete and any new people who attended the PIP were encouraged to become members.

Staff membership

The staff constituency is a single constituency divided into the following classes:

- Doctors and dentists
- Nurses and midwives (including health care assistants)
- Allied Health Professionals
- Support staff

Staff membership is open to all those employed by the Trust on a permanent basis,

those who have a fixed term contract of at least 12 months, and those who have been working at the Trust for at least 12 months. Staff are automatically members of the Staff Constituency unless they 'opt-out' from membership. In addition, those working at the Trust through the temporary staffing bank become staff members providing they have been registered on the Trust's bank for at least 12 months and continue to be registered. Staff membership will cease at the point that the staff member leaves the service of the Trust. Anyone eligible to be a staff member of the Foundation Trust cannot be a public member.

Staff Membership at 31 March 2020

At 31st March 2020, the Trust had 3818 staff members. Staff membership is validated once a year in Quarter 1, or when there is an election we validate and update our data looking at staff on permanent contracts, who are on fixed terms for one year, or who have been on the bank for a year in order for the system to be updated. The table provides a breakdown by staff group. Each staff group includes bank staff who meet the Trust's eligibility criteria for staff membership:

Staff Class	Number of members
Doctors and Dentists	516
Nurses, Midwives & Healthcare	1679
Allied Health Professionals, Scientific and Technical	343
Support staff	1280
Total	3818

Membership Development and Engagement

The Trust has a Membership Development and Engagement Strategy agreed in February 2018 and which will be refreshed in 2020/21. The Strategy describes the Trust's objectives for the membership and the approach used to ensure the Trust develops and engages with a representative membership. The strategy was produced with the guidance and input of the Council of Governors.

Key actions to grow membership and improve engagement which have been used in the reporting period:

- Encourage governors to attend local groups and events (e.g. Resident Associations) to engage with the public and recruit new members
- Support fund-raising events organised by the Trust or other local organisations
- Encourage Governors and members to sign up family, friends and members of

the public

- Invite ex-staff, their family and friends to become public members
- Encourage all volunteers to sign up as public members
- Use social media (e.g. Twitter) to attract new members.

Summary of Stakeholder Relations

'People in Partnership' meetings, open to the public and advertised to members of the Trust, are held at Hillingdon Hospital four times a year, chaired by a Governor. The meetings are preceded by an opportunity for members and governors to meet over refreshments. A survey was distributed to members and the public asking for their ideas about how these meetings could be made more interesting and/or accessible.

During 2019/20, Governors were included in the circulation of the weekly staff bulletin. Governors reported that this enabled them to be more effective in communicating with their constituencies and have received regular communication in respect of COVID-19.

Public governors attended various community events, especially residents' associations, where they talked with local residents. Feedback at these events from members and the public was reported to the chair and/or directors. During 2019/20, issues raised included disabled car-parking at the Hillingdon site, safe staffing levels, facilities for patients and staff and the quality of the estate. There was strong interest in the news that seed funding had been approved for planning a new hospital.

Governors are also able to communicate with members through the quarterly members' newsletter – 'the Pulse' which regularly features a Governor article.

Donations, Creditors and Income Disclosure

The paragraphs below ensure compliance with the assorted disclosure requirements in the Annual Reporting Manual for these sections.

Statement of compliance with cost allocation and charging guidance

The Trust has complied with cost allocation and charging guidance issued by HM Treasury. In particular, where relevant the Trust has referred to chapter 6 of Managing Public Money in the setting of fees and charges. The Trust considers that fees and charges set during the year are reasonable.

Political Donations

No political donations have been made in 2019/20 by either Board members or senior members of staff.

Better Payment Practice Code

The Trust aims to comply with the Better Payment Practice Code, which is that 95% of invoices in terms of numbers and value are paid by the due date of payment (or within 30 days of receipt of goods or a valid invoice). The Trust has been unable to achieve the target in 2019/20 due to liquidity issues; performance is stated in the table below. While still significantly below the target of 95%, the Trust's performance in 2019/20 is significantly stronger than 2018/19, when only 58% of non-NHS and 24% of NHS creditors were paid in line with the policy.

The Trust paid out £15k in 2019/20 for interest on late payments under the Commercial Debts (Interest) Act 1998 (£12k in 2018/19).

	Actual 31/03/2020 YTD Number	Actual 31/03/2020 YTD £'000
Non NHS		
Total bills paid in the year	92,233	189,454
Total bills paid within target	33,864	123,671
Percentage of bills paid within target	36.7%	65.3%
NHS		
Total bills paid in the year	2,291	30,727
Total bills paid within target	399	12,482
Percentage of bills paid within target	17.4%	40.6%
Total		
Total bills paid in the year	94,524	220,181
Total bills paid within target	34,263	136,153
Percentage of bills paid within target	36.2%	61.8%

Income Disclosure

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. In 2019/20, the Trust met this requirement, with 92% of the Trust's income generated by activities for the purpose of the health service in England.

As the vast majority of Trust income is categorised as generated by activities for the purpose of the health service in England, it is the Board's view that other income does

not detract from NHS provision to any material extent. Where other income is generated it supports the Trust to make optimum use of its assets and is used to directly support principal patient care activities.

REMUNERATION REPORT

The narrative elements of the Remuneration Report are not subject to audit: the salary and pension information has been audited along with details on the median salary as a ratio of the highest paid director's remuneration. The Remuneration Report includes details of the remuneration paid to the Chairman and voting Directors of the Trust (the 'senior managers' who influence decisions of the Trust as a whole).

Annual Statement on Remuneration

Name	Role	Term of Office
Sir Amyas Morse	Chairman	Appointed October 2019 to September 2022
Prof Elisabeth Paice	Deputy Chairman	Appointed February 2014 to January 2021
Richard Whittington	Non-Executive Director and Senior Independent Director	Appointed October 2014 to September 2020
Dr Linda Burke	Non-Executive Director	Appointed April 2019 to March 2022
Janet Campbell	Non-Executive Director	Appointed August 2019 to July 2022
Catherine Jervis	Non-Executive Director	Appointed April 2019 to March 2022
Simon Morris	Non-Executive Director	Appointed May 2019 to April 2022
Name	Role	Date of appointment
Sarah Tedford	Chief Executive	In post throughout 2019/20
Jason Seez	Deputy Chief Executive	In post throughout 2019/20
Dr Catherine Cale	Medical Director	In post throughout 2019/20
Camilla Wiley	Chief Nurse	Appointed October 2019
Jenny Greenshields	Director of Finance	In post throughout 2019/20
Tina Benson	Chief Operating Officer	Appointed December 2019

Tahir Ahmed	Director of Estates & Facilities	Appointed June 2019
Terry Roberts	Director of People & Organisational Development	In post throughout 2019 and until February 20/20
Dean Spencer	Interim Chief Operating Officer	February 2019 – June 2019
Melissa Mellett	Interim Chief Operating Officer	September 2019 – December 2019
Siobhan Gregory	Interim Chief Nurse	May – August 2019
Ema Ojiako	Internal Director of HR and Organisational Development	February 2020 – May 2020
Piers Young	Interim Hospital Director – operations	June – September 2019

The notice period for Executive Directors has been set at six months. Payments for loss of office are made on the basis of contractual requirements under employment laws.

Board Remuneration Committee

The Remuneration Committee of the Board sets the remuneration for the Chief Executive and Executive Directors.

Membership

The Committee is:

- Chaired by the Deputy Chairman of the Board and attended by all Non-Executive Directors
- The Chief Executive attends all meetings except those at which their salary and terms of conditions are being discussed
- The Director of Workforce and Organisational Development attends the committee in an advisory capacity
- The Company Trust Secretary attends the committee to take minutes

The Committee's role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and the other Executive Directors including:

- All aspects of salary (including any performance related elements and / or bonuses)

- Provision for other benefits including pensions
- Arrangements for the termination of employment and other contractual terms , including associated risks

The Committee also makes recommendations to the Board on the remuneration and terms of service of Officer Members of the Board (and other senior employees) as necessary to ensure they are rewarded fairly for their Individual contribution at the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate.

Senior Managers Remuneration Policy

	Salary/fees	Taxable benefits	Annual performance related bonus	Pension related benefits
Reason for pay delivery of the strategic objectives of the Foundation Trust	Ensure the recruitment/retention of directors of sufficient calibre to deliver the Trust's strategic and operational objectives	none disclosed	yes	To ensure the recruitment and retention of directors is of sufficient calibre to deliver the Trust's objectives
Performance period	As determined by Remuneration Committee	none disclosed	As determined by Remuneration Committee	As determined by Remuneration Committee
How the component operates	Paid monthly	none disclosed	annually	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme
Maximum payment	Salaries are determined by the Trust's Remuneration Committee in accordance Senior Managers' Remuneration Policy	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance	Performance Development Review assessed by Remuneration Committee	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Not applicable
Performance measures	Based on objectives agreed by Remuneration Committee	none disclosed	If some or all objectives are achieved, up to 10% of basic pay may be paid back in the following year	Contributions are made in accordance with the NHS Pension Scheme

There are no obligations within the service contracts of senior managers which could give rise to, or impact on, remuneration payments of loss of office which are not disclosed within the Remuneration Report.

Chairman and Non-Executive Director Remuneration Policy

Elements of Pay	Purpose and link to strategy	Operation
Basic remuneration	To attract and retain high performing Non-Executive Directors who can provide the Board with a breadth of experience and knowledge.	Reviewed by the Governors Nominations and Remuneration Committee who make recommendations to the Council of Governors.

There are no provisions for the recovery of sums paid to directors or for withholding the payment of sums to senior managers.

Expenses

No material expenses were paid to governors during the year 2019/20. Expenses paid to Non Executives and Executives are shown in the senior managers' remuneration table below.

Salary and Pension Entitlements of Senior Managers

The definition of 'senior managers' for the purpose of this 2019/20 report is those persons in voting or non-voting Executive Director or Non-Executive Director roles within the organisation during the reporting period.

Remuneration 2019/2020

Senior Managers' Remuneration

(a) Table 1: 2019/20 single table (audited)

Name and title	Current financial year 2019-20						Previous financial year 2018-19					
	Salary and fees (in bands of £5,000)	Taxable benefits (total to the nearest £100)	Performance- related bonuses (in bands of £5,000)	Long-term performance- related bonuses (in bands of £5,000)	Pension-related benefits (in bands of £2,500)	Total	Salary and fees (in bands of £5,000)	Taxable benefits (total to the nearest £100)	Performance- related bonuses (in bands of £5,000)	Long-term performance- related bonuses (in bands of £5,000)	Pension-related benefits (in bands of £2,500)	Total
Sarah Tedford, Chief Executive	200-205	0	0	0	0 95-97.5	295-300	60-65	0	0	0	0 32.5-35	95-100
Catherine Cale, Medical Director	165-170	0	0	0	0 60-62.5	225-230	10-15	0	0	0	0 72.5-75	85-90
Terry Roberts, Director of People (to 09/02/2020)	90-95	5000	0	0	0 32.5-35	125-130	105-110	0	0	0	0 5-7.5	110-115
Ema Ojako, Acting Director of People (from 10/02/2020)	15-20	0	0	0	0 32.5-35	45-50	N/A	N/A	N/A	N/A	N/A	N/A
Jason Seez, Deputy Chief Executive and Director of Strategy	145-150	8300	0	0	0 137.5-140	295-300	20-25	0	0	0	0 0-2.5	20-25
Dean Spencer, Chief Operating Officer (to June 2019)	30-35	0	0	0	0	0 30-35	10-15	0	0	0	0 2.5-5	15-20
Melissa Mellett, Chief Operating Officer (01/09/2019 to 15/12/2019)	30-35	0	0	0	0 55-57.5	85-90	N/A	N/A	N/A	N/A	N/A	N/A
Tina Benson, Chief Operating Officer (from 16/12/2019)	35-40	0	0	0	0 87.5-90	125-130	N/A	N/A	N/A	N/A	N/A	N/A
Jenny Greenshields, Director of Finance	125-130	0	0	0	0 75-77.5	200-205	N/A	N/A	N/A	N/A	N/A	N/A
Siobhan Gregory, Interim Chief Nurse (May 2019 - Aug 2019)	30-35	0	0	0	0	0 30-35	N/A	N/A	N/A	N/A	N/A	N/A
Camilla Wiley, Chief Nurse (from Sept 2019)	55-60	0	0	0	0 85-87.5	140-145	N/A	N/A	N/A	N/A	N/A	N/A
Tahir Ahmed, Estates Director	115-120	0	0	0	0	0 115-120	N/A	N/A	N/A	N/A	N/A	N/A
Richard Sumray, Chair (to July 2019)	15-20	0	0	0	0	0 15-20	45-50	0	0	0	0	0 45-50
Lis Paice, Interim Chair (August and September 2019, otherwise Non-Executive director)	25-30	0	0	0	0	0 25-30	10-15	0	0	0	0	0 10-15
Amyas Morse, Chair (from October 2019)	20-25	0	0	0	0	0 20-25	N/A	N/A	N/A	N/A	N/A	N/A
Soraya Dhillon, Non-Executive Director (to December 2019)	5-10	0	0	0	0	0 5-10	10-15	0	0	0	0	0 10-15
Linda Burke, Non-Executive Director	10-15	0	0	0	0	0 10-15	5-10	0	0	0	0	0 5-10
Janet Campbell, Non-Executive Director (from August 2019)	5-10	0	0	0	0	0 5-10	N/A	N/A	N/A	N/A	N/A	N/A
Catherine Jarvis, Non-Executive Director (from May 2019)	10-15	0	0	0	0	0 10-15	N/A	N/A	N/A	N/A	N/A	N/A
Rima Makarem, Non-Executive Director (to May 2019)	0-5	0	0	0	0	0 0-5	0-5	0	0	0	0	0 0-5
Carl Powell, Non-Executive Director (to April 2019)	0-5	0	0	0	0	0 0-5	10-15	0	0	0	0	0 10-15
Simon Morris, Non-Executive Director (from May 2019)	10-15	0	0	0	0	0 10-15	N/A	N/A	N/A	N/A	N/A	N/A
Richard Whittington, Non-Executive Director	10-15	0	0	0	0	0 10-15	10-15	0	0	0	0	0 10-15

1. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual
2. Dean Spencer and Siobhan Gregory (both on secondment from NHS Improvement) were not employees of the Trust during the reported period. As such, these directors do not have pension benefits recorded
3. Due to a change in role, the pension benefits for the Estates Director fell during the period. To comply with the NHS Foundation Trust (FT) Annual Reporting Manual, the Trust has entered a figure of zero
4. Non-executive directors do not accrue pension benefits for their role

(b) Pension Benefits 2019/20 (audited)

	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
Sarah Tedford, Chief Executive	5-7.5	5-7.5	55-60	150-155	1083	128	1239	29
Catherine Cale, Medical Director	2.5-5	0-2.5	65-70	160-165	1275	86	1394	16
Terry Roberts, Director of People (to 09/02/2020)	0-2.5	0-2.5	30-35	70-75	535	41	590	13
Ema Ojiako, Acting Director of People (from 10/02/2020)	0-2.5	N/A	5-10	N/A	66	21	89	2
Jason Seez, Deputy Chief Executive and Director of Strategy	5-7.5	12.5-15	55-60	120-125	800	137	958	21
Melissa Mellett, Chief Operating Officer (01/09/2019 to 15/12/2019)	2.5-5	N/A	20-25	N/A	163	32	200	5
Tina Benson, Chief Operating Officer (from 16/12/2019)	2.5-5	5-7.5	45-50	100-105	684	83	785	6
Jenny Greenshields, Director of Finance	2.5-5	5-7.5	40-45	90-95	639	88	743	18
Camilla Wiley, Chief Nurse	2.5-5	10-12.5	50-55	150-155	974	112	1111	8
Tahir Ahmed, Estates Director	0	0	25-30	50-55	485	0	488	13

1. As stated above, Dean Spencer and Siobhan Gregory were seconded to the Trust during the reported period, rather than being employees of the Trust. As such, these directors do not have pension benefits recorded and they have been excluded from this table
2. Pension contributions for the Acting Chief Operating Officer have been disclosed for the period when she was in the role. Her overall pension contributions for 2019/20 were £14k.3
3. Due to a change in role, the pension benefits for the Estates Director fell during the period. To comply with the NHS FT Annual Reporting Manual, the Trust has entered a figure of zero
4. Non-Executive directors do not accrue pension benefits for their role.

(c) Fair Pay Multiple (audited)

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

	2019/20	2018/19
Band of highest paid director's remuneration	200-205	180-185
Median remuneration	27,636	33,379
Ratio	7.33	5.47

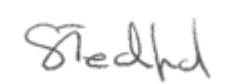
The midpoint of the banded remuneration of the highest paid director at Hillingdon Hospitals NHS Foundation Trust in financial year 2019/20 was £202,500 (financial year 2018/19 was £182,500). This is 7.33 times (5.47 in 2018/19) the median remuneration of the workforce, which was £27,636 (2018/19 median remuneration was £33,379).

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

We strive to operate with openness and transparency when reviewing and setting the pay levels for senior management, adhering to the Trust's policy on equality, diversity and inclusion and other related policies.



Prof Elisabeth Paice OBE
Deputy Chair



Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust
24 June 2020

Staff Report

Staff numbers and gender profile

The average headcount employed by the Trust is 3,452 in the following staff groups:

Average Substantive Staff (WTE and headcount) by Staff Group

Staff Group	Substantive Staff (WTE)	Substantive Staff (headcount)
Nursing and Midwifery Registered	937	1028
Administrative and Clerical	612	677
Additional Clinical Services	544	606
Medical and Dental	438	462
Estates and Ancillary	308	365
Allied Health Professionals	160	187
Add Prof Scientific and Technic	85	94
Healthcare Scientists	27	29
Students	4	4
Grand Total	3115	3452

The Trust employed a predominantly female workforce with 77.6% of our employees being female and 22.4% male. Trend data shows that there has been a shift of +1.2% towards the female workforce. Women represent 71.4% of senior staff at bands 8a and above, a shift of +0.4% towards the female workforce. The table below breaks down the staff in post gender profile by pay band.

Workforce Gender Split by Pay Groupings

Pay Band	Female Headcount	%	Male Headcount	%	Total Headcount	Total %
Band 1	124	63.6%	71	36.4%	195	100.0%
Band 2	513	82.6%	108	17.4%	621	100.0%
Band 3	304	81.1%	71	18.9%	375	100.0%
Band 4	155	82.4%	33	17.6%	188	100.0%
Band 5	412	83.4%	82	16.6%	494	100.0%
Band 6	507	86.8%	77	13.2%	584	100.0%
Band 7	271	85.2%	47	14.8%	318	100.0%
Band 8 - Range A	86	74.1%	30	25.9%	116	100.0%
Band 8 - Range B	29	70.7%	12	29.3%	41	100.0%
Band 8 - Range C	16	69.6%	7	30.4%	23	100.0%
Band 8 -	9	69.2%	4	30.8%	13	100.0%

Range D						
Band 9	2	33.3%	4	66.7%	6	100.0%
Other (inc. Medical Grades)	252	52.7%	226	47.3%	478	100.0%
Grand Total	2680	77.6%	772	22.4%	3452	100.0%

There is a higher than average percentage of male employees in both Band 8a+ roles and Other (non AfC grades) which comprises Doctors.

The tables below show the gender split for Board members and Senior Leaders for comparison:

Board Members as at 31st March 2020

Board Members		
Gender	Number	%
Female	11	68.8
Male	5	31.3
Total	16	100

*Including Chairman & Non-Executive Directors

Senior Leaders in the Trust as at 31st March 2020

Board Members		
Gender	Number	%
Female	60	69.0
Male	27	31.0
Total	87	100

*Band 8b and above (excluding Board members)

Sickness absence

Type of Sickness Indicator	2019-2020
Long Term Sickness Rate (21 days or more)	2.80%
Short Term Sickness Rate	1.70%
FTE Days Lost	50248.38
Estimated Salary Cost of Sickness	£4,664,531.60

Sickness absence rates were on average at 4.5% for 2019/20 compared to 4% for 2018/19. When benchmarked against our local Trusts using Model Hospital Data the average sickness rate for our comparators (North West London Group) is 3.56%.

We continue to support the health and wellbeing of our workforce, in particular the impact of Covid-19, through a range of interventions including the health and wellbeing hub.

However, when benchmarked against our local Trusts using the latest Model Hospital data available (Dec 2019) we are behind 5 Trusts and ahead of two, with the average sickness rate for our comparators* being 3.56% and in the top quartile with Hillingdon in quartile 2.

*Local comparators: North West London group

Equality, Diversity & Inclusion

The Trust remains committed to providing services and employment opportunities that are inclusive across all strands of equality – Age, Disability, Gender Reassignment, Marriage & Civil Partnership, Pregnancy & Maternity / Ethnicity, Religion or Belief, Gender / Sex and Sexual Orientation – in accordance with the Equality Act 2010 and our public sector duties.

Work is continuing to progress in this area:

- Board oversight – a non-executive director has been appointed to work with the Director of HR and Organisational Development
- Structure – a Black, Asian, Minority Ethnic (BAME) Staff Group has been established, sponsored by the Chief Executive it is chaired by a member of our BAME workforce
- Training – compliance with mandatory Equality, Diversity & Inclusion training which incorporates the Equality Act legislation is compulsory for all staff
- Reporting – the Trust complied with all national reporting (e.g. WRES and gender) as well as taking part in the WRES data collection and processes across London
- Staff Support – the Trust has established a diverse range of staff who are designated Freedom To Speak Up (FTSU) Champions and CARES Ambassadors offering support to other staff members to address issues within the workplace
- Interpreting Service – the Trust has an Interpreting Policy and uses language line for its interpretation and translation services. The interpreting services ensure staff members meet the needs of clients whose first language is not English or who have sight or hearing impairment
- Chaplaincy Services – the Chaplaincy Department seeks to offer high quality pastoral and spiritual care to all patients, carers and staff within the Trust; it is available to all and welcomes referrals from colleagues and carers alike. The Trust also has a designated staff chaplain and prayer room facilities
- Equality Impact Assessments – a policy and associated processes are in place, along with a staff training programme that can be accessed for anyone who is not sure on how to conduct these
- Positive about Disability – in line with the Workforce Disability Equality Standard,

the Trust has reviewed its action plan to improve the experience of staff with disabilities

Staff Engagement

Staff engagement and communication is a key priority for the Trust, particularly given the impact of COVID-19, and a diverse range of activities have taken place:

- Regular communication via daily Global emails (which started during the Covid situation and previously was provided as a weekly staff bulletin), the Chief Executive's blog, and the monthly Team Brief.
- The Board Patient Safety Walkabout programme.
- Listening events to provide opportunities for staff to share their experiences of working for the Trust, raise any concerns, and ask questions.
- A story from a patient, carer, staff or volunteer is given at each Trust Board meeting, providing an opportunity for the Board to connect with patients, carers, frontline staff and volunteers.
- The Annual General and Annual Members meetings.
- Engagement events and forums to discuss specific initiatives and feedback with staff for example the Senior Leaders Forum and the Health & Wellbeing Forum.
- The intranet and various social media platforms including an anonymous dialogue system called "SpeakInConfidence", which can also be used for the purposes of raising concerns.
- Annual NHS Staff Survey and internal surveys and action planning.
- Annual appraisal process for all staff.
- A corporate induction programme supported by an enhanced local induction.
- The daily staff recognition award (which started in April 2020 and was previously monthly), which actively recognises how staff and teams are living the CARE values of the Trust

The Partnership Agreement sets out the Trusts commitment to communicate, consult and negotiate with staff and their representatives on matters that affect their interests. The trust has formal mechanisms in place to facilitate these processes including the Trust Partnership Forum, the Joint Local Negotiating Committee for Doctors and the Junior Doctors Forum.

Health & Wellbeing

Given the challenges facing our NHS at present, it is more important than ever to support the health and wellbeing of our staff if they are to continue to be safe, productive, and compassionate in their care for patients.

In conjunction with the newly created Health and Wellbeing Committee, the Occupational Health team lead this important work, promoting the physical and mental wellbeing of staff, helping them to work safely and effectively to maximise the success of the organisation. The Service offers a wide range of support, advice and interventions from pre-employment screening, health surveillance, vaccines, blood tests, needle stick injuries assessment and management, fast track referral to physiotherapy, flu

immunisations, management referrals, confidential Employee Assistance Programme with access to counselling, legal advice, financial and debt management to lifestyle events and therapies.

Health & Safety

Through its Health and Safety policy and arrangements the Trust continues to work towards best practice standards in Health and Safety for all our staff, patients, and others who may be affected by what we do.

The Health and Safety Team provide advice and support for the Trust on general Health and Safety matters, medical device safety and moving and handling. The team also work closely with other functions such as, but not limited to, Estates and Facilities (including Fire Safety and Security), Procurement, Occupational Health, Infection Control, Patient Safety, Emergency Planning and Human Resources to ensure there is a multidisciplinary approach to Health and Safety matters.

- **Health and Safety governance:** The Health and Safety Committee have met on seven occasions throughout 2019/20, with reports provided to the Audit and Risk Committee when requested. Under leadership of the current Chief Operating Officer and Trust Head of Health and Safety, there is key ongoing strategic work to improve the function and efficiency of the Health and Safety Committee and its reporting.
- **Training 2019/20:** The Health and Safety team continue to monitor training levels for the Statutory Mandatory (STaM) subjects of “Health, Safety and Welfare” and “Manual Handling Level 1 and 2” across the Trust. Throughout 2019/20, the Trust has maintained an overall compliance level of above the 90% for each subject against a compliance target of 90%. Work is underway to develop and monitor specific Health and Safety training for departmental safety representatives and improve Health and Safety responsibilities awareness among managers.
- **Performance 2019/20:**
 - **611** incidents were reported under the following incident type:
 - Accident to Staff
 - Accident to Visitors, Contractors and Public
 - Equipment (non-clinical)
 - Environmental

This is a notable **reduction by 105** incidents compared to the previous year.

- **386** incidents were reported under the incident type “Violence & Aggression- Towards staff”. This was a slight **increase by 24** compared to the previous year.
- **237** incidents were reported under the incident type “Equipment (clinical)”. This was a slight **reduction by 19** compared to the previous year.

- **11** incidents were reported to the Health and Safety Executive (HSE) under the Injuries Diseases and Dangerous Occurrences Regulation (RIDDOR) 2013. This is a significant **reduction by 14** compared to the previous year.

Incidents relating to Health and Safety are all assessed by the Health and Safety team and support, advice and information is provided for managers where necessary to improve the quality of investigation and learning. There is also ongoing work to identify, monitor and respond to areas that present particular challenges including working conditions, infrastructure and medical devices.

Countering Fraud and Corruption

The Board is committed to maintaining an honest, open and well-intentioned culture and to the elimination of any fraud and corruption in the Trust. The Trust has procedures in place that reduce the likelihood of fraud occurring; these include Standing Orders, Standing Financial Instructions, systems of internal control and risk assessment and Standards of Business Conduct. The Trust's Counter Fraud Policy provides guidance to employees, setting out roles and responsibilities and the steps that must be taken where fraud or corruption is suspected or discovered.

The Trust has nominated a Local Counter Fraud Specialist (LCFS) whom staff can contact promptly and in confidence if they have any concerns that a fraud may have taken place. LCFS provide expert advice, undertake proactive reviews of policies and processes, and case investigations.

Staff Survey 2019

Staff engagement and communication is a key priority for the Trust and as already mentioned, a range of activities and mechanisms are in place to facilitate this. The Staff Survey is an important tool in monitoring engagement and learning from staff feedback to inform future strategies. The response rate this year was 51.3%, a slight increase from last year's score of 50% and higher than the average response of 49%.

The 10 key themes are provided below, with the Trust's scores compared to the national average. The Trust scores higher in four areas, the same in one area, and lower in six areas. All scores are an average across the questions that make up the theme and are out of a maximum of 10.



In response to the staff survey the Trust has developed an action plan to address staff feedback.

Expenditure on Consultancy

The Trust's expenditure on consultancy during 2019/20 was £4.2m compared with £2.0m in 2018/19. The difference largely relates to expenditure for developing future plans for the Trust's site and use of additional resource for developing options for the Trust's Cost Improvement Programme.

Off payroll arrangements

Summary of 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	2
<i>of which</i>	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	2
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0

Number that have existed for four or more years at time of reporting	0
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Summary of 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	2
<i>of which</i>	
Number assessed as within the scope of IR35	
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Summary of 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.	1
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	24

Staff costs (audited)

	2019/20			2018/19
Pay element	Permanent (£k)	Other (£k)	Total (£k)	Total (£k)
Salaries and wages	127,707	18,735	146,442	139,501
Social security costs	13,739	1,563	15,302	14,685
Apprenticeship levy	626	93	719	690
Employer contributions to NHS Pension Scheme	15,581	575	16,156	15,521
Additional contributions to NHS Pensions funded by NHS England	6,932	256	7,188	-
Pension costs - other	51	-	51	26
Termination benefits	-	-	-	102
Temporary staff costs	-	9,697	9,697	10,453
Total gross staff costs	164,636	30,919	195,555	180,978
Less recoveries in respect of seconded staff	- 1,751	-	- 1,751	- 1,709
Total staff costs	162,885	30,919	193,804	179,269

Staff numbers (audited)

	2019/20			2018/19
Staff group	Permanent	Other	Total	Total
Medical and dental	478	63	541	523
Administration and estates	734	67	801	790
Healthcare assistants and other support staff	622	110	732	734
Nursing, midwifery and health visiting staff	876	186	1,062	1,059
Scientific, therapeutic and technical staff	315	32	347	384
Healthcare science staff	55	9	64	24
Total staff numbers	3,080	467	3,547	3,514

Aggregate director remuneration (audited)

	2019/20		2018/19	
	Remuneration (£k)	Number of directors	Remuneration (£k)	Number of directors
Executive directors	1,447	13	1,085	13
Non-executive directors	147	11	134	9
Total staff costs	1,594	24	1,219	22

Analysis of directors' remuneration (£000s)	2019/20	2018/19
Gross pay	1,299	1,003
Employer pension contributions	148	104
Employer NI contributions	147	112
Total director remuneration	1,594	1,219

Exit packages (Audited)

There have been no exit packages agreed during 2019/20.

NHS Oversight Framework (pre- August 2019 known as the Single Oversight Framework)

The 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.

The Trust is currently in segment 3. 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	2018/19	2019/20
Financial sustainability	Capital service capacity	4	4
	Liquidity	4	4
Financial efficiency	Income & Expenditure margin	4	4
Financial controls	Distance from financial plan	4	4
	Agency spend	1	1
Weighted Average		3.4	3.4
Overall scoring after Overrides		3	3

Key:

Capital Service Capacity – (how well the Trust can finance its debt)

Liquidity – (how long the Trust can cover its liabilities with the cash it has)

Income & Expenditure – (how 'profitable' the Trust is)

Performance between the end of 2018/19 and the end of 2019/20 is unchanged.

Annual Governance Statement 2019/2020

1. 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.

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

3. Capacity to handle risk

The Trust is committed to a Risk Management Strategy and Policy which minimises risk to all of its stakeholders through a comprehensive system of internal controls, based upon the support and leadership offered by the Board of Directors, its Committees, the Trust Management Executive and the Risk Management Group. The Risk Management Strategy and Policy provides a framework for taking this forward through internal controls and procedures which encompass strategic, financial, quality, reputational, compliance and Health and Safety risks. Its aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centred services that achieve excellent results and promote the best possible use of public resources, through an integrated approach to managing risks from all sources. The strategy and policy also seeks to support consistency and standardisation through the gathering and dissemination of intelligence on risks and mitigation control measures amongst all staff.

The Trust Board is responsible for establishing principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that effective systems are in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and the Corporate Risk Register.

The high-level Board committee structure discharging overall responsibilities for risk management is summarised below:

Committee	Responsibilities
Audit and Risk Committee	<p>The Board delegates responsibility to the Audit and Risk Committee for:</p> <ul style="list-style-type: none"> ● Assessing the quality and strength of the assurances received on the Trust's risk management, quality and financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) and that this supports the achievement of the Trust's objectives ● Testing the integrity and completeness of the risk management system through reviewing the strength of operational and strategic risk management and internal control. ● Assessing the accuracy, adequacy of the assurances provided on the effectiveness of controls and the actions being taken to address gaps in control processes that indicate the effectiveness of the management of principle corporate and clinical risks. ● Identifying gaps in assurance, assessing the adequacy and robustness of the actions being taken to address these gaps and the progress being made to close them ● Regularly reviewing and testing the contents of the Board Assurance Framework (BAF), Corporate Risk Register (CRR), and local Risk Registers (RRs) in pursuit of the above responsibilities ● Regularly reviewing and testing the contents of the Trust's Risk Management Strategy and Policy and associated policies in pursuit of the above responsibilities. ● Ensuring there is independent scrutiny of the Trust's risk management and governance systems and processes and of the strength and adequacy of related assurances through internal and external audit work programmes ● Making recommendations to the Trust Board on the development and implementation of the Risk Management Strategy and Policy ● Reviewing and testing all risk and control-related disclosure statements (e.g. the Annual Governance Statement) to provide assurance to the Board that they are accurate and adequate.

	<ul style="list-style-type: none"> ● Reviewing the Trust's Risk Management Annual Report, and agree recommendations on actions for improving the Trust's risk management systems and processes ● Reviewing the effectiveness of Internal Audit, External Audit and Local Counter Fraud Services.
Quality and Safety Committee	<p>The Board delegates responsibility to the Quality and Safety Committee for</p> <ul style="list-style-type: none"> ● Assessing the quality and strength of the assurances received on the Trust's quality and clinical governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of quality and clinical governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives ● Testing the integrity and completeness of the quality governance system through reviewing the strength of operational and strategic management and internal control of quality and clinical risks. ● Assessing the accuracy and adequacy of quality reporting and the assurances developed through the Trust's quality management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic objectives ● Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board ● Assessing the effectiveness of the controls implemented through the Trust's quality management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic objectives ● Escalating concerns about areas of inadequate control to the Board ● Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for quality improvement ● Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities ● Reviewing and testing all clinical and quality related statements (e.g. the Quality Account) to provide assurance to the Board that they are accurate and adequate. ● Making recommendations to the Trust Board on the development and implementation of the Quality Strategy ● Regularly reviewing and testing the contents of the

	Quality Improvement Plan, Clinical Governance Annual Report and associated policies in pursuit of the above responsibilities
Finance and Performance Committee	<p>The Board delegates responsibility to the Finance and Performance Committee for:</p> <ul style="list-style-type: none"> • Assessing the quality and strength of the assurances received on the Trust's financial governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of financial governance across the whole of the Trust's activities and that this supports the achievement of the Trust's objectives • Assessing the accuracy and adequacy of financial reporting and the assurances developed through the Trust's financial management system; identifying gaps in assurance and overseeing the actions being taken to address these gaps and ensure assurances are focused on the key risks to achievement of the Trust's strategic objectives • Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board • Assessing the effectiveness of the controls implemented through the Trust's financial management system; identifying gaps in control and overseeing the actions being taken to address these gaps and ensure controls are focused on managing the key risks to achievement of the Trust's strategic objectives • Escalating concerns about areas of inadequate control to the Board • Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for financial improvement • Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities • Reviewing and testing all financial statements (e.g. the Financial Accounts) to provide assurance to the Board that they are accurate and adequate. • Making recommendations to the Trust Board on the development and implementation of the Trust's Financial Strategy
People Committee	<p>The Board delegates responsibility to the People Committee for:</p> <ul style="list-style-type: none"> • Assessing the quality and strength of the assurances received on the Trust's workforce and organisational development governance systems and processes and providing assurance to the Board that the Trust has established and maintains an effective integrated system of workforce and organisational development governance across the whole of the Trust's activities and that this

	<p>supports the achievement of the Trust's objectives</p> <ul style="list-style-type: none"> • Escalating concerns about areas of inadequate control to the Board • Escalating concerns about areas of insufficient, incomplete or inadequate assurance to the Board • Monitoring delivery progress on actions to address gaps in control or assurance and agreeing recommendations on actions for improvements relating to the workforce or organisational development • Regularly reviewing and testing the contents of the BAF, CRR, and local RRs in pursuit of the above responsibilities • Regularly reviewing and testing the contents of the People Strategy, Organisational Development Programmes and associated policies in pursuit of the above responsibilities
Trust Management Executive	<p>The Trust Management Executive is responsible for:</p> <ul style="list-style-type: none"> • Ensuring the effective identification, evaluation and management of operational and strategic risk in all aspects of the Trust's business and providing effective and proactive leadership of risk management within the Trust by implementing the Trust's Risk Management Strategy and Policy and the associated framework of processes, procedures and controls that enable risks to be managed directly and through delegated powers and ensure the Trust meets its strategic objectives • Ensuring the Trust's Risk Management Strategy and Policy is developed, regularly reviewed and updated taking into account recommendations for improvement arising from internal and external scrutiny and recommending these to the Board for approval. • Developing and providing assurance to the Board and its Committees on the effectiveness of the Trust's risk management systems • Reviewing the local RR, CRR and Board Assurance Framework routinely to ensure risks and controls are described clearly and accurately, rated consistently, and managed appropriately to reduce risks to the agreed target level. Recommending the BAF to the Board for approval. • Identifying gaps in assurance or control and ensuring actions to address these gaps are agreed and delivered in a timely manner to make the necessary improvements, taking action as required to address delays and enable and support successful delivery • Escalating risks, gaps in control or gaps in assurance to the Board • Promoting continuous quality improvement with regard to the management of clinical and non-clinical risk and the control

	<p>environment throughout the Trust by examining and challenging action plans developed to control risks, and assessing their wider impact.</p> <ul style="list-style-type: none"> ● Assessing the quality and strengths of the assurances developed through the Trust's quality management system and its sub-groups to provide evidence of the effectiveness of quality risk management within the Trust, taking action to strengthen assurances as required ● Assessing the quality and strengths of the assurances developed through the Trust's performance management system to provide evidence of performance risk management within the Trust, taking action to strengthen assurances as required ● Assessing the quality and strengths of the assurances developed through the Trust's financial management system to provide evidence of financial risk management within the Trust, taking action to strengthen assurances as required ● Considering the wider strategic implications of risks and themes arising, and opportunities to improve management of risk by taking a corporate approach ● Delegating powers for the management of risk to the appropriate management groups as set out in their approved Terms of Reference.
Risk Management Group	<p>The Risk Management Group is responsible for ensuring on behalf of the Trust Management Executive:</p> <ul style="list-style-type: none"> ● That the risk management policy and processes are being followed; ● To ensure risk management conforms with best practice standards ● Ensure risks are appropriately and consistently described, scored with actions in place to address any gaps in controls or assurances; ● Recommend risks for escalation onto the Corporate Risk Register that meet the defined criteria; ● Provide advice and support on risk management to divisions and corporate directorates.
Divisional Governance Groups	<p>The Divisional Governance Groups are responsible for:</p> <ul style="list-style-type: none"> ● the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. ● developing, populating and reviewing their risks, drawing on risk processes within the services, to ensure that Service, Directorate and Divisional Risk Registers are kept up to date through regular review.

The Risk Management Strategy ensures that risks are identified from the bottom up: risk registers are managed within each service line and corporate area. Risk identification,

assessment and control is carried out locally with accountability through divisional directors and review by the Risk Management Group (RMG)

The RMG meets on a monthly basis. During this meeting, all risks on the Trust corporate risk register are discussed and reviewed and each clinical division and corporate directorate presents its local risk register on rotation (two per meeting) as part of the RMG's cycle of business. The aim of the RMG is to provide assurance to the Trust Management Executive (TME) and to the Audit and Risk Committee that the Trust has adequate risk management arrangements in place and is operating effectively, ensuring that risk is kept under control in accordance with the Trust Boards risk appetite and minimising exposure to harm.

Risks within the Board Assurance Framework and the Corporate Risk Register are aligned to the sub-committees of the board and reported to these committees at least quarterly as per the committee's cycle of business.

Staff are trained and supported to manage risk in a way appropriate to their authority and duties through targeted training of individuals and access to the Trust's Patient Safety, Health and Safety, and Governance Systems team. Guidance is provided in writing through the Risk Management Strategy and Policy. This includes the process to identify and manage local risks, the systematic means by which these local risks are escalated to Board level attention through the Corporate Risk Register and how risks are controlled and monitored. Further operational procedures for risk and incident management are referenced in the Risk Management Strategy and Policy which is available to all staff through the Trust's policy management system.

The Trust developed a training needs analysis as part of its updated Risk Management Strategy and Policy in October 2019 and seeks to strengthen its risk management programme in 2020/21.

4. Risk Control Framework

4.1. Risk Management Strategy

The Trust understands that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances will always involve an inherent degree of risk. Good risk management practice requires that identified risk is analysed, evaluated, treated and actions followed up for the purposes of monitoring and review to further improve.

The key elements of the risk management strategy and the Trust's approach to risk management and risk appetite are summarised as follows.

Possible risks are identified through a variety of mechanisms, both reactive and proactive. Proactive identification may arise from local risk assessments, impact assessments and gap analyses of published reports on healthcare subjects or inspections of other care providers. Reactive identification can be flagged as a result of a serious incident, a trend in incidents or complaints, observations from a Trust Board walkabout or as a result of an audit, either internal or external.

Risks are analysed, scored, and current controls evaluated. The aim of this process is to decide what further action to control the risk is required (treat the risk), or if the risk must be tolerated at its existing level (accept the risk). The evaluation of the risk assessment will involve the analysis of the individual risk to identify the consequences/severity and likelihood of the risk being realised. Within the Trust, the severity and likelihood of risk is given a numeric score based on the following matrix:

	Consequence →				
Likelihood ↓	1 Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost certain	5	10	15	20	25

The process of evaluation includes a set of risk metrics for risk consequence and likelihood which aims to improve consistency of risk assessments taking place within the Trust, for example:

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Recommendations for inclusion onto the corporate risk register (CRR) are overseen by the Risk Management Group and come from risks with a total risk score of 15 or above, have a consequence score of 5, could significantly impact the Trust strategic objectives or cannot be mitigated solely by the division or corporate directorates, and will be compiled from divisional and corporate directorate risk registers.

The risk assessment template is structured in a way that requires the recording of an initial risk rating, a target risk rating and a residual (current) risk rating, the latter being post-mitigation and reviewed on a regular basis.

The Trust's risk appetite is defined by the Trust Board. The Trust Board makes a decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, the Trust's risk appetite will address several dimensions

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

Risks throughout the organisation will be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement is communicated to relevant staff involved in the management of risk and is used to determine the target risk rating throughout the risk management process.

The following risk appetite levels form the background to the Board's discussion and decision when defining the Trust's risk appetite. Using this model as guidance the Trust Board agrees an appetite statement that aligns to the Trust's strategic aims. The statement should then be considered when assessing risk target and tolerances in the Board Assurance Framework, Corporate and Local (Divisional) Risk Registers.

Risk Appetite Levels

Appetite Level	Description
None (zero)	Avoid: There is a requirement to avoid risk and uncertainty to deliver an agreed organisational objective
Low (1)	Minimal: There is a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate (2)	Cautious: There is a preference for safe delivery options that have a low degree of inherent risk and an acceptance that these may only have limited potential for reward.
High (3)	Open: There is a willingness to consider all potential delivery options and choose those which balance acceptable levels of risk with an acceptable level of reward in terms of improvement and/or value for money.
Significant (4)	Seek: There is a preference to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk and there is evidence that the organisation is Mature: There is confidence in accepting high levels of risk because we are assured that controls, forward scanning and responsiveness systems are robust.

Risk Tolerance

Risk 'tolerance' reflects the Trust's appetite for risk and the level of escalation required to support both effective risk management and provision of assurance in relation to its effectiveness.

The Board have agreed that all risks with a total risk score of 15 or above, have a consequence score of 5, could significantly impact the Trust strategic objectives or cannot be mitigated solely by the division or corporate directorates will be considered for defining as Corporate Risks and as such require executive oversight. These will be agreed by the Risk Management Group for ratification by the Trust Management Executive (TME). The Risk Management Group is responsible for ensuring that Corporate Risks are managed and controlled in accordance with the Trust's risk appetite defined by the Board and within the Risk Management Policy.

4.2 Quality Governance Arrangements

Key quality governance and leadership systems and structures are in place to support the Trust in ensuring that the quality and safety of care is being routinely monitored across all services, including:

- monthly reporting to the Board in the form of an integrated quality and performance report with exception narrative
- presentations on clinical and quality governance issues (including discussion on risk areas, performance reviews against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit) are considered at every Quality & Safety Committee (QSC) meeting
- deep dive reviews at each QSC meeting on the key aims of the Quality and Safety Improvement (QSI) Strategy. Any external quality and safety intelligence is presented at the QSC on a bi-monthly basis, and a summary of performance against the QSI strategy annual action plan is also reported
- in February 2020, the Trust introduced a Quality Oversight Group to oversee the implementation of the Trusts quality governance framework ensuring that the Trust has in place robust arrangements to effectively identify and monitor the quality of services provided and triangulate information from multiple sources. The Quality Oversight Group will also oversee the development and implementation of the Trust's Quality Strategy
- clinical divisional governance boards review quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis, with divisional exception reports being considered by the Patient Safety Group (PSG). Any concerns on quality are escalated to the QSC
- a process of reporting the investigation of Serious Incidents (SIs) and the related follow up of outcomes and action plans via a weekly Serious Incident Review Group (SIRG). Root cause analysis is used and forms the basis of SI reports

together with the creation of action plans which are monitored by divisional governance boards through to completion. In 2019/20 the Trust made substantial improvements to its incident reporting and SI process and implemented forums for learning via the Hillingdon Hospitals Learning and Safety programme (HiHLS) as described in section 4.12 below

- the Trust is reviewing the system of complaints management, with the aim of instituting auditable and proven learning where complaints are received. This will be related to other forms of patient feedback
- the Chief Nurse, Chief Executive Officer and other Board members make regular visits to clinical departments where they have the opportunity to talk to staff and patients about their experiences
- 'Themed Clinical Fridays' provide a forum to engage with staff, patients and carers on wards and in departments to review the environment and delivery of care, agree actions required and take these forwards. Any issues or concerns are escalated accordingly to the Executive Team and Trust Board
- a robust framework is in place to ensure that all service changes are subject to a Quality Impact Assessment (QIA) which is reviewed and signed off by the Medical Director and Chief Nurse to ensure appropriate actions are being taken to mitigate any associated risks to quality
- listening to patients and governors: A range of opportunities exist to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation striving for quality improvement
- opportunities exist for patients and members of the public to attend the Trust's People in Partnership (PiP), Council of Governors and the Trust Board meetings. There are also specialty-based focus and support groups where patient feedback can be obtained

4.3 Well Led Framework

The Trust has had regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality. Further details are provided below. No material inconsistencies have been identified between the Annual Governance Statement, Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any subsequent action plans. Work is underway within the Trust to prepare for the next CQC visit which it is anticipated will take place in 2020/21.

In July 2019, the Board received and approved a completed action plan put in place to address recommendations from an external governance review undertaken in 2018/19. This confirmed all actions had been addressed or were significantly in progress the Executive can confirm all were fully completed within the financial year 2019/20 although it is recognised further improvement and strengthening on our governance arrangements and embedding these fully below the Board Sub Committee level will continue in 2020/21.

Topics covered which have supported us in the Well Led area across the year have included the development of our Board Assurance Framework and the development of our risk management systems and processes, our Quality Improvement Programme, and our strategic planning with the updating of our clinical services strategy and the development of plans for our new hospital as well as laying the foundations for our divisional re-organisation which is progressing in earnest early in 2020/21.

With the establishment of the current Executive team, the Trust commissioned NHSE/I to undertake a review of the planning of the new Hillingdon Hospital, with the finalised Gateway report issued in October 2019. All the recommendations of the review were implemented with the Trust updating its clinical services strategy as part of the development of the Strategic Outline Case for a new hospital, the appointment of a highly experienced Redevelopment Programme Director, and ensuring that the programme governance arrangements were strengthened. These significant improvements have ensured that the programme has now been robustly established, which has been recognised by the Department of Health and Social Care in providing the Trust with £5m of capital funding to support the development of the new hospital.

A significant commitment was made by the Board in carrying out a comprehensive review (conducted by the GGI) of the Board Assurance Framework (BAF), including arrangements for the identification, moderation and escalation of risk. This methodology has been embedded Trust-wide and underpins the Trust's governance structures and operations.

4.4 Register of interests for decision-making staff

The Trust maintains a Register of Interests for decision-making staff as required by 'Managing Conflicts of Interest in the NHS'. The Register is available via the Trust public website. The Trust also maintains a register for gifts and Hospitality.

4.5 Workforce Strategies

The approach to strategic workforce planning is integral to the Trusts strategic planning processes and is focused on safe staffing, the size and quality of the workforce. This is managed through the Trust Safe Staffing policy. On an annual basis, workforce plans are developed at a Trust level. This process ensures input from relevant clinical, operational and corporate teams, making plans reflective of the clinical environment and issues affecting the Trust as a whole. Workforce plans form part of divisional business plans and are reviewed as part of the quarterly divisional review process. Progress with achievement of the deliverable outcomes of the workforce plan (and the overarching Trust People Strategy) is reported via the FPC (People Committee from 2019/20), and direct to the Trust Board. Workforce development and performance is also assured through the Board Assurance Framework.

Key workforce planning initiatives include:

- ***Skill mix and balancing supply and demand:*** the integrated business planning process for 2019/20 included processes for reviewing skill mix and linking Divisional plans to workforce need. Whilst achieving a balance between supply and demand for

staff and skills is a significant challenge, the Trust has plans to do this through a range of initiatives including overseas recruitment for nurses and for medics, use of the Apprenticeship Levy, productive use of our existing staff, and supporting the development and use of new roles;

Agency and bank collaborative work across the Sustainability and Transformation Partnership (STP): with North West London colleagues, the Trust is looking at options for collaborative overseas recruitment; further monitoring of bank and agency rates and collaborative staff bank arrangements:

- **Apprenticeship Levy:** the Trust continues to utilise the Apprenticeship Levy across the organisation and to support Divisions with their workforce planning so that the Levy is used to maximum benefit. Specific initiatives are being implemented to use the Apprentice Levy to support new roles (see below)
- **Nurse Associate Apprentices:** the Trust recruited 13 trainee Nurse Associate Apprentice in collaboration with Bucks New University (BNU) in 2019/20. This initiative was supported through Health Education England (HEE) funding. The Trust will pursue funding to support the funding for BSc Nurse Apprentices again in 2020/21, this will enable current nursing support staff to develop advanced care skills and a route into nursing
- **New roles:** the Trust is actively planning to implement and extend the use of new salaried roles, including physician associates and advanced nurse practitioners. Voluntary services will be enhanced to support care staff and improve patient experience in 2020/21
- **E-Rostering and e-job planning:** the Trust has implemented an e-rostering system for use across all medical staff and is planning to further this technology in 2020/21. E-job planning is already in use for consultants and the Trust recognises the importance of expanding both e-job planning and e-rostering for all clinical staff.
- **Overseas staff:** the Trust is supporting EU staff in respect of the UK's exit from the EU. Although this has not reduced EU staff to date, the impact on our workforce (particularly clinical) is regularly assessed. The increase in the immigration health surcharge for overseas staff has been met by the Divisions and has placed an additional financial burden on the organisation at a time when overseas staff are most needed

4.6 Care Quality Commission (CQC) Compliance

The CQC inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March and April 2018. NHSI visited the Trust in May 2018 to conduct a 'Use of Resources' assessment as part of the revised inspection regime. The outcome of the inspection was published on 24 July 2018.

Overall, the CQC rated the Trust as 'Requires Improvement', the same rating as provided in 2015. The Safety and Well Led domains for the Hillingdon Hospital site were rated as 'Inadequate', deterioration from the Requires Improvement rating from the last inspection. To address the issues flagged in the CQC report the Trust developed an action plan to address the 'Must' and 'Should Do's' identified and Requirement Notices issued by the CQC. However, the action plan failed to sufficiently address all areas for

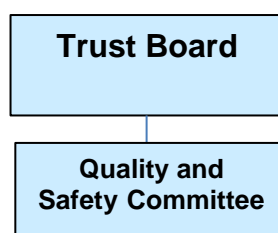
improvement identified by the Senior Leadership Team and therefore a more comprehensive action plan was developed, the Hillingdon Improvement Plan (HIP); this outlined the actions required to address all areas for improvement relating to patient safety and service quality.

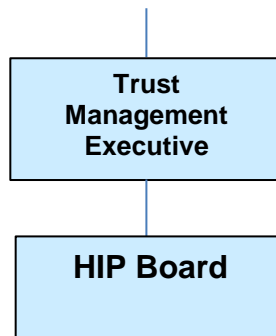
The plan comprises 13 work streams and related actions. The 13 work streams are:

- HI 1 Safety Culture
- HI 2 Governance (Corporate and Clinical)
- HI 3 Deteriorating Patient (including Sepsis)
- HI 4 Emergency Department
- HI 5 Transitional Care
- HI 6 Safe Care
- HI 7 Safeguarding
- HI 8 Medicines Management
- HI 9 End of Life Care and Mortality
- HI 10 Data Quality
- HI 11 Hospital at Night
- HI 12 Medical Devices
- HI 13 Operational Standards and National Quality Requirements

An Executive Director has been assigned as Senior Responsible Officer (SRO) for each work stream with accountability for ensuring the actions are implemented within the agreed timescales. In addition, NHSE/I have provided an Improvement Director to support the Board and the Trust has appointed, on an interim basis, a Quality Improvement Director to give clinical oversight to the assurance of the programme.

The governance arrangements for the HIP are outlined in the diagram below;





The HIP Board meets twice a month and met for the first time on 18 April 2019. External stakeholder representatives from the CQC, Healthwatch, Hillingdon CCG and NHSE and NHSI, are invited to attend on a monthly basis.

SROs are required to submit monthly highlight reports, summarising in-month progress, to the HIP Board. Going forward, a monthly progress report will be submitted to the Trust Management Executive (TME), before being submitted to the Quality and Safety Committee, prior to Trust Board receiving a monthly update on progress. In addition, SROs are periodically required to present a deep dive report on progress to HIP Board. The table below details deep dive presentations to date:

Ref	Subject	Date	Outcome	Action
1	Critical Care Outreach Team (CCOT) & Hospital at Night (H@N)	02.05.2019	Align CCOT with H@N staffing requirements, training & operational delivery; progress recruitment	Progress overseas medic recruitment, escalate delivery risks to HIP Board
2	Sepsis	02.05.2019	Implement recommendations from NHSI Sepsis Lead & progress Sepsis Lead Nurse appointment as a priority	Return to HIP Board July to update on progress
3	WHO Safety Checklist	16.05.2019	Work with Audit Team for outcomes to inform action plan	Return to HIP Board July to update on progress
4	Medicines Management	16.05.2019	Review of local action plan, change control required to align actions in HIP workstreams & to include local action plan	Audit medication storage compliance present findings to July HIP Board
5	Record Keeping	13.06.2019	Appoint new chair & reconvene Clinical Records Committee	Return to HIP Board September to update on progress
6	Management of Vulnerable Patients	13.06.2019	Progress Learning Disability Lead Nurse appointment & complete training needs analysis to inform delivery plan	Return to HIP Board November to update on progress
7	Infection, Prevention & Control (IP&C)	27.06.2019	Develop a programme of work based on NHSI IP&C Assurance Framework	Return to August HIP Board with the action plan
8	Training & StaM	27.06.2019	Good assurance however concern at compliance rate with Data Security & Fire Safety compliance in Surgery, Medicine & Temporary Staffing	Return to HIP Board September to update on compliance rates No employment of non-compliant bank staff medics
9	Discharge Planning - Delayed transfers of care	27.06.2019	Evidenced reduced lengths of stay & stranded patients	Return in September with update on Criteria Led Discharge

Ref	Subject	Date	Outcome	Action
10	Medicines Management	10.07.2019	Improved but not assured compliance in all areas	Represent audits fortnightly until assured compliance
11	WHO Safety Checklist	10.07.2019	Improved but not assured compliance in all areas	Represent audits fortnightly until assured compliance
12	HI 6 Safe Care	29.08.2019	In progress, recognition that significant work to do	Return to HIP Board October to update on progress
13	Record Keeping	24.09.2019	Update ToR & membership of Clinical Records Group	Change control to upload recommended actions into HIP
14	Discharge Planning - Criteria Led Discharge	24.09.2019	Roll out trustwide by 31.10.2019	Monitor deadlines via HIP Board action log
15	Training & StaM	30.09.2019	Trustwide compliance now achieved, however Data Security, Fire Safety, IP&C Level 2 & Safeguarding Children Level 3 not achieving compliance standard	Divisional weekly reports to Director of P&OD
16	HI 3 Deteriorating Patient	20.10.2019	Progress noted	Return in March with an updated report
17	HI 6 Safe Care	20.10.2019	Progress noted	Return in March with an updated report
18	HI 2 Clinical & Corporate Governance	14.11.2019	In progress, recognition that significant work to do	Return in February with an updated report
19	HI 4 Emergency Department	14.11.2019	Good progress noted	Escalate delivery risks to Emergency Care Recovery Board
20	HI 1 Safety Culture	14.11.2019	Good progress noted	Escalate delivery risks to HIP Board
21	HI 9 End of Life & Mortality	12.12.2019	Further work required on Bereavement Service	Return to February HIP Board with an action plan
22	HI 10 Data Quality	12.12.2019	Good progress noted	Escalate delivery risks to HIP Board
23	HI 11 Hospital at Night	16.01.2020	Good progress noted	Escalate delivery risks to HIP Board
24	HI 5 Transitional Care	16.01.2020	Good progress noted	Escalate delivery risks to HIP Board
25	HI 12 Medical Devices	30.01.2020	Delivery risks noted	Discussion at Execs and update to HIP Board 27 February
26	HI 2 Clinical & Corporate Governance	30.01.2020	Good progress noted	Escalate delivery risks to HIP Board

In addition, the ward and department accreditation programme introduced in March 2019 (based on an improvement model utilised successfully to improve CQC ratings in some other organisations) reports to HIP Board to ensure action plans to address areas of concern are delivered to deadline and that findings are triangulated with the Improvement Plan. The CARES+ Programme supports Trust staff with the right knowledge and tools to demonstrate evidence of continuous quality improvement.

4.7 Data Security

The Trust has committed to the implementation of a large cyber security programme of work to protect data networks, clinical devices and the computing infrastructure. This work is in addition to the existing security monitoring and protection tools, such as anti-virus. The cyber security programme includes:

- vulnerability management software to electronically monitor, identify and mitigate known vulnerabilities in information systems and networks
- Intrusion Detection System (IDS) that learns and monitors network and machine behaviour and which will provide alerts when abnormal or unusual behaviour is detected
- anti-exploit software that prevents malicious payloads from executing
- next generation firewalls to protect diagnostic modalities and medical devices and give an oversight of the network security around these vital clinical systems

Incidents are reported and monitored at the Digital Services Governance Group as well as Data Security and Protection Group, which meets a minimum of four times a year and is chaired by the Trust's Senior Information Risk Owner. Relevant incidents are also reported via the Data Security and Protection Incident Reporting Tool.

4.8 The organisation's major risks

The key risks to delivering the Trust's strategic objectives are recorded in detail in the Board Assurance Framework and monitored by the Board of Directors.

In 2019/20 the Trust identified 21 risks which could impact on the delivery of the Trust's strategic objectives, these were:

1.	Quality - The care we provide to our patients will be safe, effective and result in a good experience
1.1	There is a risk that the appropriate standards of care will not be provided to patients, resulting in patient harm poor quality of care and poor patient experience
1.2	There is a risk that the culture within the Trust reduces its ability to comply with regulatory and legislative requirements resulting in poor patient care, heightened scrutiny and reputational damage.
1.3	There is a risk that the Trust is unable to embed effective governance structures impacting on operational, financial and quality performance resulting in poor patient care, heightened scrutiny and reputational damage.
1.4	There is a risk that the Trust is unable to recruit and retain sufficient numbers of appropriate good quality substantive staff impacting on the sustainability and delivery of services and resulting in reduced quality of care.
1.5	There is a risk that the environment as a consequence of not being fit for purpose results in a poor staff and patient experience.
1.6	There is a risk that the improvement methodology is not embedded across the organisation or underpinned by timely and accurate benchmarked data resulting in unacceptable variations in care.
2.	Workforce - We will value our people and equip them with the skills to provide the right care.
2.1	There is a risk that the Trust is unable to sustain an appropriately representative workforce impacting on staff motivation and morale and resulting in poor patient care.
2.2	There is a risk that the Trust fails to support and empower staff to maximise their potential resulting in poor care.
2.3	There is a risk that the Trust fails to adopt changed ways of working and new roles resulting in a workforce that is not appropriately resourced and skilled to provide integrated care in line with the NHS Long Term Plan.
2.4	There is a risk that the Trust does not support staff to ensure they are healthy and have a work life balance resulting in loss of staff and their skills.
3.	Performance - We will deliver the right care, at the right time, and in the right place for our patients.
3.1	There is a risk that the Trust does not have the capability to consistently deliver operational performance targets (such as RTT) resulting in poor patient care, reputational damage and regulatory intervention.
3.2	There is a risk that the Trust's systems and processes are unable to support clinical services and business functions impacting on efficiency, financial performance and the delivery of services and resulting in poor patient care, heightened scrutiny and reputational damage.
3.3	Excessive demand leading to failure of operational performance targets

4.	Finance - We will use our resources effectively to eliminate waste, achieve financial balance, and support the system.
4.1	There is a risk that ineffective use of resources and missed identification of investments and opportunities impacts on the ability of the Trust to deliver required financial targets and resulting in an inability to invest appropriately.
4.2	There is a risk that the organisation is unable to develop and implement its Estates Strategy impacting on the Trust's ability to maintain and improve its infrastructure resulting in reduced quality of care and poor staff morale.
5.	Well Led – We will harness the potential of our people to deliver continuous improvement.
5.1	There is a risk that the Trust does not have sufficient management and leadership capacity and capability to drive improvement and deliver the Trust's strategy resulting in a failure to meet quality, performance and financial standards.
5.2	There is a risk that our people do not have the skills to challenge poor performance and lead change resulting in reputational damage and regulatory action.
6.	Partnership Working - We will work with all of our partners, including patients and the public, to deliver our strategy, including a new hospital.
6.1	There is a risk that a failure to work effectively with partners results in adverse staff and patient experience.
6.2	There is a risk that a failure to engage the system results in poor use of resources, poor performance, and failure to deliver good quality care within available system resources.
6.3	There is a risk that a failure to engage effectively with education partners results in an inability to fulfil our workforce and clinical strategies.
6.4	There is a risk that the lack of a NW London Strategy to supersede Shaping a Healthier Future results in a lack of clarity for the development of the proposed new hospital.

Against each of the strategic risks a responsible Executive Director is assigned to the risk and is tasked with identifying control measures to mitigate the risk, gaps in control and assurance measures and actions required.

Risks within the Board Assurance Framework and the Corporate Risk Register are aligned to the sub-committees of the Board and reported to these committees at least quarterly as per the committee's cycle of business to provide assurance to the Board the extent to which the Trust is managing the principal risks to its strategic objectives and to support driving the agendas of Board committees in line with the Trusts principal risks.

Responding and recovering from the COVID-19 pandemic

The COVID-19 pandemic is the biggest threat to the health of the population in a generation resulting in an unprecedented level of demand for hospital critical and medical care. The Trust has and will continue to respond to the pandemic in line with national and local guidance and has effectively deployed its pandemic flu plan and internal incident procedures operating a gold, silver and bronze command and control

structure. The Trust maintains a COVID-19 risk register to support the identification, escalation and mitigation of risk associated with the pandemic that is maintained by the silver control team and reviewed at least weekly by the Executive team. The Trust has also developed a COVID-19 Board Assurance Framework to provide onward assurance to the Board the extent to which the Trust is managing the risks associated with the COVID-19 pandemic.

As well as responding to the pandemic itself the Trust is closely monitoring all waiting lists and key quality and performance metrics to monitor and maintain patient safety and business as usual functions as far as reasonably practicable, to ensure the Trust is able to monitor the impact on non-COVID-19 patient care and re-commence planned work in a flexible and timely manner as capacity and quality parameters permit.

The Trust will also assess and mitigate the risks associated with the impact of the COVID-19 pandemic on its strategic objectives via the Boards Assurance Framework and Corporate Risk Register.

4.9 Compliance and Validity of the NHS Foundation Trust condition 4 (FT Governance): Corporate Governance Statement

The Trust has assessed its compliance with NHS Foundation Trust condition 4 (FT governance). Assurances to support the validity of the conditions are reviewed in detail annually by the Executive team and the Audit and Risk Committee and are agreed by the Board alongside the Annual Report and Accounts. This process also identified any risks to compliance and mitigating actions. All statements were 'confirmed'.

The following risks to compliance and actions to mitigate have been identified through the Trust's 2019/20 review process:

Risk: A partial external governance review was completed in 2019/20. The new developmental framework recommends that a full governance review is undertaken every 3-5 years.

- **Action:** Depending on what may be required following a CQC visit (if this takes place during the 2020 calendar year) the Trust will consider commissioning an external governance review in the latter part of 2020/21 in liaison with our NHS England and NHS Improvement relationship manager

Risk: Some weaknesses in the Trust arrangements for ensuring the quality of performance data have been highlighted by our external auditor, with reference to their work carried out on their work on the Quality report in 2018/19 where errors were found with regard to the A&E four hour wait and 62 day cancer performance indicators.

- **Action:** The required actions to improve data quality will be driven by the Data Quality Steering Group with assurance overseen by the Audit and Risk Committee.

An external organisation (MBI Health Group) has been commissioned to look into the operational processes and data quality of all the constitutional standards

(RTT, Cancer and Diagnostics). MBI have conducted audits and implemented operational and technical changes where required. Standard Operating Procedures have been documented and approved by respective Programme Boards.

In 2019/20 the Trust Internal Auditors also undertook a review of access and activity data and presented findings to the April 2020 Audit and Risk Committee. The Trust will work through the recommendations from this audit and provide onward assurance via the Data Quality Governance structure and the Audit and Risk Committee that the Trust has implemented the actions required to address recommendations.

The Governance structure, around non-constitutional data quality standards, is undergoing review by the Chief Information Officer and the Director of Finance to further strengthen data quality governance via a Data Quality Steering Group.

Risk: The Trust is at risk of not being able to comply with its licence in three areas: Improving its CQC rating, financial performance, and achieving the required level of performance against A&E targets.

Actions: The Trust has instituted a number of key actions to address the concerns raised as follows:

- CQC: Developed a holistic HIP. A programme for improving quality and safety has been put in place comprising of Ward Accreditation and Clinical Service Reviews. These strands of work support the delivery of the HIP in the form of a series of internal inspections to identify areas for improvement
- Developed a deliverable financial plan to March 2021 which will include an understanding of the underlying financial position and detailed analysis of the causes of the underlying financial position; a well-developed CIP and a link to workforce optimisation
- Developed a plan for A&E performance recovery ("the A&E Plan")

4.10 Equality, Diversity and Human Rights

Control measures are in place to ensure that all of the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality impact analysis/assessments (EIA) are carried out as standard procedure for all Trust policies and new developments/service changes. An equality and diversity toolkit is available for staff on the Trust's intranet to support them with completing an EIA. The Trust has an Equality, Diversity and Inclusion Forum which reports to the People Committee of the Board. The Trust Board receives an annual report on Equality, Diversity and Inclusion. The Trust has published its statutory equality & diversity report providing assurance that the Trust is compliant with equality legislation.

Freedom to Speak Up

The Board is committed to an open and honest culture and recognises the importance of enabling staff to speak up about any concerns at work in order to improve services for all patients and the working environment for staff.

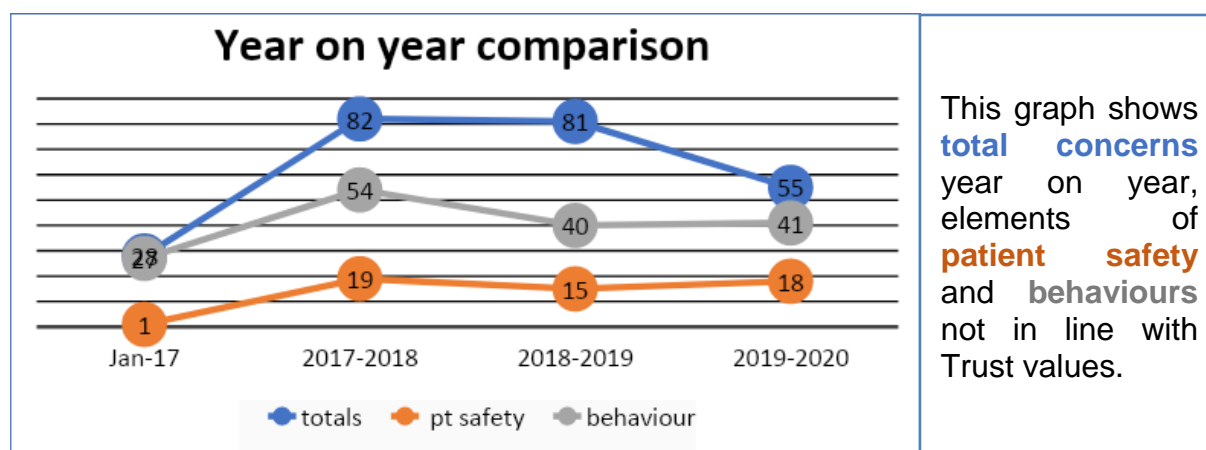
In 2016 the Trust adopted the standard integrated policy issued by NHS Improvement and NHS England, the 'Freedom to speak up: raising concerns (whistleblowing) policy for the NHS'. This policy was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS.

In most circumstances, concerns will be raised and resolved informally through the management structure of the Trust. A number of other options are available to staff who do not feel able to raise concerns in this way, including access to the Freedom to Speak Up Guardian (FTSUG). The Trust has appointed a FTSUG, as recommended in the Francis review and a number of champions to help support the 'speaking up' agenda.

The FTSUG acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.

The FTSU Guardian has handled nearly 250 concerns raised by workers since January 2017 from a variety of professional backgrounds, two of which have been published nationally by the NGO recently.

The main category of concern is shown in the graph below:



The FTSU Guardian operates both locally and regionally on behalf of the Trust - this include awareness presentations and planned events during speaking up months locally, publications of closed cases both locally and nationally, and participating in regional and national events.

Overseas operations

The Trust does not have any overseas operations.

Bribery

The Trust contracts a specialist local counter fraud service which reports quarterly on fraud and bribery to the Audit and Risk Committee. The Trust has a Counter Fraud Policy in place which was co-authored with the Trusts Counter Fraud Service, and a Standards of Business Conduct and Conflicts of Interest policy which covers bribery and this is being updated early in 2020/21. These policies combined make a Board level commitment to taking preventative and reactive steps to ensure that we have adequate and appropriate controls in place. The Finance Team have received fraud and bribery awareness training and it has been rolled out through e learning modules for all staff.

Modern Slavery

The Trust recognises the issue of modern slavery which may take a variety of different forms, the most recognised of which are:

- Sexual exploitation
- Labour exploitation
- Organ harvesting
- Forced criminality
- Domestic servitude

The Safeguarding Vulnerable Adults Policy recognises Modern Slavery. Additionally, our Procurement Policy requires that suppliers are compliant with our Modern Slavery Code of Practice.

Control measures are in place to ensure that all of the Trusts obligations under equality diversity and human rights legislation are complied.

The Trust will be producing a comprehensive single policy statement as part of its equalities programme in 2020/21, which will be published on the website.

4.11 Engagement with Stakeholders

The Trust works with its key public stakeholders in managing its risks. This is carried out through the following mechanisms:

- engagement with the local Healthwatch
- the Council of Governors who are an integral part of our governance infrastructure as a Foundation Trust are consulted throughout the year on key issues and risks as part of the annual operational planning process
- regular 'People in Partnership' Forums enable the Trust to listen to the views and opinions of the communities we serve, to share information about what the Trust is doing (including planned future developments), and to provide an opportunity to communicate with staff, governors and fellow members

- Annual Members' Meeting
- engagement with user and support groups e.g. Maternity Voices Partnership, Patient-led Assessment of the Care Environment, Stroke Forum
- Public members and local stakeholders are invited to joint Trust staff to agree priorities for the Quality Report.
- The Trust developed a patient booklet titled 'My Stroke Journey – Working Together', co-produced by patients and staff, utilising “always event” methodology
- The Trust has benefitted from having an established Lay Strategic Forum comprising of patients and carers who use Trust services. Three meetings were held during 2019/20 providing members with the opportunity to have their views valued and listened to, representing the voice of the patients. Several members regularly attended the monthly staff induction programme to deliver a session on 'what matters to patients'.
- Throughout the year members attended various committees providing a patient viewpoint to discussions. Members were also involved in patient safety walkabouts, discussions relating to the layout and signage of the redeveloped ED and the development of patient information.
- The Trust has continued to engage with patients and the public in respect of the patient safety and quality agenda and service improvement through CARES+.

4.12 Incident Reporting

Structured processes and systems are in place in respect of incident reporting, the investigation of Serious Incidents and following up outcomes from Board commissioned external reports. The Board, through the Risk Management Strategy & Policy and the Incident Policy, promotes open and honest reporting of incidents, risks and hazards. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the organisation. The latest available National Reporting Learning System (NRLS) report (covering April 2019 to September 2019) does not indicate any evidence of potential under-reporting at the Trust.

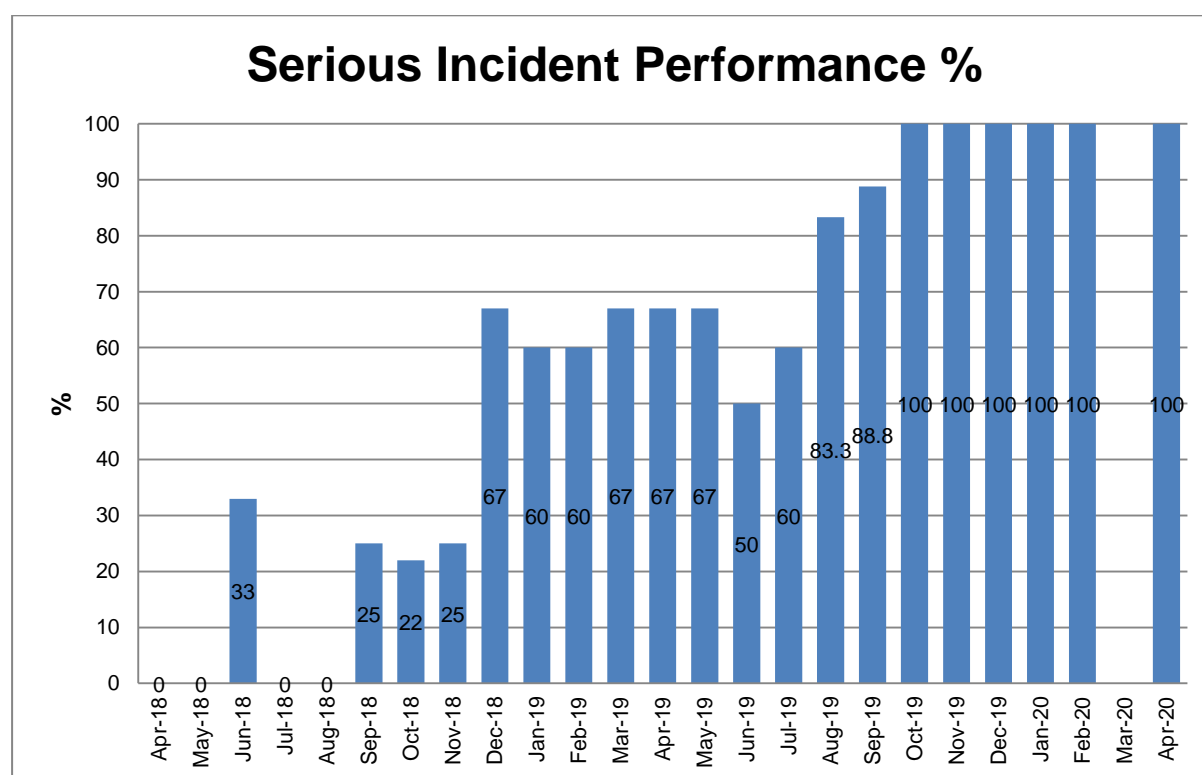
Serious Incidents

The Trust was issued with a contract performance notice in November 2018 in relation to concerns with the Trust's management of SIs in accordance with the NHS England Serious Incident Framework March 2015. The performance notice identified that the Trust was not meeting the requirement to report onto the Strategic Executive Information System (StEIS) within two working days of an SI being identified and the Trust had demonstrated poor compliance with regard to investigation reports being submitted within the 60 working day timeframe.

The Trust developed a remedial action plan to strengthen the SI process which included a number of initiatives including:

- Delivering a series of training programmes to strengthen the Trusts resources to undertake SI investigations
- Revising and strengthening the Trusts Incident and SI policy and processes, which included a daily review of incidents and a weekly Serious Incident Review Group chaired by the Medical Director
- Implementing technology to support the SI process and the management and monitoring of actions, themes and learning from SIs

The Trust implemented its remedial action plan and in November 2019 The CCG formally agreed to close the contract performance notice in recognition of the improvements made to the SI process and the improved consistency with reporting and investigating SI's within the timeframe. The Trust has consistently met the requirements for declaring and submitting serious incidents since October 2019 and has retained 100% compliance.



** Zero SIs were due in March 2020.

There is universal agreement across the Trust around the importance of protecting patients from avoidable harm. The Trust has clearly defined processes and procedures to follow which help to reduce the risk of these events occurring and recurring. However, where a SI does occur, the incident is investigated thoroughly through a

process of root cause analysis (RCA). The RCA investigation leads to the development of associated and appropriate learning resulting in recommendations and actions identified to prevent reoccurrence.

To support the sharing of learning from the investigations of SIs and Never Events across the Trust, a summary of each SI investigation report is circulated and discussed via the Divisional Governance meetings, the Divisional Triumvirates and the Patient Safety Group.

In July 2019, the Trust launched the Hillingdon Hospitals Learning and Improvement programme (HiHLS). The programme consists of a Safety Summit, and a monthly bulletin. The learning summit is held once a month and is open to all staff. There is a dedicated theme where staff will present SI and complaint cases. This is followed up by an open discussion into the cases presented and how the learning can be applied and cascaded throughout the Trust. The monthly learning bulletin is cascaded to all staff and includes learning from the learning summit, SIs, complaints, claims and inquests, clinical audit and mortality reviews. The Trust also produces a quarterly consolidated learning report in order to triangulate themes which are presented to the Quality Surveillance Group and the Quality and Safety Committee.



4.13 Emergency Preparedness Resilience and Response

The Trust has key responsibilities in responding to large scale emergencies and major incidents, both locally and as part of wider geographically coordinated activities. Throughout the year the Trust's Emergency Planning and Business Continuity functions have worked to ensure that the Trust was adequately prepared for any such events.

Compliance against NHS England's Emergency Planning Resilience and Response (EPRR) Framework 2015 and associated guidance is assessed annually by NHSE. In 2019, the Trust's overall assurance rating was reduced to 'partially compliant' (from the 'substantial assurance' achieved the previous year). Of the 69 core standards, 13 were deemed to be 'partially compliant', 1 'non-compliant' and 55 'fully compliant'. The slippage in assurance was mainly attributed to the fact the Trust was going through a transition period with regards to its organisational restructure and changes to key emergency planning personnel. In response, an assurance action plan which is overseen by the EPRR committee which currently meets on a monthly basis and is chaired by the Trust's Chief Operating Officer, who is also the Trust's Accountable Executive Officer for EPRR, and reports through the governance process up to the Board.

Within recent months there has also been a rapidly escalating response to the emergence of the COVID-19 virus. Driven by the EPRR team at NHSE/I, Trusts have

been tasked with developing and implementing challenging action plans to ensure they are adequately prepared to deal with the potential risk the virus may present to the public, patients, staff and the organisation.

4.14 Registration with the CQC

The Trust is fully registered with the CQC and has been issued with its certificate for 2020/21.

4.15 Pension Scheme

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.

4.16 Assessing our Impact on the Environment

The Trust has undertaken risk assessments and 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.

The Trust recognises the need to operate as a financially and socially responsible organisation, minimising its impact on the environment in order to deliver the highest quality healthcare to the communities we serve, now and in future. Extensive audits have been carried out on both sites to identify opportunities to reduce energy consumption and associated carbon emissions. Water surveys have also been conducted on both sites to understand usage profiles and patterns better and to pinpoint areas where consumption can be optimised.

Waste minimisation efforts have been focused on reducing reliance on plastic-based packaging and replacing with either cardboard based or bio degradable alternatives. All takeaway food in Trust restaurants is served in compostable packaging. The Trust has continued its high focus on recycling and the percentage of waste that is sent for recycling continues to grow reducing the amount sent to landfill. The Trust's procurement contracts require suppliers to demonstrate that they minimise any impact on the environment with the products and services they provide and suppliers are required to regularly confirm and provide evidence of their sustainability initiatives through contract review processes. There has also been considerable progress in reducing patient food waste through the use of smaller portion trays and through closer monitoring of meal uptake and ordering.

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

NHS provider Trusts are set financial targets on an annual basis by NHSI. Trusts are expected to set a financial plan for income and expenditure during the financial year that allows these financial targets to be achieved. As part of this process, Trusts are eligible for additional funding through the achievement of targets during the year. In 2019/20, the Trust failed to achieve financial targets set for it by NHS Improvement, primarily as a result of:

- Under delivery of CIP savings, so that expenditure was higher than planned
- As the Trust's actual performance moved away from plan as the financial year progressed, the Trust lost £12.7m in additional funding

The table below shows planned and actual financial performance in 2019/20 and includes 2018/19 information for context.

	18/19 Actual (£m)	19/20 Plan (£m)	19/20 Forecast (£m)	19/20 Actual (£m)
Deficit Excluding PSF/FRF/MRET Funding	(£27.7)	(£23.7)	(£33.8)	(£34.5)
PSF/FRF/MRET Funding	£2.3	£21.1	£8.4	£8.4
Deficit Including PSF/FRF/MRET Funding	(£25.4)	(£2.7)	(£25.4)	(£26.1)

The Trust planned for a deficit of £23.7m in 2019/20 which after the inclusion of £21m of non-recurrent PSF, FRF and MRET funding reduced the deficit to an agreed deficit control total of £2.7m.

The Trust ended the year with a deficit of £26.1m including non-recurrent funding or £34.5m excluding £8.4m of non-recurrent funding actually received during the year.

In order to deliver savings wherever possible, Trusts are encouraged to keep their current expenditure under review. The ARC advises the Board on the work of Trust management in respect of ensuring the economic, effective and efficient use of resources and The FPC (which meets monthly) receives regular reports on achievement against the savings plan.

The following key governance processes have been established within the Trust:

- a Scheme of Delegation and Reservation of Powers approved by the Board sets out the decisions, authorities and duties delegated to officers of the Trust
- Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that an

organisation's financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness

- robust competitive processes are used for procuring non-staff expenditure items. Procurement of items above £25k involves competitive tendering
- all procurement tendering activities are published within nominated publications and in accordance with Public Contracts Regulations (2015)
- the Trust's CIP Board oversees the identification and delivery of efficiency savings which comprises Divisional and Trust-wide cost-cutting programmes of work
- opportunities have been identified on the basis of the Model Hospital initiative, national and peer benchmarking, and locally developed analysis
- performance is reported via divisional management teams to the weekly Recovery meetings, chaired by the Chief Operating Officer and Director of Finance
- all schemes within the CIP are signed off by Operational, Clinical, Executive and Finance leads
- Quality Impact Assessments (QIAs) are completed for all schemes. QIAs scoring under 10 are signed off by the Medical Director; QIAs scoring above 10 and all cross-cutting schemes are signed off via the Clinical Advisory Panel
- the Programme in 2019/20 resulted in savings of £8.1m. This was delivered through enhanced governance and a focus on efficiency projects

The financial performance in 2019/20 indicated areas where greater budgetary management was possible and development on this will continue in 2020/21.

ARC receives quarterly reports regarding losses, special payments and compensations (with those of high value – over £50K approved by the Board), write-off of bad debts and contingent liabilities. The value of losses and special payments has remained at an immaterial level (0.044% of Trust turnover in 2019/20). In addition to receiving reports from the Transformation Improvement Board (which manages CIP), the Trust's Finance and Performance Committee reviews the Trust's financial performance, transformation programme and major strategic service change business cases, including the use of information technology to lever change.

5.1 Compliance with the Code of Governance

The Board has reviewed itself against the NHS Foundation Code of Governance. Accordingly, the Board has made disclosures required by the Code in the governance

section of the Directors' Report, including explanations for non-compliance with provisions of the Code. Attendance records and coverage of work for each Board committee is also included in this section of the annual report.

5.2 Going Concern

In line with paragraphs 4.11 – 4.15 of the DH Group Accounting Manual (GAM), Department of Health and Social Care (DHSC) group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. This has not happened in the case of the Trust, and services are expected to continue for the foreseeable future.

The Trust's financial statements (which form part of the Trust's annual report) have therefore been prepared on the going concern basis.

Given the Trust's financial position, consideration has been given to the Trust's broader financial sustainability for the 'foreseeable future' (which is determined as a period of 12 months following the approval of the financial statements – to 30 June 2021); as well as the circumstances in which the Trust (and all other NHS providers) are currently operating. Based on this review, we note the following:

- The recurrent financial position of the Trust is in deficit. The reported deficit for 2019/20 was £26.2m (2018/19: deficit of £25.9m). While the Trust's 2020/21 operational plan currently forecasts a breakeven position, this is after receipt of £20.3m of non-recurrent funding, so the underlying position is for a £20.3m deficit
- The Trust has £111.2m of DHSC loans on the balance sheet. In April 2020, DHSC announced changes to the cash regime, which means that in September 2020, the Trust will receive £95.0m in Public Dividend Capital (PDC) to repay the majority of these loans; this PDC will be added to the balance sheet. This will reduce the exposure of the Trust to future loan payments, but the revenue position of the Trust will deteriorate by approximately £2.0m per year due to the additional PDC dividends payable
- The trust has £7m of loan principal falling due during 2020/21 which it is forecasting to pay. This will have a significant impact on cash balances
- As with all other NHS provider organisations, the Trust is currently being funded on a block contract arrangement for the period up to July 2020, as the DHSC provides certainty in cash flows for all NHS organisations during the COVID-19 pandemic. National planning and contracting rounds for 2020/21 have been frozen until further notice
- NHS Improvement issued a letter to all NHS providers on 27 May stating that future cash flows would be at levels similar to those previously provided. However, the letter does not provide a guarantee to underwrite any underlying deficits arising during the period up to 30 June 2021.

Given that the mechanism the DHSC is using for agreeing cash support is on a month-to-month basis, the continued provision of revenue funding for the period up to 30 June 2021 is uncommitted. These conditions constitute a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern.

However, as stated above, for the purposes of the financial statements, in line with the existing financial reporting framework, the Trust is considered by management to be a going concern.

5.3 Information Governance

Risks to information are managed and controlled in accordance with the Trust's Information Governance Policy. The Trust Caldicott Guardian is responsible for the protection of patient information.

The Trust has implemented the latest guidance for incident reporting issued by NHS Digital. The guidance, based on the requirements of the GDPR, Data Protection Act 2018 and the National Data Security Standards, requires incidents to be reported using the tool in the Data Security and Protection Toolkit (DSPT).

The Trust reported one incident to the Information Commissioners Office (ICO) in 2019/20; whereby a contractor (a solicitor) left personal confidential information of a member of staff on a train. The ICO has closed the case and has advised that no further action would be taken.

The Trust was assessed as 'Standards Not Met' on the 2018/19 Data Security and Protection Toolkit with an NHS Digital Approved Improvement Plan for the six outstanding assertions. In 2019/20 the submission date for the Toolkit was extended from 31 March 2020 to 30 September 2020 due to the COVID-19 pandemic for organisations which required it. The Trust had satisfactorily met all but one assertion and made its submission on 30 April 2020 with an Improvement Plan for the outstanding item, marking significant improvement over the previous year's assessment. KPMG issued an assurance rating of 'significance assurance with minor improvements' when an audit was carried of the Toolkit in February 2020.

6. Data Quality Governance

The following have been put in place to assure the Board appropriate controls are in place to ensure the accuracy of data. The constitutional standards are covered by the various Executive-led Programme Boards with the Data Quality Improvement Steering Group to take on a more holistic approach by reviewing data quality issues not currently being monitored and allocating them to the working groups that already exist.

An external consultancy firm (MBI Health Group) was commissioned to review operational and technical processes around the constitutional standards. This included providing recovery services around RTT including backlog validation and identifying training needs. Divisions were challenged by the scale of validation required and it became apparent that a central validation resource was required. Over the 2019/20

period the Trust underwent a number of operational process changes (including moving from local to national RTT outcome codes), commissioning of an external training company to provide dedicated RTT training to staff, and implementation of a new validation software (Luna) to support daily validation by operational staff.

Within A&E completion rates within the Emergency Care Data Set (ECDS) since April 2018 continue to be a high priority for the Trust. The Trust has agreed with its commissioners to comply with a set completion rate trajectory which has not been met.

MBI Health Group has conducted a review of the cancer processes and work has been initiated around their recommendations. New Data Quality reports are being created for the Cancer team to provide better assurance around the data.

MBI Health Group has reviewed the Information Team's reporting database scripts and processes to ensure they are in line with national standards. Operational processes have been reviewed as well, but still need to be imbedded in line with recommendations from MBI. These changes are being monitored through the RTT Programme Board and are forecasted to have a more significant downward impact on the performance than the script changes.

In 2019/20 the Trust Internal Auditors also undertook a review of access and activity data and presented findings to the April 2020 Audit and Risk Committee. The Trust will work through the recommendations from this audit and provide onward assurance via the Data Quality Governance structure and the Audit and Risk Committee that the Trust has implemented the actions required to address recommendations.

The Governance structure, around non-constitutional Data Quality standards, is undergoing review by the Chief Information Officer and the Director of Finance to further strengthen data quality governance via a Data Quality Steering Group.

The Trust recognises there are some weaknesses in its Data Quality Governance arrangements and a revised structure for monitoring and escalating Data Quality issues is currently under review by the Chief Information Officer and Director of Finance to further strengthen the processes of Data Quality Governance via a Data Quality Steering Group.

7. 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 and Risk Committee, the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides the Board of Directors with an opinion about the effectiveness of the assurance framework and internal controls as part of the internal audit work plan. The Head of Internal Audit Opinion for the 2019/20 gave an overall opinion of 'Partial Assurance with improvements required' on the overall adequacy and effectiveness of the organisations framework of governance, risk management and control. In issuing their opinion Internal Audit have recognised that the organisation has implemented the recommendations raised as a result of their work to address issues identified within agreed timeframes and have also seen improvements in audit work undertaken toward the latter part of the year.

The table below summarises the assurances ratings for internal audit work undertaken in 2019/20.

1	GDPR – Post implementation	Partial assurance with improvements required
2	Incident management	Partial assurance with improvements required
3	HR business processes: Temporary staffing	Partial assurance with improvements required
4	Divisional governance	Partial assurance with improvements required
5	Access and activity data	Partial assurance with improvements required
6	Data Security and Protection Toolkit	Significant assurance with improvement opportunities
7	Core financial systems: Cash management	Partial assurance with improvements required
8	Board Assurance Framework	Significant assurance with improvement opportunities

This review of effectiveness is also informed by the external audit opinion which concluded an adverse opinion with regard to the Trusts use of resources to secure economy, efficiency and effectiveness in its use of resources, Inspections carried out by the CQC and other external agencies.

The Trust was inspected by the CQC in March 2018, with its report being issued in July 2018. The report indicated that overall the Trust was rated 'Requires improvement' with the same rating being given across all five indicators with the exception of 'Are services safe' – rated 'Inadequate' and 'Are services caring' – rated 'Good'. The same report rated the principal Hillingdon Hospital site as overall 'Inadequate' with the same ratings as the overall Trust given across all five indicators with the exception of 'Are services Well Led' which was rated 'Inadequate'. This report and rating continued to be in place throughout the 2019/20 period.

To address the issues flagged in the CQC report the Trust developed an action plan to address the 'Must' and 'Should Do's' identified and Requirement Notices issued by the CQC. However, the action plan failed to address all areas for improvement identified by the Senior Leadership Team. A more comprehensive action plan was therefore developed, the HIP, outlining the actions required to address all areas for improvement

relating to patient safety and service quality as described in section 4.6 above. The Trust was expecting a CQC inspection imminently and submitted its provider information request in February 2019, however due to the COVID-19 pandemic the CQC inspection process has been temporarily suspended.

In May 2018, the Trust agreed enforcement undertakings in relation to governance including undertaking an externally commissioned governance review to inform the strengthening of governance arrangements. Interim improvement measures from that review released in January 2019 indicated that improvements were required with regards to: capacity and capability within the Trust's leadership team and project management office, development of Trust strategy, governance structures and membership of groups within those structures, the Board Assurance Framework, arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management.

- In July 2019, the Board received a completed action plan in respect of the recommendations from the external governance support commissioned in 2018/19. Over the last year the Trust has made significant progress in establishing robust governance systems, which have supported the implementation of our HIP. The key highlights are -
- The Trust was expecting a CQC inspection imminently before the COVID-19 pandemic, which would have negated the need for an external Governance Review. However, the Trust will review its position once the CQC inspection regime resumes and consider the need to commission an external Governance review if required in 2020/21
- In 2019/20 the Trust commissioned the Good Governance Institute to undertake a governance structural review, a review of risk management and the Board Assurance Framework (BAF). As a result of this review the Trust has implemented a refreshed governance structure with defined and aligned reporting lines, cycles of business, terms of reference and clarity in terms of management groups and assurance committees (Board Committees)
- A revised and refreshed Board Assurance Framework (BAF) was signed off in Quarter 3 (October 2019) following significant work with the Board in Quarters one and two through a series of board development sessions, workshops, seminars and stakeholder engagement. The BAF now reflects the principal risks to the Trust's objectives. The BAF is updated monthly by the executive team, aligned to the assurance committees and regularly reviewed to support driving the agendas of the assurance committees, to seek onward assurance and maintain oversight on the extent to which the Trust is managing the principal risks to its strategic objectives. Our Internal Auditors reviewed the revised BAF and concluded 'Significant assurance with improvement opportunities' in April 2020
- In September 2019, the Trust strengthened risk management arrangements with the introduction of the Risk Management Group. The group is chaired by the Deputy Chief Executive Officer and has been established with the aim of improving and strengthening risk management within the organisation, to ensure

that the Trusts risk management process is robust and that risks are managed in a timely and consistent manner. The Trust continues to play an active role in the system wide A&E Delivery Board. The Trust, in conjunction with the health and social care partners has developed a comprehensive system wide A&E recovery plan. The plan focusses on four key areas, Demand Management, Processes in A&E, improved flow through the hospital and more timely discharge

- The Trust has produced a plan for A&E performance recovery (“the A&E Plan”). Performance against the plan is monitored Monthly by NHSI
- The Trust recognises weaknesses in Data Quality Governance arrangements and a revised structure for monitoring and escalating data quality issues is currently under review by the Chief Information Officer and Director of Finance to further strengthen the processes of Data Quality Governance via a Data Quality Steering Group

The Trust has described in this Annual Governance Statement the financial challenges it faces and the pressures on financial sustainability including matters which are not wholly within the control of the Trust. To address these challenges the Trust has:

- Developed a deliverable financial plan to March 2021 which meets the financial improvement trajectory (FIT) in consultation with budget holders from all divisions across the Trust. The financial plan includes an understanding of the underlying financial position and detailed analysis of the causes of the underlying financial position; a well-developed CIP and a link to workforce optimisation

The Trust has appointed a Chief Transformation Officer who will bring together the Trust’s Transformation and Programme Management Office functions to enable the Trust to be self-sufficient in running its own Transformation Improvement Plans (TIPs).

The Trust Estate also presents a significant challenge. As outlined in detail in the report the available funds within the Trust are insufficient to keep pace with the scale of backlog maintenance. Many buildings and services have failed, or are beyond their economic and design life cycle, resulting in major facilities (e.g. Theatres, Critical Care and many wards) whose design and condition are incompatible with the delivery of high-quality, modern healthcare.

Currently, the Trust has one of the highest backlog maintenance liabilities across England and without significant investment the estate will continue to deteriorate. In the short term the Trust has successfully obtained emergency capital funding to address immediate critical plant (i.e. equipment) and infrastructure risks associated with water treatment, generator replacement and to make upgrades to the ventilation service and lifts.

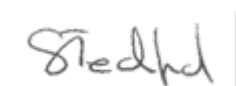
For the medium to long term, it is planned that the vision will be delivered through the new hospital build and the Trust will develop plans for the new hospital to be delivered by 2025.

The Trust had an Enforcement Notice issued on 30 January 2020 by London Fire Brigade due to several failures to comply with fire safety requirements. In response to the enforcement notice:

- The Trust has an outcome rating of 'Reasonable Assurance' from the ALFOR (Authorised Engineer) report into fire safety and an action plan was developed to address improvement measures around fire safety
- Following the Enforcement Notice action was also requested on specific issues around elements such as fire risk assessments, means of detection and warning, equipment and clear access in corridors. These requirements were incorporated into the ALFOR report action plan to form one integrated action plan for fire safety
- At a meeting held with the London Fire Brigade on 5 March 2020 the action plan was discussed and supported
- A weekly Executive Oversight Fire Safety Group, chaired by the Chief Executive was convened, to monitor the action plan
- A Trust-wide Fire Safety Group was also set up which has a wide membership and reports to the Health & Safety Committee
- A new ICT system for fire safety management and audit has also been procured to support the actions needed to improve fire safety and fire training across the Trust sites
- An emergency capital application has been submitted to NHSE/I for funding to improve and enhance fire safety in the Trust

8. Conclusion

In conclusion, on the basis of the evidence provided and except for the matters noted above, I am satisfied that the Trust has effective governance assurance systems in place which enable the identification and control of risks reported through the Board Assurance Framework and Corporate Risk Register. Internal and external reviews, audits and inspections provide assurance that no significant internal control issues have been identified during 2019/20 except for the issues noted in the section above. Where weaknesses have been identified, appropriate plans are in place to deliver the required improvements. These are monitored and assurance sought via the Trusts Governance framework.



Sarah Tedford


Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

24 June 2020

Accounting Officer approval of the Accountability Report

As Accounting Officer, I am satisfied that this accountability report provides a true and accurate summary of the performance of the Trust during the year 2019/20.

A handwritten signature in black ink, appearing to read 'S Tedford', enclosed within a thin black rectangular border.

Sarah Tedford

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

24 June 2020

Statement of the Chief Executive's responsibilities as the Accounting Officer of the 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 The Hillingdon Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Hillingdon Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

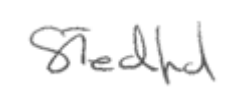
- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the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

A handwritten signature in black ink, appearing to read 'S Tedford', enclosed within a thin black rectangular border.

Sarah Tedford
Chief Executive
The Hillingdon Hospitals NHS Foundation Trust

24 June 2020

Appendix

The Hillingdon Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

The Hillingdon Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2020, have been prepared by the Hillingdon Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006, and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) of the National Health Service Act 2006.

Signed

A handwritten signature in black ink, appearing to read 'S Tedford', enclosed within a thin black rectangular border.

Name	Sarah Tedford
Job title	Chief Executive
Date	24 June 2020

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST

Report on the audit of the financial statements

1. Opinion

In our opinion the financial statements of The Hillingdon Hospitals NHS Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the foundation trust statement of comprehensive income;
- the foundation trust statement of financial position;
- the foundation trust statement of changes in equity;
- the foundation trust statement of cash flows; and
- the related notes 1 to 32.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

2. Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

3. Material uncertainty relating to going concern

We draw attention to note 1.2 in the financial statements and the disclosures in the Annual Governance Statement, which describe a material uncertainty with respect to the foundation trust's ability to continue as a going concern. As set out within the Statement of Comprehensive Income, the foundation trust incurred a net deficit of £26.2m for the year ended 31 March 2020 (31 March 2019: deficit of £25.9m) and, as disclosed in Note 24.1, the foundation trust has DHSC ("Department for Health and Social Care") loans on the balance sheet of £111.2m. £7m of loan principal falls due in 2020/21.

DHSC has put in place alternative contracting and funding arrangements during the Covid-19 outbreak which are due to expire on 31 July 2020.





The foundation trust has prepared a cash flow forecast for 12 months to the end of June 2021. Within that forecast, the foundation trust has assumed that it will receive £20.3m to fund its deficit that is not currently committed. There is no mechanism in place to guarantee that any deficits incurred after 31 July 2020 will be funded. Given that the mechanism the DHSC is using for agreeing cash support is on a month-to-month basis, the continued provision of revenue funding for the period up to 30 June 2021 is uncommitted. These conditions constitute a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern.

In response to this, we:

- reviewed the foundation trust's financial performance in 2019/20 including its achievement of planned cost improvements in the year;
- held discussions with management to understand the current status of contract negotiations with its commissioners, the financing required and the related funding arrangements that have been agreed. Where funding has been agreed, we have confirmed this to signed loan agreements;
- reviewed the foundation trust's cash flow forecasts and the foundation trust's provisional financial plan submitted to NHS Improvement;
- challenged the key assumptions used in the cash flow forecasts by reference to NHS Improvement guidance including guidance issued in May 2020 in response to Covid-19; and
- assessed the historical accuracy of the budgeting process used by the foundation trust.

As stated in note 1.2, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the foundation trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

4. Summary of our audit approach

Key audit matters	<p>The key audit matters that we identified in the current year were:</p> <ul style="list-style-type: none">• Recognition of NHS Revenue• Property valuation• Going concern (see material uncertainty related to going concern)• Arrangements to secure value for money (see matters on which we are required to report by exception – use of resources section) <p>Within this report, key audit matters are identified as follows:</p> <ul style="list-style-type: none"> Newly identified Increased level of risk Similar level of risk Decreased level of risk
Materiality	<p>The materiality that we used for the financial statements was £5.3m which was determined on the basis of 2% of Revenue.</p>
Scoping	<p>Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control. The foundation trust does not have any subsidiaries and is structured as a single reporting unit and so the whole foundation trust was subject to a full audit scope.</p>
Significant changes in our approach	<p>We have included a Key Audit Matter in relation to the property valuation due to the inclusion this year of a material uncertainty in the valuer's report as a result of Covid-19. Our other Key Audit Matters remain consistent.</p>

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

In addition to the matter described in the 'material uncertainty relating to going concern' section and the matter described in the matters on which we are required to report by exception – 'use of resources' section, we have determined the matters described below to be the key audit matters to be communicated in our report.

A new Key Audit Matter in the year relates to the material valuation uncertainty disclosed in the financial statements in relation to property due to the 31 March 2020 valuation date falling shortly after the outbreak of Covid-19.

5.1. NHS revenue and provisions

Key audit matter description

As described in note 1, Accounting policies and other information, there are significant judgements in recognition of revenue from care of NHS patients and in accounting for disputes with commissioners due to the judgemental nature of accounting for disputes, including in respect of outstanding overperformance income for quarters 3 and 4. We have therefore concluded that there is a risk of fraud in recognition of NHS revenue due to the level of judgement required.

Details of the foundation trust's income are shown in note 3 to the financial statements. Receivables from NHS and DHSC group bodies of £18m (2017/18: £17.6m) are shown in Note 20.1 to the financial statements.

The majority of the foundation trust's income comes from three commissioners, NHS Hillingdon (£139.3m), NHS Ealing (£20.1m) and NHS England (£6.4m), increasing the significance of associated judgements. The settlement of income with Clinical Commissioning Groups continues to present challenges, leading to disputes and delays in the agreement of year-end positions.

How the scope of our audit responded to the key audit matter

We obtained an understanding of the relevant controls over recognition of NHS income.

We performed detailed substantive testing on a sample basis of the validity of unsettled income and evaluated the results of the agreement of balances exercise.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

Key observations

The evidence we obtained from our audit procedures supported the revenue, receivables and provisions balance held by the foundation trust and the appropriateness of the assumptions used in its accounting for disputes.

5.2. Property valuation

Key audit matter description

The foundation trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £130.3m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.

As detailed in note 1.24, 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. As noted by the foundation trust's

external valuer, the pandemic has caused extensive disruption to businesses and economic activities and the uncertainties created have increased the estimation uncertainty over the valuation of properties at the balance sheet date. We have therefore concluded that there is a risk of misstatement in the valuation of the foundation trust's estate and related disclosures.

How the scope of our audit responded to the key audit matter

We worked with Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's properties.

We have reviewed the disclosures in note 1.24 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.

We considered the impact of uncertainties relating to the Covid-19 pandemic upon property valuations in evaluating the property valuations and related disclosures including the adequacy of the disclosure of the material valuation uncertainty.

We assessed whether the valuation was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

Key observations

While we note the increased estimation uncertainty in relation to the property valuation as a result of Covid-19, and as disclosed in note 1.24, we consider the valuation amounts disclosed in the accounts to be appropriate and based on the best information available.

6. Our application of materiality

6.1. Materiality

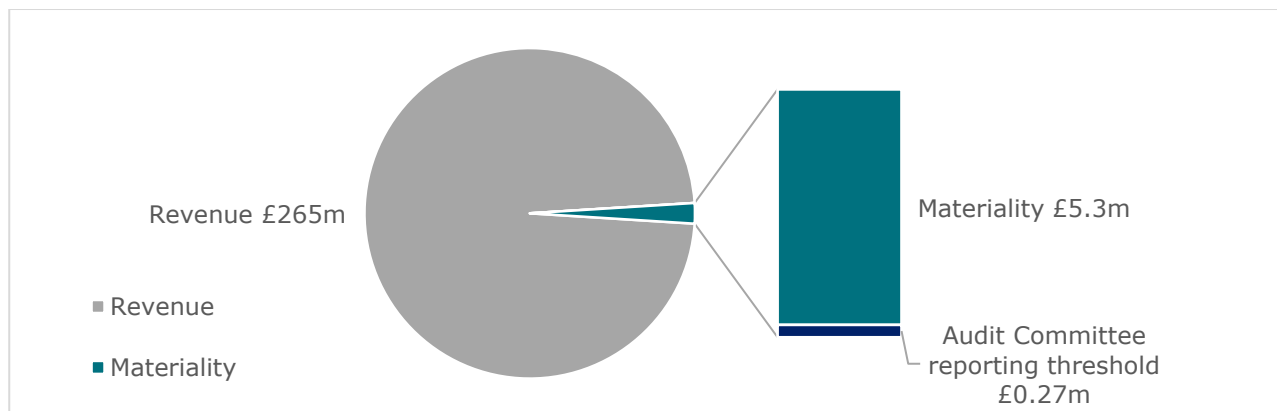
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Foundation trust financial statements

Materiality	£5.3m (2018/19: £5.1m)
Basis for determining materiality	2% of revenue (2018/19: 2% of revenue)

Rationale for the benchmark applied	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.
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6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Performance materiality was set at 60% of materiality for the 2019/20 audit (2018/19: 60%). In determining performance materiality, we considered:

- our risk assessment, including our assessment of the foundation trust's overall control environment, the fact that we do not rely on controls as part of the audit; and
- the adverse conclusion recorded in relation to arrangements to secure value for money; and

6.3. Error reporting threshold

We agreed with the Audit and Risk Committee that we would report to the Committee all audit differences in excess of £265k (2018/19: £253k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit and Risk Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the foundation trust and its environment, including internal controls, and assessing the risks of material misstatement at the foundation trust level. Audit work at the interim stage was performed at the foundation trust's head offices in Hillingdon directly by the audit engagement team, led by the audit partner. Due to the outbreak of Covid-19, the final stage of the audit was conducted remotely directly by the audit team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and information technology systems.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

9. Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation 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 the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. Auditor's responsibilities for the audit of the financial statements

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

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

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

12. Matters on which we are required to report by exception

12.1. Use of resources

We are required to report to you if, in our opinion the NHS Foundation Trust 'the foundation trust') has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

12.1.1. Basis for adverse conclusion

- In June 2018, the foundation trust undertook enforcement actions issued by NHS Improvement ("NHSI") under section 106 of the Health and Social Care Act 2012. NHSI stated that it had reasonable grounds to suspect that the foundation trust has provided and is providing health services for the purpose of the health service in England while failing to comply with the following conditions of its Licence: FT4 (5) (d) (f) (g) and FT4 (7). These breaches demonstrated shortcomings in corporate governance arrangements and financial management standards. Key areas particularly flagged at that time included, but were not limited to: A&E performance, delivery of cost improvement plans and weaknesses in the Project Management Office team. Following release of the CQC report in July 2018, further enforcement actions were issued by NHSI in relation to the delivery of quality. Undertakings under this further document included, but were not limited to: a required review to determine reasons why lack of progress against CQC targets was not identified, development of an assurance framework, deploying a framework to ensure patient safety issues are escalated, a review of risk management policies, and improvements to medical engagement. These enforcement actions continued to be in place throughout the 2019/20 period. The regime in place to review and update the status of these undertakings was suspended due to Covid-19. The foundation trust's 2019/20 Annual Governance Statement sets out actions taken and management's view on progress made in response to addressing these undertakings. However, whilst progress has been made during the year, some weaknesses in arrangements were present for at least part of the year, and as the enforcement undertakings remain in place, we have identified there were still significant weakness in arrangements for the 2019/20 year.
- The foundation trust was last inspected by the CQC in March 2018, with its report being issued in July 2018. The report indicated that overall the foundation trust was rated 'Requires improvement' with the same rating being given across all five indicators with the exception of 'Are services safe' – rated 'Inadequate' and 'Are services caring' – rated 'Good'. The same report rated the principal Hillingdon Hospital site as overall 'Inadequate' with the same ratings as the overall foundation trust given across all five indicators with the exception of 'Are services well-led' which was rated 'Inadequate'. This report and rating continued to be in place throughout the 2019/20 period. We note that the CQC inspection regime was suspended due to Covid-19. The foundation trust's 2019/20 Annual Governance Statement sets out actions taken and management's view on progress made in response to addressing findings arising from the CQC visit. However, whilst progress has been made during the year, some weaknesses in arrangements were present for at least part of year, and as the CQC has not performed a further inspection that would enable them

to reassess their rating, we have still identified this as a significant weakness in arrangements for the 2019/20 year.

- Our 2018/19 conclusion included an exception in relation to governance arrangements. This related to the May 2018 undertaking to have an externally commissioned governance review to inform the strengthening of governance arrangements. As reported in the prior year, interim improvement measures from that review, released in January 2019, indicated that improvements were required with regards to: capacity and capability within the foundation trust's leadership team and project management office, development of foundation trust strategy, governance structures and membership of groups within those structures, the Board Assurance Framework, arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management. Whilst the foundation trust has focused resources on improving arrangements in this area, including changes at Board Level, reformulation of the Board Assurance Framework and Risk Management Framework, changes took some months to deploy and the areas of governance in need of improvement continued for a substantial period in the 2019/20 period. We note that no external review of governance arrangements has been performed since the January 2019 report. The foundation trust's 2019/20 Annual Governance Statement sets out action taken and management's view on progress made in response to issues identified.
- The Trust had an Enforcement Notice issued on 30 January 2020 by London Fire Brigade due to several failures to comply with fire safety requirements. An Action Plan is in place to address the issues raised but the notice was still in force at 31 March 2020.

These issues are evidence of weaknesses in proper arrangements for acting in the public interest, through demonstrating and applying the principles and values of sound governance.

- Our 2018/19 conclusion identified weaknesses in the Trust's risk management arrangements and Board Assurance Framework. These weaknesses included, but were not limited to: the way in which key risks and actions are articulated to the Board and impact on the Board and committee agendas; the process for capturing and considering emerging risks and reviewing the risk register; the way in which risks are linked to strategy; the process for escalation and moderation of risks; and the timely completion of actions to address risks. The Trust has focused resources on improving arrangements in this area, including a reformulation of the Board Assurance Framework that was reviewed by internal audit in the period achieving a "substantial assurance with limited improvements required" rating. However these improvements were rolled out during the year meaning the older risk management arrangements continued to be in place for a substantial length of time within the 2019/20 period. The Trust's 2019/20 Annual Governance Statement sets out actions taken and management's view on progress made in response to issues identified.
- There are weaknesses in the internal control environment of the Trust that have been identified by the Trust's internal auditor including arrangements in respect of: GDPR Implementation, Incident Management, HR Business Processes: Temporary Staffing, Divisional Governance, Access and Activity Data and Core financial systems – Cash Management. In 2019/20 there continued to be work performed to address internal audit recommendations raised in 2018/19 in the following areas: consultant job planning; the retention programme; core financial systems; the Trust's outsourced contact management; business continuity; discharge planning; and the governance of the CQC Action Plan. Some internal audit recommendations were carried forwards from previous periods into the 2019/20 period and some internal audit recommendations remain outstanding at the year-end.

These issues are evidence of weaknesses in proper arrangements for managing risks effectively and maintaining a sound system of internal control

- Our 2018/19 conclusion identified weaknesses in the Trust's arrangements to ensure the quality of performance data as evidenced by our limited assurance report on the content of the quality report and mandated performance indicators which contained a qualified conclusion because of errors identified which affected the Accident and Emergency 4 hour wait performance indicators in 2018/19. We have previously identified that recommendations raised as part of previous assurance work in this area have not been effectively implemented. The 2019/20 assurance requirements on

the quality report have been removed and so we are not in a position to comment whether there have been improvements in this area. As our 2018/19 findings were raised in May and June 2019, we expect some of the identified issues to have persisted in the 2019/20 period being evaluated. We note that internal audit concluded with "Partial Assurance" in relation to their work on the Referral to Treatment indicator. The Trust's 2019/20 Annual Governance Statement sets out actions taken and management's view on progress made in response to issues identified.

This issue is evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable performance information to support informed decision making and performance management.

The Trust has described in its Annual Governance Statement the financial challenges it faces and the pressures on financial sustainability including matters which are not wholly within the control of the Trust. Particular indicators of pressure on sustainable finances include the following:

- The Trust incurred a deficit of £26.2m for the year ended 31 March 2020, against an originally planned deficit of £2.9m. Due to poorer than expected financial performance, the Trust has only been able to claim Provider Sustainability Funding ("PSF") of £8.4m against a planned receipt of £21.1m. PSF of £21.1m was included in the plan based on achieving a deficit control total of £23.7m, excluding PSF. The Trust's 2020/21 latest plan submission shows a forecast deficit for 2020/21. In order to fund these future deficits, the Trust received financial support in the form of new loans from the Department of Health in 2019/20 of £48.6m and is seeking further financial support in 2020/21.
- The Trust has estimated its backlog maintenance to be £211m across the estate but, due to limitations in available funding, has allocated only limited funding to capital developments. The Trust had capital expenditure in 2019/20 of £24.6m and plans capital expenditure of £48.1m in the 2020/21 year. The Trust is exposed to risks related to the age and condition of the estate that could impact levels of service provision. The CQC noted in their July 2018 report that, since their 2015 reports highlighting the poor condition of the Trust's buildings and estate, there had been little or slow progress in addressing this issue.
- The divergence from plan evident in the financial results noted above indicates there are weaknesses in the Trust's arrangements for developing budgets and monitoring costs and cash flow against budgets, particularly in relation to significant variances to planned pay and non-pay costs.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, we are not satisfied that, in all significant respects, The Hillingdon Hospitals NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

12.2. Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;

- the foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

12.3. Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- 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; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

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



Jonathan Gooding, FCA (Senior statutory auditor)

For and on behalf of Deloitte LLP

Statutory Auditor

St Albans, UK

24 June 2020

Statement of Comprehensive Income

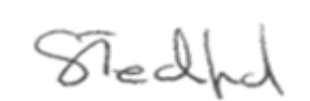
		2019/20	2018/19
	Note	£000	£000
Operating income from patient care activities	3	230,096	222,968
Other operating income	4	35,110	30,803
Operating expenses	6, 8	<u>(289,426)</u>	<u>(275,789)</u>
Operating (deficit) from continuing operations		<u>(24,220)</u>	<u>(22,018)</u>
Finance income	11	81	54
Finance expenses	12	<u>(3,643)</u>	<u>(3,171)</u>
PDC dividends payable		<u>(2,696)</u>	<u>(3,528)</u>
Net finance costs		<u>(6,258)</u>	<u>(6,645)</u>
Other gains	13	<u>4,306</u>	<u>2,769</u>
(Deficit) for the year		<u>(26,172)</u>	<u>(25,894)</u>
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,714)	-
Revaluations	17	9,597	-

Statement of Financial Position

		31 March 2020 £000	31 March 2019 £000
	Note		
Non-current assets			
Intangible assets	14	4,060	3,902
Property, plant and equipment	15	160,057	139,710
Investment property	18	50,162	45,856
Receivables	20	2,002	1,821
Total non-current assets		216,281	191,289
Current assets			
Inventories	19	3,167	2,964
Receivables	20	23,373	25,695
Cash and cash equivalents	21	9,791	1,032
Total current assets		36,331	29,691
Current liabilities			
Trade and other payables	22	(38,701)	(40,719)
Borrowings	24	(103,709)	(2,932)
Provisions	26	(151)	-
Other liabilities	23	(1,357)	-
Total current liabilities		(143,918)	(43,651)
Total assets less current liabilities		108,694	177,329
Non-current liabilities			
Borrowings	24	(21,077)	(73,233)
Provisions	26	(1,700)	(1,967)
Total non-current liabilities		(22,777)	(75,200)
Total assets employed		85,917	102,129
Financed by			
Public dividend capital		78,937	74,860
Revaluation reserve		53,357	48,579
Income and expenditure reserve		(46,377)	(21,310)
Total taxpayers' equity		85,917	102,129

The notes on pages 19 to 66 form part of these accounts.

Signed



Name
Position
Date

Sarah Tedford
Chief Executive
24 June 2020

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	74,860	48,579	(21,310)	102,129
(Deficit) for the year	-	-	(26,172)	(26,172)
Other transfers between reserves	-	(1,105)	1,105	-
Impairments	-	(3,714)	-	(3,714)
Revaluations	-	9,597	-	9,597
Public dividend capital received	4,077	-	-	4,077
Taxpayers' and others' equity at 31 March 2020	78,937	53,357	(46,377)	85,917

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	73,426	49,837	3,326	126,589
(Deficit) for the year	-	-	(25,894)	(25,894)
Other transfers between reserves	-	(1,258)	1,258	-
Public dividend capital received	1,434	-	-	1,434
Taxpayers' and others' equity at 31 March 2019	74,860	48,579	(21,310)	102,129

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

		2019/20	2018/19
	Note	£000	£000
Cash flows from operating activities			
Operating (deficit)		(24,220)	(22,018)
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,209	9,337
Net impairments	7	1,635	-
Income recognised in respect of capital donations	4	(86)	(77)
(Increase) / decrease in receivables and other assets		2,434	1,642
(Increase) / decrease in inventories		(203)	279
Increase / (decrease) in payables and other liabilities		(4,258)	1,748
Increase / (decrease) in provisions		(175)	(414)
Other movements in operating cash flows		(86)	-
Net cash flows from / (used in) operating activities		(15,750)	(9,503)
Cash flows from investing activities			
Interest received		81	54
Purchase of intangible assets		(866)	(1,510)
Purchase of PPE and investment property		(20,633)	(5,587)
Net cash flows from / (used in) investing activities		(21,418)	(7,043)
Cash flows from financing activities			
Public dividend capital received		4,077	1,434
Movement on loans from DHSC		49,577	23,150
Capital element of finance lease rental payments		(843)	(1,262)
Capital element of PFI, LIFT and other service concession payments		(252)	(230)
Interest on loans		(1,868)	(1,297)
Other interest		(75)	(11)
Interest paid on finance lease liabilities		(136)	(166)
Interest paid on PFI, LIFT and other service concession obligations		(1,564)	(1,520)
PDC dividend (paid) / refunded		(2,989)	(3,619)
Net cash flows from / (used in) financing activities		45,927	16,479
Increase / (decrease) in cash and cash equivalents		8,759	(67)
Cash and cash equivalents at 1 April - brought forward		1,032	1,099
Cash and cash equivalents at 31 March	21	9,791	1,032

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, 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

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.

Note 1.2 Going concern

In line with paragraphs 4.11 – 4.15 of the DH Group Accounting Manual (GAM), Department of Health and Social Care (DHSC) group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. This has not happened in the case of the Trust, and services are expected to continue for the foreseeable future. The Trust's financial statements (which form part of the Trust's annual report) have therefore been prepared on the going concern basis.

Given the Trust's financial position, consideration has been given to the Trust's broader financial sustainability for the 'foreseeable future' (which is determined as a period of 12 months following the approval of the financial statements – to 30 June 2021); as well as the circumstances in which the Trust (and all other NHS providers) are currently operating. Based on this review, we note the following:

1. The recurrent financial position of the Trust is in deficit. The reported deficit for 2019/20 was £26.2m (2018/19: deficit of £25.9m). While the Trust's 2020/21 operational plan currently forecasts a breakeven position, this is after receipt of £20.3m of non-recurrent funding, so the underlying position is for a £20.3m deficit.
2. The Trust has £111.2m of DHSC loans on the balance sheet. In April 2020, DHSC announced changes to the cash regime, which means that in September 2020, the Trust will receive £95.0m in Public Dividend Capital (PDC) to repay the majority of these loans; this PDC will be added to the balance sheet. This will reduce the exposure of the Trust to future loan payments, but the revenue position of the Trust will deteriorate by approximately £2.0m per year due to the additional PDC dividends payable.
3. The Trust is also forecasting to repay £7m in loan principal during 2020/21. This will have a significant impact on cash balances.
4. As with all other NHS provider organisations, the Trust is currently being funded on a block contract arrangement for the period up to July 2020, as the DHSC provides certainty in cash flows for all NHS organisations during the COVID-19 pandemic. National planning and contracting rounds for 2020/21 have been frozen until further notice.
5. NHS Improvement issued a letter to all NHS providers on 27 May to provide some certainty around future cash flows. However, it does not provide a guarantee to underwrite any underlying deficits arising during the period up to 30 June 2021.

Given that the mechanism the DHSC is using for agreeing cash support is on a month-to-month basis, the continued provision of revenue funding for the period up to 30 June 2021 is uncommitted. These conditions constitute a material uncertainty that may cast significant doubt over the Trust's ability to continue as a going concern.

However, as stated above, for the purposes of the financial statements, in line with the existing financial reporting framework, the Trust is considered by management to be a going concern.

Note 1.3 Revenue from contracts with customers

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

Revenue in respect of 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.

Revenue is recognised to the extent that collection of consideration is probable. 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 effect of readmissions is not material, or is reflected in the contract baseline and thus in the transaction price.

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.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

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

Note 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the 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.

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.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. 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.

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential 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
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar 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, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. The last full revaluation exercise took place on 31st March 2017, and was deemed unnecessary for 31 March 2020. However, having consulted with our Trust surveyors, Gerald Eve, a desktop revaluation was carried out.

The surveyors are MRICS qualified and registered valuers and are experienced in the healthcare sector. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- 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.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the 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.

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.

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.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	60
Dwellings	5	5
Plant & machinery	2	20
Transport equipment	2	5
Information technology	2	15
Furniture & fittings	5	15

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Recognition

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

Software

Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	15

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.10 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.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 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.

Note 1.13 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.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market 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 (note 1.14) described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses. Further information is disclosed in note 20.2.

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).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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.

Note 1.14 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.

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.

Note 1.15 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:

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

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

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

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the 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 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under 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.

Note 1.16 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, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised 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.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

Note 1.18 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.

Note 1.19 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*.

Note 1.20 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.

Note 1.21 Early adoption of standards, amendments and interpretations

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

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

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. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

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

The Trust had carried out significant work to assess lease arrangements ahead of the original transition date. However, this work was not completed and the revision of the transition date offers the Trust an opportunity to ensure the completeness of records and to be fully ready ahead of 1 April 2021. 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 in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

No other standards have been issued or adopted for the public sector that are expected to have a significant impact on the financial statements.

Note 1.23 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements about the carrying amount of assets and liabilities, and to disclose material judgements here. The Trust considers that no material judgements have been made during the production of the financial statements.

Note 1.24 Sources of estimation uncertainty

In the application of the Trust's accounting policies management is required to make estimates, and assumptions about the carrying amount of assets and liabilities. 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.

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

In this disclosure, in line with accounting standards, we focus only on uncertainties that have a potential material impact on the financial statements.

Going concern

We have commented further on going concern in note 1.2. The accounts have been prepared on the going concern basis.

Asset valuations and asset lives

In line with the Trust's Property, Plant and Equipment (PPE) policy (and to comply with accounting standards) an interim valuation of all land and property owned by the Trust was undertaken in March 2020 by Gerald Eve LLP, an independent firm of professional valuers. This valuation was carried out in accordance with the Valuation – Global Standards 2020 of the Royal Institution of Chartered Surveyors (RICS) and was consistent with the requirements of HM Treasury, the Department of Health and Social Care and NHS Improvement and International Financial Reporting Standards (IFRS).

As a result of the impact of the novel coronavirus (COVID-19), which was declared a global pandemic on 11 March 2020, on market activity, the external valuers have included a 'material valuation uncertainty' statement in their report.

The clause states that: "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. In the UK, market activity is being impacted in all 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 on the basis of 'material valuation uncertainty' per 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 COVID-19 might have on the real estate market, we recommend that you keep the valuation under frequent review."

To reflect their judgement on the impact of COVID-19 on prevailing land values, the valuer has made an adjustment of - 7.5% to the land value rate adopted from £2.4m per acre to £2.2m per acre. Based on a 25.2 acre site, the impact of COVID-19 on the valuation is £5.0m.

Within the valuation, other factors also considered were build cost inflation, differing choice of cost rates for individual assets, differing non-physical obsolescence judgements, positive adjustments or impairments on capital improvements held at cost until revaluation, differing assumptions on professional fees levels, finance costs etc. the majority of which are inter-linked and are not analysed here.

Note 2 Operating Segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely available and the cost to develop this information would be significant.

Significant amounts of income are received from transactions with the Department of Health and other NHS bodies. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	2019/20 £000	2018/19 £000
Acute services		
Elective income	29,072	31,322
Non elective income	50,393	65,454
First outpatient income	15,771	15,898
Follow up outpatient income	21,285	19,320
A & E income	14,828	12,753
High cost drugs income from commissioners (excluding pass-through costs)	13,070	12,583
Other NHS clinical income	72,480	56,527
Ambulance services		
Patient transport services income	1,182	1,150
Community services		
Community services income from CCGs and NHS England	2,079	2,419
All services		
Private patient income	141	191
Agenda for Change pay award central funding*	-	2,745
Additional pension contribution central funding**	7,188	-
Other clinical income	2,606	2,606
Total income from activities	230,096	222,968

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**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.

Note 3.2 Income from patient care activities (by source)

	2019/20 £000	2018/19 £000
Income from patient care activities received from:		
NHS England	21,139	14,023
Clinical commissioning groups	205,710	202,888
Department of Health and Social Care	-	2,745
Other NHS providers	500	515
Non-NHS: private patients	141	191
Non-NHS: overseas patients (chargeable to patient)	1,389	1,440
Injury cost recovery scheme	1,142	1,053
Non NHS: other	75	113
Total income from activities	230,096	222,968
Of which:		
Related to continuing operations	230,096	222,968

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	1,389	1,440
Cash payments received in-year	874	740
Amounts added to provision for impairment of receivables	(39)	(231)
Amounts written off in-year	425	175

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	421	-	421	345	-	345
Education and training	9,196	134	9,330	9,415	49	9,464
Non-patient care services to other bodies	7,254	-	7,254	8,790	-	8,790
Provider sustainability fund (PSF)	1,847	-	1,847	2,062	-	2,062
Financial recovery fund (FRF)	5,182	-	5,182	-	-	-
Marginal rate emergency tariff funding (MRET)	1,581	-	1,581	-	-	-
Income in respect of employee benefits accounted on a gross basis	590	-	590	576	-	576
Receipt of capital grants and donations	-	86	86	-	77	77
Rental revenue from operating leases	-	3,118	3,118	-	3,417	3,417
Other income	5,701	-	5,701	6,072	-	6,072
Total other operating income	31,772	3,338	35,110	27,260	3,543	30,803
Of which:						
Related to continuing operations			35,110			30,803

Note 5 Income from activities arising from 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	2018/19
	£000	£000
Income from services designated as commissioner requested services	189,592	168,124
Income from services not designated as commissioner requested services	40,504	54,844
Total	230,096	222,968

Note 6.1 Operating expenses

	2019/20	2018/19
	£000	£000
Staff and executive directors costs	191,073	176,739
Remuneration of non-executive directors	147	134
Supplies and services - clinical (excluding drugs costs)	25,518	34,758
Supplies and services - general	4,050	3,975
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,156	18,156
Inventories written down	38	60
Consultancy costs	4,200	2,025
Establishment	6,418	5,242
Premises	8,607	7,884
Transport (including patient travel)	1,961	1,837
Depreciation on property, plant and equipment	8,501	8,752
Amortisation on intangible assets	708	585
Net impairments	1,635	-
Movement in credit loss allowance: contract receivables / contract assets	163	758
Movement in credit loss allowance: all other receivables and investments	276	13
Increase/(decrease) in other provisions	(44)	(262)
Audit fees payable to the external auditor		
audit services- statutory audit	128	121
other auditor remuneration (external auditor only)	-	71
Internal audit costs	89	111
Clinical negligence	10,789	8,326
Legal fees	157	179
Insurance	213	258
Research and development	401	363
Education and training	1,778	1,727
Rentals under operating leases	711	508
Redundancy	-	73
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	497	550
Car parking & security	467	376
Hospitality	35	41
Losses, ex gratia & special payments	4	110
Other services, e.g. external payroll	2,750	2,303
Other	-	16
Total	289,426	275,789
Of which:		
Related to continuing operations	289,426	275,789

Note 6.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	71
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	-	71

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	1,635	-
Total net impairments charged to operating surplus / deficit	1,635	-
Impairments charged to the revaluation reserve	3,714	-
Total net impairments	5,349	-

The Trust had a desktop revaluation undertaken as at 31 March 2020. There are some buildings on the Trust's sites which have advanced levels of obsolescence, and the valuation reflected that. In particular, some assets have a low or zero revaluation reserve balance; and when the valuation was updated and showed further downward movement due to the age and condition of the assets, these amounts were taken to I&E in line with accounting standards.

Note 8 Employee benefits

	2019/20	2018/19
	Total	Total
	£000	£000
Salaries and wages	146,442	139,501
Social security costs	15,302	14,685
Apprenticeship levy	719	690
Employer's contributions to NHS pensions	23,344	15,521
Pension cost - other	51	26
Termination benefits	-	102
Temporary staff (including agency)	9,697	10,453
Total gross staff costs	195,555	180,978
Recoveries in respect of seconded staff	(1,751)	(1,709)
Total staff costs	193,804	179,269
Of which		
Costs capitalised as part of assets	1,228	842

Note 8.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £93k (£14k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate for 2019/20 is 20.6%.

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

Note 10 Operating leases

Note 10.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where The Hillingdon Hospitals NHS Foundation Trust is the lessor.

The most significant operating leases generating income for the Trust are located at the Mount Vernon site, most notably the BMI Bishops Wood hospital. In addition the Trust generates some income through the rental of mobile phone masts on the Trust's tower block.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	2,710	2,760
Contingent rent	408	657
Total	3,118	3,417
	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	1,919	2,455
- later than one year and not later than five years;	7,010	8,772
- later than five years.	95,312	100,057
Total	104,241	111,284

Note 10.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Hillingdon Hospitals NHS Foundation Trust is the lessee.

The Trust is involved in non-material operating leases for temporary buildings and medical equipment. The most significant is for the Bevan ward, for which the Trust pays £350k per year and has three years to run.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	666	474
Contingent rents	45	34
Total	711	508
	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	780	508
- later than one year and not later than five years;	2,167	1,727
- later than five years.	-	72
Total	2,947	2,307

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	81	54
Total finance income	81	54

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,868	1,439
Finance leases	136	140
Interest on late payment of commercial debt	16	12
Main finance costs on PFI and LIFT schemes obligations	824	1,520
Contingent finance costs on PFI and LIFT scheme obligations	740	-
Total interest expense	3,584	3,111
Unwinding of discount on provisions	59	60
Total finance costs	3,643	3,171

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	16	12

Note 13 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	-	-
Fair value gains / (losses) on investment properties	4,306	2,769
Total other gains / (losses)	4,306	2,769

Note 14.1 Intangible assets - 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	8,337	968	9,305
Additions	60	806	866
Valuation / gross cost at 31 March 2020	8,397	1,774	10,171
Amortisation at 1 April 2019 - brought forward	5,403	-	5,403
Provided during the year	708	-	708
Amortisation at 31 March 2020	6,111	-	6,111
Net book value at 31 March 2020	2,286	1,774	4,060
Net book value at 1 April 2019	2,934	968	3,902

Note 14.2 Intangible assets - 2018/19

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	7,294	-	7,294
Additions	542	968	1,510
Reclassifications	501	-	501
Valuation / gross cost at 31 March 2019	8,337	968	9,305
Amortisation at 1 April 2018 - as previously stated	4,818	-	4,818
Provided during the year	585	-	585
Amortisation at 31 March 2019	5,403	-	5,403
Net book value at 31 March 2019	2,934	968	3,902
Net book value at 1 April 2018	2,476	-	2,476

Note 15.1 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	50,792	82,823	1,731	3,587	32,332	18	17,603	93	188,979
Additions	-	5,272	-	18,841	447	-	40	-	24,600
Impairments	(172)	(5,142)	(35)	-	-	-	-	-	(5,349)
Revaluations	1,460	8,137	-	-	-	-	-	-	9,597
Reclassifications	-	1,963	-	(1,997)	-	-	34	-	-
Valuation/gross cost at 31 March 2020	52,080	93,053	1,696	20,431	32,779	18	17,677	93	217,827
Accumulated depreciation at 1 April 2019 - brought forward	-	9,466	780	-	23,949	18	14,982	74	49,269
Provided during the year	-	5,404	372	-	1,925	-	797	3	8,501
Accumulated depreciation at 31 March 2020	-	14,870	1,152	-	25,874	18	15,779	77	57,770
Net book value at 31 March 2020	52,080	78,183	544	20,431	6,905	-	1,898	16	160,057
Net book value at 1 April 2019	50,792	73,357	951	3,587	8,383	-	2,621	19	139,710

Note 15.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	50,792	77,321	1,700	2,658	31,170	18	16,883	93	180,635
Additions	-	4,702	31	2,712	1,162	-	238	-	8,845
Reclassifications	-	800	-	(1,783)	-	-	482	-	(501)
Valuation/gross cost at 31 March 2019	50,792	82,823	1,731	3,587	32,332	18	17,603	93	188,979
Accumulated depreciation at 1 April 2018 - as previously stated	-	4,515	390	-	21,701	18	13,824	69	40,517
Provided during the year	-	4,951	390	-	2,248	-	1,158	5	8,752
Accumulated depreciation at 31 March 2019	-	9,466	780	-	23,949	18	14,982	74	49,269
Net book value at 31 March 2019	50,792	73,357	951	3,587	8,383	-	2,621	19	139,710
Net book value at 1 April 2018	50,792	72,806	1,310	2,658	9,469	-	3,059	24	140,118

Note 15.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020								
Owned - purchased	51,480	67,516	544	20,431	4,199	1,824	16	146,010
Finance leased	-	-	-	-	2,174	74	-	2,248
On-SoFP PFI contracts and other service concession arrangements	600	8,955	-	-	-	-	-	9,555
Owned - donated	-	1,712	-	-	532	-	-	2,244
NBV total at 31 March 2020	52,080	78,183	544	20,431	6,905	1,898	16	160,057

Note 15.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	50,192	62,257	951	3,587	5,062	2,419	19	124,487
Finance leased	-	-	-	-	2,780	202	-	2,982
On-SoFP PFI contracts and other service concession arrangements	600	9,255	-	-	-	-	-	9,855
Owned - donated	-	1,845	-	-	541	-	-	2,386
NBV total at 31 March 2019	50,792	73,357	951	3,587	8,383	2,621	19	139,710

Note 16 Donations of property, plant and equipment

The Trust received £86k of donated equipment in year. None of the individual items were significant in value (the largest was £20k) - these were all designated for specific wards at the Trust's site and are being used in those areas.

Note 17 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued as at 31 March 2020 on a desktop basis by qualified independent valuers Gerald Eve. The assets were revalued on the basis of their current value in existing use.

The last full valuation of the Trust's sites took place as at 31 March 2017. There has not been significant change to the valuation methodology since that time. Most of the hospital buildings on both the Hillingdon and Mount Vernon sites are designated as specialised assets (on the grounds that there is no active market for them and hospital buildings are seldom sold in the market). On this basis, valuation guidance available in the RICS Red Book determines that a Depreciated Replacement Cost basis be used to value such assets.

The valuation of land assets has been completed using available and comparable market information, which represents an estimate of the likely sale price in the unlikely event that it were to be sold. As is common in NHS organisations, the size of the site is calculated using a Modern Equivalent Asset methodology, which aims to estimate what size site the Trust's buildings would occupy if it were newly built at the valuation date.

Dwelling assets are not specialised, and are valued at market value.

The values for buildings reported in the accounts reflect the significant amount of investment made in the site over the last 2-3 years, but also the advanced obsolescence of some parts of the site.

Assets are depreciated on the straight line basis, with the useful economic lives of the buildings reflecting their level of obsolescence.

Note 18.1 Investment Property

	2019/20	2018/19
	£000	£000
Carrying value at 1 April - brought forward	45,856	43,087
Movement in fair value	4,306	2,769
Carrying value at 31 March	<u>50,162</u>	<u>45,856</u>

Note 18.2 Investment property income and expenses

	2019/20	2018/19
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(2,222)	(1,753)
Direct operating expense arising from investment property which did not generate rental income in the period	(208)	(194)
Total investment property expenses	<u>(2,430)</u>	<u>(1,947)</u>
Investment property income	3,081	3,026

Note 19 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	1,630	1,334
Consumables	1,375	1,470
Energy	80	20
Other	82	140
Total inventories	3,167	2,964

Inventories recognised in expenses for the year were £173k (2018/19: £28,706k). Write-down of inventories recognised as expenses for the year were £38k (2018/19: £60k).

The write down noted above relates to pharmacy stocks.

Note 20.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	20,236	22,812
Allowance for impaired contract receivables / assets	(1,210)	(1,518)
Allowance for other impaired receivables	(964)	(688)
Prepayments (non-PFI)	2,126	2,180
PDC dividend receivable	441	148
VAT receivable	893	836
Other receivables	1,851	1,925
Total current receivables	23,373	25,695
Non-current		
Contract receivables	1,499	1,294
Allowance for other impaired receivables	(327)	(283)
Prepayments (non-PFI)	810	810
Other receivables	20	-
Total non-current receivables	2,002	1,821
Of which receivable from NHS and DHSC group bodies:		
Current	18,006	17,610
Non-current	20	-

Note 20.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April - brought forward	1,801	688	-	1,904
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	1,229	(1,229)
New allowances arising	166	276	771	13
Reversals of allowances	(3)	-	(13)	-
Utilisation of allowances (write offs)	(427)	-	(186)	-
Allowances as at 31 Mar 2020	1,537	964	1,801	688

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2019/20	2018/19
	£000	£000
At 1 April	1,032	1,099
Net change in year	8,759	(67)
At 31 March	9,791	1,032
Broken down into:		
Cash at commercial banks and in hand	221	266
Cash with the Government Banking Service	9,570	766
Total cash and cash equivalents as in SoFP	9,791	1,032
Total cash and cash equivalents as in SoCF	9,791	1,032

Note 22 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	12,229	19,266
Capital payables	7,854	4,257
Accruals	11,936	8,959
Receipts in advance and payments on account	-	1,394
Other taxes payable	4,041	4,174
Other payables	2,641	2,669
Total trade and other payables	38,701	40,719
Of which payables from NHS and DHSC group bodies:		
Current	13,717	12,435

Note 23 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,357	-
Total other current liabilities	1,357	-

Note 24.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	102,805	1,715
Obligations under finance leases	651	964
Obligations under PFI, LIFT or other service concession contracts	253	253
Total current borrowings	103,709	2,932
Non-current		
Loans from DHSC	8,345	59,719
Obligations under finance leases	1,519	2,049
Obligations under PFI, LIFT or other service concession contracts	11,213	11,465
Total non-current borrowings	21,077	73,233

Prior to 31 March 2020, most of the Trust's loans were deemed as being repayable in at least two or three years. However, the Department for Health and Social Care stated in April 2020 that interim (emergency) loans would be converted into Public Dividend Capital with effect from 1 April 2020. As such, DHSC has clarified that it expects Trusts with such loans to account for them as current borrowings, rather than non-current.

This impacts approximately £95m of the Trust's loan base, and therefore accounts for the majority of the movement between years.

We have also included disclosure note 32 around events after the end of the reporting period, where more information is included on this issue.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	61,434	3,013	11,718	76,165
Financing cash flows - payments and receipts of principal	49,577	(843)	(252)	48,482
Financing cash flows - payments of interest	(1,868)	(136)	(824)	(2,828)
Non-cash movements:				
Application of effective interest rate	2,007	136	824	2,967
Carrying value at 31 March 2020	111,150	2,170	11,466	124,786

Note 24.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	37,959	4,275	11,948	54,182
Cash movements:				
Financing cash flows - payments and receipts of principal	23,150	(1,262)	(230)	21,658
Financing cash flows - payments of interest	(1,297)	(166)	(1,520)	(2,983)
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	180	-	0	180
Application of effective interest rate	1,442	166	1,520	3,128
Carrying value at 31 March 2019	61,434	3,013	11,718	76,165

Note 25 Finance leases

Note 25.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

The Trust has no finance lease arrangements in which it is the lessor.

Note 25.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2020 £000	31 March 2019 £000
Gross lease liabilities	2,394	3,328
of which liabilities are due:		
- not later than one year;	747	1,087
- later than one year and not later than five years;	1,543	1,884
- later than five years.	104	357
Finance charges allocated to future periods	(224)	(315)
Net lease liabilities	2,170	3,013
of which payable:		
- not later than one year;	651	964
- later than one year and not later than five years;	1,417	1,710
- later than five years.	102	339

The vast majority of the Trust's finance leases as lessee relate to the lease of medical equipment. None of the individual items included are significant in value.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Other £000	Total £000
At 1 April 2019	1,595	372	-	1,967
Arising during the year	44	-	20	64
Utilised during the year	(114)	(37)	-	(151)
Reversed unused	(88)	-	-	(88)
Unwinding of discount	48	11	-	59
At 31 March 2020	1,485	346	20	1,851
Expected timing of cash flows:				
- not later than one year;	114	37	-	151
- later than one year and not later than five years;	456	148	-	604
- later than five years.	915	161	20	1,096
Total	1,485	346	20	1,851

All of the provisions held by the Trust relate to pensions. The most significant group relates to early retirement benefits for the Trust's former staff. The scheme is controlled by NHS Pensions; they inform the Trust of movements in the provision and advise when payments are due to individuals. As such, they control the timing of those cash outflows; other than that the length of the provision is determined by the longevity of the individuals concerned.

'Other' provisions relate to clinicians' pension tax, which is a new requirement in 2019/20. The Government Actuaries Department and the NHS Business Services Authority provide an estimate of £3,345 as the likely value for each scheme member eligible to claim. Based on current information, the Trust has estimated that 6 staff members are eligible to claim.

Note 26.2 Clinical negligence liabilities

At 31 March 2020, £206,150k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust (31 March 2019: £169,497k).

Note 27 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	3,905	4,258
Intangible assets	-	-
Total	3,905	4,258

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has one Local Improvement Finance Trust (LIFT) scheme on balance sheet. It relates to the Treatment Centre on the Trust's Mount Vernon site, and was added to the balance sheet in 2008/09.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	20,153	21,228
Of which liabilities are due		
- not later than one year;	1,058	1,076
- later than one year and not later than five years;	4,308	4,287
- later than five years.	14,787	15,865
Finance charges allocated to future periods	(8,687)	(9,510)
Net PFI, LIFT or other service concession arrangement obligation	11,466	11,718
- not later than one year;	253	253
- later than one year and not later than five years;	1,288	1,182
- later than five years.	9,925	10,283

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	35,837	37,280
Of which payments are due:		
- not later than one year;	2,297	2,236
- later than one year and not later than five years;	9,188	8,944
- later than five years.	24,352	26,100

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2019/20	2018/19
	£000	£000
Unitary payment payable to service concession operator	2,297	2,236
Consisting of:		
- Interest charge	824	1,520
- Repayment of balance sheet obligation	252	230
- Service element and other charges to operating expenditure	481	486
- Contingent rent	740	-
 Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	 16	 64
Total amount paid to service concession operator	2,313	2,300

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing commissioner-provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

As shown in the Statement of Financial Position, the Trust has £111.2m of loans on balance sheet (including accrued interest). However, these loans are all from the Department of Health to ensure the Trust has sufficient liquidity and working capital, and can also invest in its infrastructure. Nominally, the borrowings are for 1 – 25 years (see also note 32 for information on future cancellation of loans), in line with the life of the associated assets, and interest is generally charged at a fixed 1.5%. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust has set out in the going concern section of the accounting policies accompanying these financial statements that the accounts are being prepared on the going concern basis, despite material uncertainties around the Trust's financial position and liquidity. However, the Trust is in receipt of working capital support and does not expect this position to change in the foreseeable future. The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament.

The Trust assesses that liquidity risk, while underwritten by DH, is low.

Note 29.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2020			
Trade and other receivables excluding non financial assets	21,085	-	21,085
Cash and cash equivalents	9,791	-	9,791
Total at 31 March 2020	30,876	-	30,876

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial assets as at 31 March 2019			
Trade and other receivables excluding non financial assets	23,515	-	23,515
Cash and cash equivalents	1,032	-	1,032
Total at 31 March 2019	24,547	-	24,547

Note 29.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	111,150	111,150
Obligations under finance leases	2,170	2,170
Obligations under PFI, LIFT and other service concession contracts	11,466	11,466
Trade and other payables excluding non financial liabilities	32,627	32,627
Total at 31 March 2020	157,413	157,413

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019		
Loans from the Department of Health and Social Care	61,434	61,434
Obligations under finance leases	3,013	3,013
Obligations under PFI, LIFT and other service concession contracts	11,718	11,718
Trade and other payables excluding non financial liabilities	35,151	35,151
Total at 31 March 2019	111,316	111,316

Note 29.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	136,336	37,990
In more than one year but not more than two years	2,188	28,009
In more than two years but not more than five years	8,862	30,627
In more than five years	10,027	14,690
Total	157,413	111,316

Note 29.4 been prepared net of future interest costs in line with guidance from DHSC. For the gross basis for the maturity of financial liabilities relating to the LIFT scheme, refer to note 28.

Note 30 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	4	1	5	1
Bad debts and claims abandoned	76	431	111	189
Total losses	80	432	116	190
Special payments				
Compensation under court order or legally binding arbitration award	3	19	8	68
Ex-gratia payments	5	2	8	4
Total special payments	8	21	16	72
Total losses and special payments	88	453	132	262

Note 31 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust.

Catherine Jervis was a non-executive director at the Trust and also at Barnet, Enfield and Haringey (BEH) NHS Trust. There were no transactions with BEH in year.

The husband of the Medical Director, Dr Catherine Cale, is an executive for Thermo Fisher, a company that provides equipment, services and consumables to NHS Trusts. The Trust's balances at 31 March 2020 and transactions in 2019/20 with Thermo Fisher were as follows: income £0k, expenditure £2k, debtors £0, creditors £1k.

Sarah Pinch provided communications services to the Trust through her company, Pinch Point Communications. The Trust's balances and transactions with Pinch Point were as follows: income £0k, expenditure (excluding salaries) £84k, debtors £0, creditors (excluding salaries) £16k.

The Trust has a linked charity, Hillingdon Hospitals NHS Foundation Trust Charity (1056493). No material transactions flowed between the Trust and the Charity during 2019/20.

The Department of Health is considered a related party. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department (please note, for the purposes of this section, material is taken to mean £5.4m in line with materiality used by external audit in their review of these accounts). Material transactions occurred with the following such entities within the NHS (all numbers reported are in £000s):

	Income	Expenditure	Debtors	Creditors
Hillingdon Clinical Commissioning Group (CCG)	156,145	-	5,394	-
Ealing CCG	27,213	-	1,282	-
Harrow CCG	6,676	-	83	2
NHS England	14,727	160	3,303	244
Imperial College Healthcare NHS Trust	6,957	13,968	2,771	5,378
East and North Hertfordshire NHS Trust	6,624	1,456	29	903
Health Education England	8,454	-	115	-
NHS Pensions	-	23,344	-	-
NHS Resolution	-	10,859	-	-

In addition, the Trust has had a number of material transactions with other governmental bodies. Most of the material transactions have been with HMRC, as follows:

	Income	Expenditure	Debtors	Creditors
HM Revenue and Customs	-	15,882	893	4,041

Note 32 Events after the reporting date

The Trust has considered whether there are any material post balance sheet events to disclose. There is one material non-adjusting event that requires disclosure.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £95.4m are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

