Our Values
PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

NHS
Homerton
University Hospital
NHS Foundation Trust

Annual Report and Accounts 2020/21

VACCINATED AGAINST
We Homerton
COVID-19 • 2021

Incorporating hospital and community health services, teaching and research

Homerton University Hospital NHS Foundation Trust

Annual Report and Accounts 2020/21

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

Annual Report

Our Values

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Homerton University Hospital NHS Foundation Trust

Annual Report and Accounts 2020/21

Contents

1. Performance Report

Overview of performance

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

Chair and Chief Executive's overview

Welcome to our 2020/21 Annual Report. It contains the Annual Accounts for the financial year and much of the mandated commentary on performance that we would report in a normal year.

The Coronavirus pandemic

2020/21 was far from normal because of the Covid-19 pandemic. The year started a week after the introduction of the first national lockdown and as the first wave reached its peak. It ended as the second and larger wave subsided, the vaccination programme reached full speed, and the country took its initial steps out of the third lockdown.

The pandemic had a dramatic impact on the range of services we were able to offer, the way we cared for patients, the way our operations were financed and the way we worked with the wider NHS and with other public services. Some of these changes, for example the shift of many outpatient appointments from clinic to phone or video, are likely to continue.

Initially we plunged into an emergency response to the unprecedented wave of illness and hospitalisations. In the space of a very few days, our hospital and community services had to be transformed both to provide for the rush of admissions of Covid-19 patients and to protect staff and patients from infection.

Across the NHS, non-urgent admissions and surgery and most outpatient appointments and clinics were cancelled and our main theatres were reconfigured to provide critical care beds for patients requiring ventilation. In the community, services were reorganised to provide care by telephone and video, as well as at home, in a way which protected the vulnerable and our staff. With many staff having to isolate themselves for a period to limit infection, many staff had to work outside their normal services. At the same time, we joined others in the NHS and universities in building a better understanding of the disease and in developing and testing new treatments for it.

From June, as the levels of infection and hospitalisation fell and the lockdown was lifted, the Trust resumed a full range of services and began to tackle the backlog of elective cases. But in the autumn infection levels rose again leading to renewed restrictions in the community and another surge in hospitalisations at Christmas and the New Year. North east London was one of the areas hardest hit in this second wave and the numbers of Covid patients in the hospital were almost twice as high as in the first wave.

At the New Year, alongside dealing with the Covid infection, the Trust played its part in the drive to vaccinate the adult population particularly by vaccinating our own staff and the staff of related organisations including the ambulance service, social care staff, and cleaners, drivers and other staff employed by our contractors.

Partly as a result of the lessons from the earlier surge, we and our partners were able to maintain a wider range of services for other patients through the second surge but we know that many have had to wait longer for care or have been discouraged from seeking clinical help. The key priorities for us in the coming months are to do all we can in collaboration with neighbouring trusts, with our primary care colleagues and with local authorities, to tackle this unmet need; to address the inequalities in health outcomes that the pandemic brought out so starkly; and to build a more integrated care system for the people of City and Hackney.

We pay tribute again to staff throughout the Trust for their dedication to do the best for our patients and our communities despite the risks. The public spotlight was on the nurses and others caring directly for Covid patients in acute wards and critical care. We applaud their work including the commitment of many staff from other parts of the Trust who switched to work in these most pressured areas. But we also applaud the work of others in the hospital and the community, in the frontline of care and in management or support roles, for their work and dedication which also proved invaluable in dealing with the unprecedented demands. We also mourn again the deaths associated with the pandemic of many patients and of three members of our staff – Abdul Chowdhury, Michael Allieu and Sophie Fagan.

Other developments

Although the pandemic reshaped our service and our year, we would note some other developments and achievements during the year.

Quality and patient care

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

We measure ourselves by our patient feedback in regular surveys and by monitoring our performance on waiting times and a range of other quality indicators against other similar trusts. We also have a structured process to learn from serious incidents and from complaints. Further details are reported in our Quality Account which shows that, subject to the disruption during the two pandemic surges, we maintained low waiting times in our Emergency Department and for outpatients and for surgery.

There remain areas in which we want to improve but we are pleased that on many of the objective measures we have continued to do well compared with our peers. Like all NHS trusts we are subject to examination by the Care Quality Commission (CQC) which inspected the hospital services early in 2020. Their report, which was published last summer, revised up their rating for the Trust's acute services from "Good" to "Outstanding" which was a great tribute to the excellent work of all our staff. We have every expectation that the CQC will extend this to the whole Trust including the community services and Mary Seacole when they revise their wider ratings.

Financial performance

The Trust continued to perform well financially. The pandemic led to a change in financial allocations from payment by results to a form of block allocation for most of our services. This allowed us to achieve broad balance in the year despite the additional costs of dealing with Covid. Our cash position remains strong and enabled us in the year not just to replace and maintain our equipment and estate but to invest in improved equipment, IT, and the services we provide to our patients.

Our role in the wider health and care system

The Trust's objective is to build with our partners a truly integrated care and health system in City and Hackney while playing an effective and sustainable role in the provision of acute services across our wider region of north east London.

We saw progress in 2020/21 towards establishing an Integrated Care Partnership in City and Hackney to bring together the local authorities, primary care, community services and the acute services of Homerton and East London Foundation Trust (which provides mental health services). The boards combining providers and commissioners are expected to be launched in the summer. At executive level the Neighbourhood Health and Care Board will be led by our Chief Executive and will build on the experience of the Strategic Operational Command Group which was formed during the pandemic to ensure all the services pooled their information and collaborated effectively.

Closer collaboration in eight "neighbourhoods" is already leading to more integrated care pathways. One notable development has been the restructuring and strengthening of our adult community nursing service to work on the neighbourhood basis alongside the new Primary Care Networks and local authority services.

There have also been important developments in north east London more widely where an Integrated Care System (ICS, previously STP) has been established. In the crisis it has taken on a leadership role in coordinating the North East London (NEL) emergency response and now the recovery programme. It remains committed to integrating care and health across the region including through an Integrated Care Partnership for City and Hackney. At the end of the year, the seven NEL Clinical Commissioning Groups agreed to merge into a single Clinical Commissioning Group (CCG) for the whole of NEL in anticipation of becoming formally part of the ICS in 2022 following legislation which will also put the ICS and its partnership with local authorities on a statutory basis.

These reforms are part of a wider move across the NHS to a more collaborative approach based on boroughs and regions. In our case that means not only working with our partners in City and Hackney, but also collaborating as a provider of community services with East London Foundation Trust (ELFT) and North East London Foundation Trust (NELFT) which provide those services for the rest of NEL, and collaborating with Barts Health and Barking, Havering and Redbridge Hospitals NHS Trust on the provision of acute services across the region.

We have always had a close relationship with Barts Health with many shared clinical posts and shared pathways for patients with conditions. Although the pandemic delayed its start, we have now also launched with Barts Health and Lewisham and Greenwich NHS Trusts a shared pathology service based round a hub at the Royal London and local laboratories on each site. Cooperation and mutual aid between local acute providers deepened during the pandemic when we were able to transfer some patients at times of acute pressure to other hospitals and to take patients from them at other times. We are now working with them and the ICS to design the best way to reduce waiting lists for surgery and diagnosis and provide the best possible acute services for the whole region. This includes exploring the development of regional hubs to deal with high volume and low complexity cases for some common conditions.

People

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

We thank the Governors for their support and challenge over the year. It is a great help to the Trust to have their contribution to our governance and the connection they bring to our local area and to our key stakeholders. Under the leadership of the Lead Governor Jo Boait they have continued to play a major role in the Trust despite having to work almost exclusively online for the last year.

Turning to the Board, we welcome Dr Mike Gill, Eiri Jones and Dr Mark Rickets as non-executive directors who bring wide and varied clinical experience to the Board. We thank Martin Smith and Jude Williams for their counsel, their enthusiasm and their commitment over many years, and for staying on to help us through the first phase of the pandemic.

Finally, in recognition of the importance of our community services and our work with partners to provide integrated care, the Board, Governors and Members agreed to change the Trust's name to Homerton Healthcare NHS Foundation Trust at a special Members' meeting in March where other changes were made to bring our constitution up to date. The name change will come into effect in 2021.

Sir John Gieve
Chair
16 June 2021

Tracey Fletcher
Chief Executive
16 June 2021

About Homerton

Homerton University Hospital NHS Foundation Trust is an integrated care trust which provides hospital and community health services for Hackney, the City and surrounding communities.

The Trust provides a full range of adult, older people's and children's services across medical and surgical specialties.

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

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

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

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

The Trust's strategic vision in 2020/21

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

The Trust's ambition is to build on our current high standards and establishing the Trust as one of the country's foremost health providers, with a reputation for quality, innovation and leading the way on service integration. In the face of the disruption caused by the pandemic, the Board agreed to defer work on a long-term strategic plan in 2020 but agreed in September a new set of objectives for the period to the end of 2021/22.

The Trust's strategic objectives in 2021/22:

People: We will create the best people experience in the NHS by March 2023.

- We will deliver key projects and interventions that will begin to achieve 'Equality and Inclusion for Our People' including risk assessments, staff networks, improving fairness of recruitment and a review of conduct processes
- We will deliver key projects and interventions that 'Creates a Values-led Organisation for All Our People' including launching employee and team recognition and rewards for living Trust values and embedding the values at every stage of people's employment with Homerton
- We will 'Support Our People's Psychological Health and Wellbeing' during and post Covid-19 with psychological support and effective leadership and team development
- We will improve recruitment and retention and reduce agency spend
- We will use quality improvement methodology to engage and involve our staff in continuous improvement in service delivery and care

Quality: We aspire to be rated by the Care Quality Commission as an 'Outstanding' organisation

- **Safe** - We will provide safe services, so that people feel safe and are protected from avoidable harm
- **Effective** – We will ensure people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- **Caring** - We will deliver a great experience of our services, so that those who need to receive our support feel positively about their experience
- **Responsive** – We will ensure services meet people's needs in a timely manner and in line with national standards
- **Well Led** – We will ensure the leadership, management and governance of the organisation delivers high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Integration: We will lead our local care system working with our partners to deliver high quality care to the population of City & Hackney

- We will take a leading role in the City & Hackney system to drive improved outcomes for residents and effective management of system resources.
- We will use population health data to understand the health needs of our local population to determine priorities for prevention, treatment and care that address health inequalities and improve population health.
- We will work with our system partners to break down barriers between our services to deliver joined-up care and support to patients and residents.
- We actively contribute to the local system beyond the delivery of health services, with the aim of improving employment, education and environmental sustainability
- We will advocate and represent the health needs of our local population within the North East London health care system

System: We will actively engage and contribute to the creation and development of a sustainable health care system for north east London

- We will establish the Trust as a key member of the Acute Alliance arrangement within the North East London ICS
- We will work with other provider partners within the ICS to identify where gains can be made through a stronger collaborative approach within corporate and support services
- We will work with our partners in the Pathology Alliance to establish a new model of service provision, which successfully delivers to the standards expected and tests an alliance approach that could be applied to other service areas.
- We will maintain financial sustainability whilst working within and contributing to a system-wide financial regime

Key risks to delivering our strategic objectives

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

The key risks that could impede us from achieving our strategic objectives are set out in our annual governance statement on page 68.

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

The year continued to be dominated by the response to the coronavirus pandemic. In the first national lockdown in March 2020, we stopped all non-urgent elective work and cancelled most outpatient appointments both in the hospital and the community in line with national requirements. Having continued elective and diagnostic services between the two lockdowns within Covid isolated facilities, known as "green sites", the Trust again stopped all non-urgent elective work and most outpatient appoints during the second Covid surge. Where possible the Trust substituted face-to-face appointments with phone or video consultations. The Trust saw significant increases in patients admitted to the hospital with confirmed Covid-19 infections which had increased dramatically to a peak in the hospital of over 200 patients at the end of the year. This required a significant increase in beds with a maximum of 70 additional general beds being opened to provide 330 general adult beds in total and a maximum of 30 critical care beds.

Staffing was incredibly stretched in response to the additional beds that had been opened and the Trust operated at staffing ratios which maintained a safe service but did not represent the desired level of support for our wards. Staff were redeployed to jobs supporting the wards and critical care, including staff in corporate and support roles to assist in roles such as a ward clerk to answer telephones and coordinate dealing with queries. This was extremely helpful to pressured areas.

In April 2020 we had the highest number of people off work due to Covid which represented 16% of our permanent workforce. The Trust started its staff vaccination programme on 5 January 2021 following confirmation that vaccine would be delivered on the 1 January 2021. This was a very positive step for staff assurance and wellbeing, and by end of April 2021, approximately 80% of our 'frontline' staff had received their vaccinations. The Trust also had the remit to provide vaccinations to staff of all other City & Hackney partner organisations.

Staff wellbeing remains a concern and given the expectation of longer-term impact, a plan to support staff in this area has been created as part of the People and Culture plan, and will be kept under consideration throughout 2021.

Going concern disclosure

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

Performance against strategic priorities 2020/21

We recorded several achievements during the year:

People

- We launched our People Plan in 2020 which is detailed elsewhere in the report; this is a strategic and operational plan to improve the experience of our people who work here
- As part of this plan, we have also developed and we are delivering a comprehensive Health and wellbeing plan which focusses on best practice wellbeing support, ensuring people's basic needs are met, that they get clear and useful communications and receive expert, tertiary psychological support when they need it
- We also measurably and objectively improved the fairness of our people processes which means that the experience of our people who identify as Black, Asian or another Ethnic Group through these processes are increasingly the same of our colleagues who identify as White

Quality

- We remain one of the best performers for A&E services in London and nationally; consistently delivering over 90% for the 4-hour wait target and achieving 93.00% overall against the 95% target in 2020/21
- Despite the impact of Covid, the Trust has performed comparably well in relation to its elective care services, particularly in relation to the Trust's elective recovery programme during the Autumn of 2020 where the Trust's level of activity compared with pre-Covid levels was amongst the best in London. Additionally, the Trust has continued to deliver strong performance in relation to improving access to psychological therapies

Integration

- We worked collaboratively with health and social care partners in response to the Covid pandemic providing safe and effective care for our local population across a range of settings.

System

- We approved a full business case in July 2020 for the creation of the NHS East and South East London Pathology Partnership with Barts Health NHS Trust and Lewisham and Greenwich NHS Trust. The Partnership was formally established on 1 May 2021
- We worked with partners in the North East London Acute Alliance in response to the Covid-19 pandemic and to plan the recovery and restoration of services following the first and second waves
- We met our financial control total and we remained a break-even Trust
- Our Chief Executive was appointed System Lead Officer for the Integrated Care Partnership (ICP)

Performance summary

Review of financial performance

The Trust achieved an Income & Expenditure (I&E) surplus of £2.005m, excluding impairments, for the financial year 2020/21, compared to a planned break even position (see Table 1). Due to the financial regime in force during the year any comparison to 2019/20 would not be entirely meaningful so the revaluation surplus and adjusted financial performance are not disclosed on the Statement of Comprehensive Income (SOCI) but are included in Table 2 over page. The Trust received donations of medical equipment and PPE from DHSC which when added back resulted in an outturn for the year of £31k. The main source of income for the Trust is contracts with commissioners in respect of health care services, the Trust's main commissioner being City and Hackney Clinical Commissioning Group. In 2020/21 the Trust was mainly funded not through contracts but by block grants.

A comparison of planned and actual performance (excluding impairments) is shown in the table 1.

Table 1. Performance against plan

2020/21	Plan £m	Actual £m	Variance £m
Income			
Clinical contracts	323.0	339.0	16.0
Other income	24.7	38.7	14.1
PSF Funding	4.5	0	-4.5
Total income	352.2	377.8	25.5
Expenses			
Pay	-241.5	-258.9	-17.4
Non pay	-97.0	-103.7	-6.7
Total expenses	-338.4	-362.6	-24.2
EBITDA*	13.8	15.2	1.4
Depreciation and amortisation	-9.6	-9.6	0.1
PDC dividends	-4.0	-3.4	0.6
Net interest	-0.2	-0.2	0.0
Sub-total	-13.8	-13.1	0.7
Net Surplus	0.0	2.0	2.0
Impairment	0.0	0.0	0.0
Net Surplus (exc Impairment)	0.0	2.0	2.0

*Earnings Before Interest, Tax, Depreciation and Amortisation.

Income was £16.0m (5.0%) above plan, however this includes £9.4m for additional income relating to superannuation contributions which has a corresponding pay adjustment for the same value. As well there was additional income of £6.0m in respect of donated equipment and consumables from DHSC/NHSE for Covid response and £1.0 of income for Covid expenditure outside the funding envelope. Other income includes £10.2m of reimbursement and top up funding to support the Covid response. PSF income was not applicable in 2020/21. The variance on pay and non-pay costs include £9.4m due to superannuation contributions with the balance relating to costs to support the Covid-19 response.

Table 2: Showing Other comprehensive income and the adjusted financial performance

Other comprehensive income	Plan £m	Actual £m	Variance £m
Not reclassified to income & expenditure 2020/21			
Impairments	0.0	0.0	0.0
Revaluations	0.0	2.839	2.839
Total comprehensive income for the period	0.0	4.844	4.844
Adjusted financial performance (control total basis) 2020/21			
Surplus for the period	0.0	2.005	2.005
I&E impact of capital grants and donations	0.0	-1.388	-1.388
Net impact of inventories received from DHSC group bodies for Covid response	0.0	-0.586	-0.586
Adjusted financial performance surplus	0.0	0.031	0.031

Capital expenditure and liquidity

Capital expenditure for the year totalled £19.9m of which £4.7m related to new and replacement medical equipment including a replacement MRI scanner, ultrasound machines and incubators. £3.4m related to IT projects and £7.7m related to Estates projects, the most significant of which were the generator replacement programme and replacement MRI scanner enabling works and £2.6m on Covid related capital expenditure. The Trust received £1.45m of donated Covid related medical equipment from DHSC central supplies.

The Trust's liquidity position improved in-year by £10.1m due to the block contract arrangements and improved performance on the collection of aged debt. The Trust ended the year with debtors £12.3m lower than at the last year-end and the closing cash balance £10.1m higher.

In accordance with guidance received from NHSE/I, the Trust strives to pay all suppliers no later than seven days from receipt of goods or services or the invoice date if later.

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

Counter fraud policies and procedures

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

Operational performance

During 2020/21, because of Covid, the Trust's actual performance against national operational standards suffered (along with the rest of the country). However, given the circumstances, the Trust delivered a comparably strong operation performance against the suite of core standards.

Infection control: There were five Trust-attributable MRSA bacteraemias against a Public Health England (PHE) 'zero tolerance' target. Of these, two were secondary to underlying MRSA infections that the patients were admitted with and there were no 'lapse in care' issues. The Trust remains committed to minimising the risk of any avoidable MRSA bacteraemias and 'Post Infection Review' root cause analyses are performed on all Trust-attributable cases where there are possible "lapse of care" issues so that the learning from these reports can be shared across all stakeholder groups. There were 10 Trust-attributable *C.difficile* toxin positive cases against Public Health England's very low target for the Trust of 12 cases. This was despite the extraordinary pressures put on the staff at the Trust by the Covid pandemic including the higher than usual use of broad-spectrum antibiotics to cover for possible secondary bacterial chest infections in Covid patients. This was evidence of the educational work performed by the Antimicrobial Stewardship Team to ensure that inappropriate antibiotic use was minimised, and the commitment by the ward teams to follow that advice closely in very pressurised circumstances. For most of the year stringent new infection controls were put in place to limit Covid-19 infections among patients and staff within the hospital and clinics. Overall, our rate of Covid related nosocomial (hospital acquired) infection was low.

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

Key Performance Indicators	Target	2019/20 Performance	2020/21 Performance
A&E patients discharged <4hrs	95%	93.75%	93%
Cancer			
2 Week Wait	93%	97.86%	96.16%
31 Day Target	96%	99.30%	98.43%
62 Day Target	85%	86.93%	84.60%
Infection Control			
MRSA	0	1	5
Clostridium difficile (C.diff)	12	8	10
18 Week RTT Indicator			
Incomplete Pathways	92%	95.13%	74.08%
IAPT Indicators			
6 week target	75%	96.81%	98.02%
18 week target	95%	99.60%	99.68%

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month. Details of performance against key quality indicators that were prioritised throughout 2020/21 are presented in the Quality Account which will be published later this year.

Tracey Fletcher,
Chief Executive
16 June 2021

"You are never alone"

A doctor's unique photographic record of Covid-19 at Homerton

In the midst of the Covid-19 emergency when staff were under the greatest pressure, intensive care clinician and keen photographer, Dr Priyan Odedra decided to attempt to record images of the impact of the crisis on his colleagues through a series of photographs.

The resulting images have been widely praised and featured in the Metro newspaper.

Priyan said: "During the emergency I had begun to think about how I felt and the difficulty addressing the resurfacing emotions I tried to lock away.

"I knew I wasn't alone and as a creative outlet, I captured my colleague's portraits with the idea that they would think about their involvement in the pandemic and share with me their experiences.

"I hope they found it liberating to reflect upon the heartbreak, and found some pride in their dedication to caring for others.

"The teamwork and sheer camaraderie was inspiring. The entire hospital stood shoulder to shoulder, shift after shift, to get each other through the trauma. Where one of us faltered or fell, another would pick us up. In these dark times, we found comfort in our shared experiences and became part of a family away from our own.

Emmaline Sakyi, ICU sister
"I cannot believe I can still smile after the peak of this dreadful pandemic"

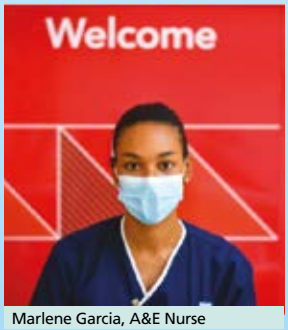
"Patients that clung to their lives with fingertips walked back through intensive care doors to thank the team, and in those moments we felt incredibly humbled and our hearts lifted together. Everything finally felt worth it.

"The pandemic was undoubtedly one of the toughest times in all of our lives. As the dust settles, I think it's important that we reflect on what we've all been through. I'm really grateful to the colleagues who let me take their pictures and shared their stories and feelings with me. They made me realise I wasn't alone, and that's the thing at Homerton - you never are."

Hadley Stewart, A&E Nurse

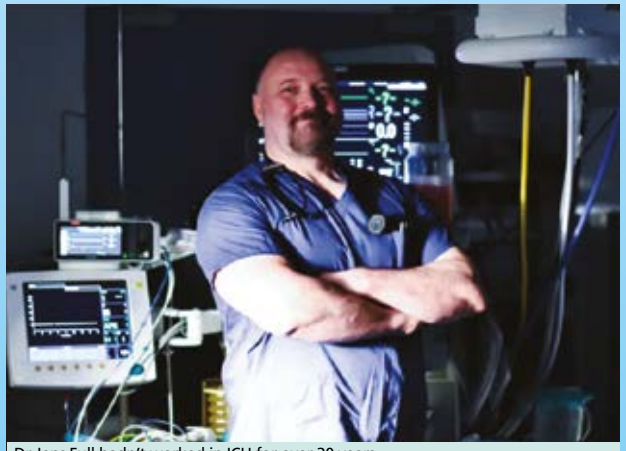
Dr Labbeka Begum, Anaesthetist

ICU consultant, Dr Catherine Peters



Marlene Garcia, A&E Nurse

Dr Davina Amin, Anaesthetist



Dr Jens Full hadn't worked in ICU for over 20 years

2. Accountability report

Directors' report

Trust Board

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

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

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

The Board held six seminars during the year to discuss strategic issues, to receive learning and development, and to hear about service and external developments including the Integrated Care System.

In case of disagreements between the Council of Governors and the Board, in the first instance, dialogue would take place to resolve this. The senior independent director is available to Governors if they have concerns that contact through the normal channels of chair, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. If the issues remain unresolved, Governors have the right to refer a question to the NHS England/Improvement independent panel for advising governors. There were no such disagreements in 2020/21.

Board members

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

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

Telephone: 020 510 5555.

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

Non-executive directors

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

Sir John Gieve, Chair

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

Before that he was a civil servant, including three years as a Managing Director of the Treasury and Permanent Secretary to the Home Office between 2001 and 2005. He is currently Chair of Nesta, the innovation foundation, and a non-executive director of Vocalink, a bank payments company.

Sir John chairs the Nomination and Remuneration Committee and is a member of the People and Culture Committee, the Finance Committee and the Trust's Charitable Funds Committee.

Dr Mike Gill, Senior Independent Director

Dr Mike Gill was appointed to the Board November 2020.

He is an experienced senior medical leader and from 2014-2018 he was Medical Director at Health 1000: The Wellness Practice, a new type of GP surgery which looked after patients with multiple medical conditions in their own homes. The Practice also supported the care of patients in nursing homes.

Before this he had been a Medical Director for over 12 years at Newham University Hospital NHS Trust, a similar role at Barking, Havering and Redbridge University Hospitals NHS Trust and Associate Medical Director at Barts Health NHS Trust. He is Chair of Council of the London Clinical Senate and Chair of Kent and Medway Acute Stroke Services Joint Committee.

Mike was Joint Clinical Director for the Health for North East London programme nine years ago which reviewed the configuration of provider services in east London.

Mike was Interim Medical Director at Homerton two years ago and his links to the hospital go back further as he was a Medical Registrar and later Senior Registrar at the hospital and on the commissioning team for the hospital in 1985/6.

Mike chairs the Clinical Ethics Advisory Panel, is the Trust's Freedom to Speak Up Champion and a member of the Audit and Risk Committee.

Cherron Inko-Tariah MBE

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

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

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

Cherron is chair of the People and Culture Committee, a member of the Clinical Ethics Advisory Panel and is the Trust's Diversity Champion and Health and Wellbeing Champion.

Rommel Pereira, Deputy Chair

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

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

His non-executive roles include the One Housing Group, London Ambulance Service NHS Trust and more recently the National Archives. He is Chair of the Audit and Risk Committee at the One Housing Group; Deputy Chair and chair of the Audit Committee at the London Ambulance Service NHS Trust and Chair of the Audit and Risk Committee at the National Archives.

Rommel is chair of the Audit and Risk Committee and a member of the Finance Committee.

Andrew Hudson

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

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

He worked for Essex County Council, becoming Deputy Chief Executive (Finance and Performance) between 2002 and 2004. He re-joined central government as CEO of the

Valuation Office Agency, and became Director General, Public Services at the Treasury for three years.

His current roles include being Chair of the Centre for Homelessness Impact, a non-executive director at Clarion Housing Group, a trustee of Volunteering Matters and Mayday Trust, and an independent member of the Oxford University Finance Committee.

Andrew is Chair of the Finance Committee and is a member of the Audit and Risk Committee.

Eiri Jones

Eiri Jones was appointed to the Board in November 2020.

Eiri is a registered nurse (adult and child) and has an MA in professional development and trained in London at Guy's and Great Ormond St hospitals.

Eiri has extensive clinical, managerial and executive leadership knowledge and skills gained during a career spanning over 40 years. She has held senior and board positions in a range of NHS trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments.

Eiri has recently finished at Cwm Taf Morgannwg Health Board as a part-time Programme Director. She is a Non- Executive Director at Salisbury NHS Foundation Trust. She was Regional Director of the Getting It Right First Time Programme in the South West of England; and has also held roles as an interim Quality Manager at NHS Crawley Clinical Commissioning Group; and interim Director of Quality Governance at Barts Health NHS Trust in recent years.

Eiri is a member of the People and Culture Committee and the Finance Committee.

Dr Mark Rickets

Dr Mark Rickets was appointed to the Board in November 2020.

Mark is a local GP and Clinical Chair (City and Hackney) of the North East London Clinical Commissioning Group (CCG).

Mark has been a GP at the local Nightingale Practice since 1995. He was clinical lead for primary care at City and Hackney (C&H) CCG from 2012 and Chair from April 2018 to March 2021. He has also been Chair of the Homerton Clinical Quality Review Board, the assurance forum for the C&H CCG (as lead commissioner) on quality outcomes for services provided by the hospital. He continues as Co-Chair of the Hackney Health and Wellbeing Board (with Hackney's elected Mayor - Philip Glanville); Co-Chair of the C&H Integrated Commissioning Board (working with Hackney Local Authority and the Corporation of the City of London) and Chair of the C&H Practitioner Forum, a fortnightly virtual meeting for all practitioners and managers across City and Hackney to come together to review and update development of services. More recently he has taken on leading roles across north

east London in finance reform and system governance, and is Clinical Lead for Primary Care for North East London (NEL) CCG & Health and Care Partnership. He was also the C&H CCG representative on the Trust's Council of Governors for several years.

Mark is a member of the People and Culture Committee, a member of the Clinical Ethics Advisory Panel and the Trust's Charitable Funds Committee.

Executive directors

Tracey Fletcher, Chief Executive

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

Dylan Jones, Chief Operating Officer

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

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

Dr Deblina Dasgupta, Medical Director

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

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

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

Catherine Pelley, Chief Nurse and Director of Governance

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

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

Phill Wells, Director of Finance

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

Phill chairs the Charitable Funds Committee.

Tom Nettel, Director of Workforce and Organisational Development

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

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

Board members who stood down during the year:

Jude Williams

Jude Williams was a non-executive director from May 2014 until October 2020.

Martin Smith

Martin Smith was a non-executive director from November 2014 to October 2020.

Further details of the expertise and knowledge of Board members who stood down this year can be found in our 2019/20 Annual Report.

Directors' Board attendance

The directors' record of attendance at Board meetings during 2020/21 is confirmed below.

Non-executive director	Board attendance	Executive director	Board attendance
Sir John Gieve	10/10	Tracey Fletcher	10/10
Dr Mike Gill	5/5	Dr Deblina Dasgupta	10/10
Andrew Hudson	10/10	Dylan Jones	9/10
Cherron Inko-Tariah	9/10	Tom Nettel	9/10
Rommel Pereira	10/10	Catherine Pelley	10/10
Dr Mark Rickets	5/5	Phill Wells	9/10
Eiri Jones	5/5		

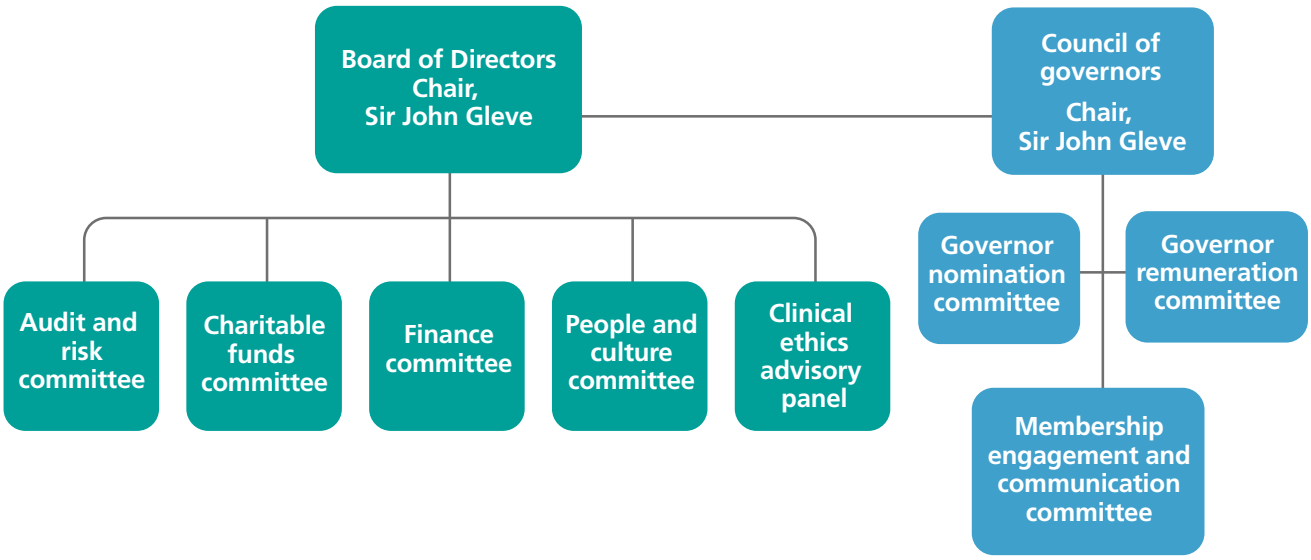
Board committees

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

Contacting the Board

Board members may be contacted via the Trust Secretary:
Email address: huh-tr.corpgov@nhs.net.
Telephone: 020 8510 5555.

Board committee structure



Recovery pack supports patients with long term Covid-19 syptoms

Homerton's ACERS* community respiratory team has been winning plaudits worldwide for their information pack which supports patients suffering the long term effects of having had Covid-19.

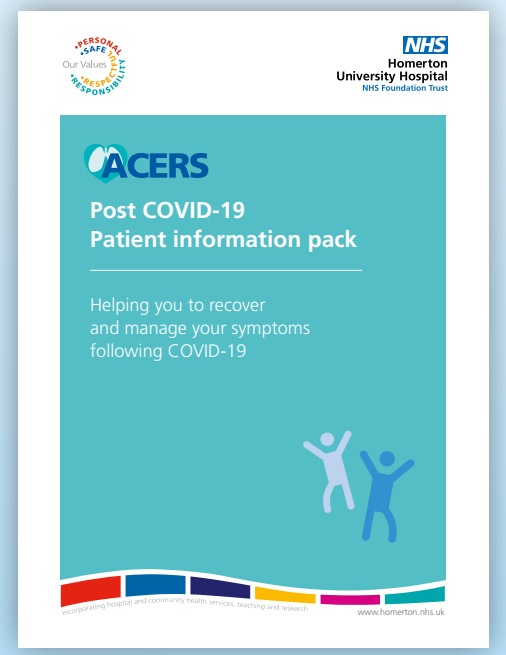
It became increasingly obvious early in the pandemic that many patients who suffered from Covid-19 retain a variety of long term after effects.

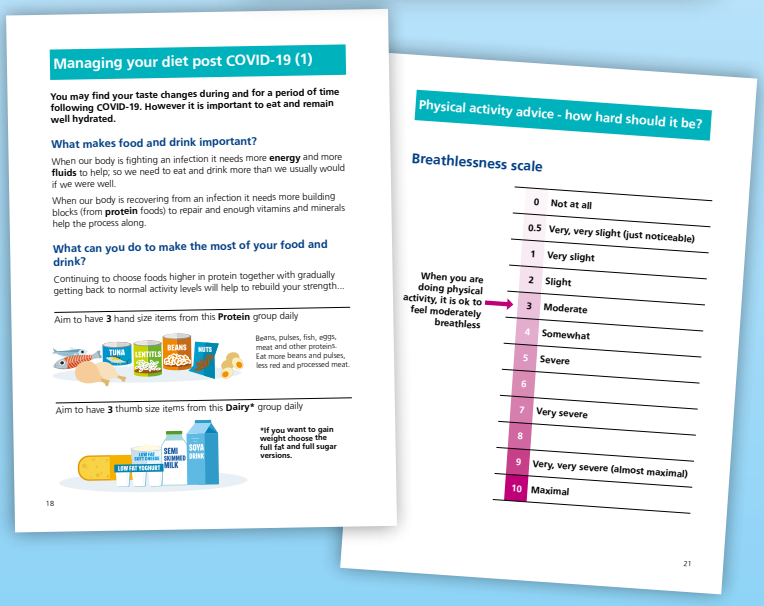
The ACERS team set out to develop information and support for these patients to help them address the varied symptoms they were suffering from.

Laura Graham, Respiratory Lead Clinician for ACERS said: "We wanted to develop something that brings together all the symptoms that we were seeing in patients recovering from Covid-19 and provide advice on how to address them."

The Patient Post Covid-19 Recovery Pack has been complied by physiotherapist Nikki Anderton and also provides advice on how to manage respiratory problems, strategies for conserving energy, relaxation techniques, recognising the emotional and psychological impact of having had Covid-19, and what to do if symptoms do not improve.

Since its publication in June, the recovery pack has been shared with many other NHS trusts and also with public health bodies around the world. A companion pack focusing on exercise and movement has since been complied by colleagues at Homerton's Locomotor community physiotherapy team.





*Adult Cardiorespiratory Enhanced and Responsive Service (ACERS)

Audit and Risk Committee

Membership and attendance

From January 2021, the Board committee structure was revised. The Audit and Risk Committees became a single entity, and a new Finance Committee was created. The Audit Committee was chaired by Rommel Pereira, a non-executive director, since 19 November 2020 replacing Martin Smith, a non-executive director, who was chair of the Audit Committee from 1 April 2020 until 1 October 2020. The Audit Committee includes two other non-executive directors. Andrew Hudson began as a non-executive member of the Audit and Risk Committee on 21 January 2021. Cherron Inko-Tariah was a non-executive member of the Audit Committee until 21 January 2021, when she resigned and was replaced by Dr Mike Gill from 25 March 2021. The Audit Committee met six times in 2020/21.

Name	Attendance
Martin Smith (chair - 3)	3/3
Rommel Periera (chair - 3)	5/6
Andrew Hudson	2/2
Mike Gill	1/1
Cherron Inko-Tariah	4/5

How the Audit and Risk Committee discharges its responsibilities

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

Significant issues considered

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

Overall, the internal auditors concluded that the organisation had an adequate and effective framework for risk management, governance and internal control. Their work identified further enhancements to ensure that it remained adequate and effective. During the year, the Internal Auditors provided eight reasonable assurance (amber/green) opinions,

one partial assurance (amber/red). Due to Covid, one piece of work agreed in the 2020/21 internal audit plan was delayed and will be concluded in 2021.

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

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

Auditors

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

The external auditors for Homerton are KPMG LLP. Their fees for audit services undertaken in 2020/21 were £64,200 (excluding VAT). KPMG's accompanying report on the Trust's financial statements is based on their audit conducted in accordance with International Financial Reporting Standards and the Financial Reporting Manual issued by NHS Improvement. Their work includes a review of the Trust's system of internal control which is used to inform the nature and scope of their audit procedures. Under the Audit Code of Practice, our external auditors have reviewed our arrangements for securing economy, efficiency and effectiveness and reported no significant weaknesses.

The Trust's external auditors may perform non-audit work where the work is clearly audit related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded. There was no non-audit work carried out during 2020/21.

As far as the directors are aware, there is no information relevant to the audit which has not been disclosed to the auditors. The directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Remuneration and Nomination Committee

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

The Committee is chaired by Sir John Gieve, Chair of the Board and all the non- executive directors are members. The Committee met on one occasion in 2020/21.

Name	Attendance
Sir John Gieve (chair)	1/1
Dr Mike Gill	1/1
Andrew Hudson	1/1
Cherron Inko-Tariah	1/1
Eiri Jones	1/1
Rommel Periera	1/1
Dr Mark Rickets	1/1

Details of salary and pension entitlements for Board members are set out in the Remuneration Report on page 40.

Homerton Hope – the Trust's Charitable Fund

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

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

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

Charity objectives

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

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

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

Capital equipment - purchase of equipment in addition to that provided by NHS funds through the Trust's Capital Programme.

Review of achievements

During 2020/21, the charity continued to support a wide range of charitable and health related activities, benefiting patients and staff in a variety of areas. Generally, funds are used to provide specialist staff, goods and services which would not have been possible using NHS funding. Some of the activities which continued over the past year are described below.

Due to Covid-19 fundraising throughout 2020 was mainly focused on coordinating the increased amount of goodwill donations. All projects were also put on hold and we are now slowly starting to work on these with the funding from NHS Charities Together and other donations.

Art programme

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

Christmas presents for patients

The charity continued its annual tradition of providing small gifts to patients who were staying in hospital during Christmas 2020.

Staff welfare

The charity provided funding for:

- Wobble rooms
- Water bottles
- Feel Good Trollies for the wards
- Microwave for Palliative care
- Garden furniture for HTNRU, Hackney Ark roof garden and MSNH
- Chairs for SCBU
- Thank you cards and breakfasts for staff

Contributions were also made to support the work of the Healthy Homerton Project and to the living wall at the front of the hospital.

Patient welfare

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

- Videos for cancer/palliative care
- Weights for therapy patients
- TV and subscription for cancer services - Dr Bhowmik

Donations and grants

Significant donations came from our Go fund me page £17,470, Virgin sport virtual events £3,000, and £20,527 from Roksanda online Instagram fashion sale. We also received £6,600 from Hackney Scrubhub, £9,663 from R&S Records and £7,320 from Host of Leyton.

NHS Charities Together raised over £130 million which is being given to NHS trusts around the country. So far we have received £162,100.

We received £51,213 in general donations and £15,342 from Justgiving pages.

We received a considerable amount of donations in-kind from local community and businesses throughout the pandemics.

We received a £1,000 grant from London Catalyst for HIV, TB and Cancer services.

Board statement on knowledge, skills and expertise to fulfil its function and appraisal of directors

The Board of Directors is satisfied that its balance of knowledge, skills, and expertise is appropriate to fulfil its function in accordance with the requirements of the NHS Foundation Code of Governance and the Trust's Terms of Authorisation. In doing so the Board has relied on the evidence of its assessment of compliance with the NHS Licence.

The annual appraisal of the Chair is completed by the Senior Independent Director who seeks the views of directors and governors. The performance of non-executive directors is evaluated annually by the Chair.

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

Governors and members

A foundation trust is accountable to the communities it serves. Trust members and the public are welcome to attend Council of Governors' meeting and raise questions. Individuals over 16 are invited to become members of the Trust and take part in the election of Governors. Individuals over 18 may stand for election as a Governor in their local constituency and, if elected, become Governors of the Trust.

There are opportunities for interested members to ask questions about the role at the Annual Members' Meeting, at membership engagement events or directly through the Trust offices.

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

- Public
- Staff

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

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

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

The Trust ended the year with 4,828 public members and 3,560 staff members which represents an improved position in relation to recruitment of public members.

Council of Governors

The Council of Governors represents the views of the members of the Trust as a whole, and the views of the public, and staff. It comprises elected public and staff members, together with representatives of partner organisations, local authorities and commissioners. The governor role is voluntary.

The Council has 26 Governors including:

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

On 31 March 2021, 25 of the 26 governor seats were occupied.

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

The Council also elects one of its members to be the Lead Governor. Jo Boait was appointed as Lead Governor in February 2020.

The following table confirms the names of our governors, their terms in office and attendance at Council meetings during 2020/21.

Name	Constituency	Current Term	End of Term	Meetings attended
Elected Governors				
Prof Jane Anderson	Staff (Clinical)	First	Oct 2023	2/2
Julia Bennett	Public (Hackney)	Third	Sept 2021	5/5
Ahmad Bismillah	Public (Hackney)	First	Sept 2022	5/5
Neil Burgess	Public (Hackney)	First	Sept 2021	0/5
Penny Crick	Public (Hackney)	First	Oct 2023	2/2
Dr Coral Jones	Public (Hackney)	Second	Sept 2022	5/5
Stuart Maxwell	Public (Hackney)	Third	Sept 2021	4/5
Nafisa Patel	Public (Hackney)	First	Sept 2022	5/5
Saleem Siddiqui	Public (Hackney)	Second	Sept 2022	5/5
Christopher Sills	Public (Hackney)	Second	Sept 2022	5/5
Samantha Tulloch	Public (Hackney)	First	Sept 2022	3/5
Jo Boait	Public (City)	First	Sept 2022	5/5
James Torr	Public (City)	First	Sept 2022	5/5
Mary Rose Thomson	Public (Outer)	First	Sept 2020	5/5
Jane Bekoe	Staff (Clinical)	First	Sept 2022	5/5
Hannah Caller	Staff (Clinical)	First	Oct 2023	2/2
Dr Helen Cugnoni	Staff (Clinical)	Second	Sept 2021	1/1
Suzanne Levy	Staff (Clinical)	Second	Sept 2020	0/1
Hilda Walsh	Staff (Clinical)	Third	Sept 2022	5/5
Kristian Ademola	Saff (Non-Clinical)	First	Oct 2023	0/2
Ibrahim Hafeji	Staff (Non-Clinical)	First	Sept 2020	1/5
Partnership appointed Governors				
Malcolm Alexander	Healthwatch Hackney	First	Oct 2022	5/5
Randall Anderson	City of London	First	May 2024	4/5
Julie Attenborough	City University	First	Sept 2022	3/5
Sharon Ellis	Queen Mary University	First	Feb 2023	2/5
Dr Paul Kelland	City and Hackney CCG	First	June 2021	2/5
Yvonne Maxwell	Hackney Council	First	Oct 2021	4/5

Governors who stood down in 2020/21

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

Name	Constituency	Current term	End of term	Meetings attended
Dr Helen Cugnoni	Staff (Clinical)	first	Sep 2021	1/1
Suzanne Levy	Staff (Clinical)	second	Sep 2020	0/1
Arun Prapathan	Staff (Non Clinical)	first	Sep 2022	1/1

Role of the Council of Governors

The Council has several statutory responsibilities including:

- Holding the non-executive directors to account for the performance of the Board
- Representing the interests of the members of the Trust as a whole and the interests of the public
- Appointing or removing the Chair and non-executive directors
- Appointing or removing the Trust's auditors

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

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

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

The Governors held five meetings in 2020/2021 including two joint meetings of the Council and the Board.

Director attendance

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

Non-executive director	Council attendance	Executive director	Council attendance
Sir John Gieve	5/5	Tracey Fletcher	5/5
Dr Mike Gill	1/2	Deblina Dasgupta	5/5
Andrew Hudson	5/5	Dylan Jones	2/5
Cherron Inko-Tariah	1/5	Tom Nettel	3/5
Eiri Jones	1/2	Catherine Pelley	4/5
Rommel Pereira	5/5	Phill Wells	4/5
Dr Mark Rickets	1/2		
Martin Smith	3/3		
Jude Williams	3/3		

The Council receives regular reports from the non-executive directors on items of interest to the Board, including clinical and financial performance, quality standards and reports from the Chair of the Audit Committee. The Chief Executive updates the Governors on service developments and collaborative work within the East London Health and Care Partnership and the City and Hackney Integrated Care Partnership.

Covid-19 was the key focus for several months in 2020. The Council of Governors received a briefing by videoconference in April 2020 and regular e-mails during the period that highlighted the impact on Homerton Hospital and the wider community services, together with details of the work being undertaken by the Board. All the Governors are very proud of Homerton's Covid-19 response and the amazing work undertaken by staff at this time. Staff across all Homerton departments pulled together and worked very hard to try to ensure the best outcomes for patients. The Governors were concerned about the welfare of staff and received assurances about the additional support measures that were put in place, both during the height of the pandemic and afterwards. The Governors also received details of the People Plan post Covid and the deployment of students during the pandemic.

The Council of Governors also reviewed two key proposals: the renewal of the Soft Facilities Management contract and the planned change to the delivery of the Pathology service. It was clear to the Governors from the changes to some of the arrangements for the Soft Facilities Management staff that the views of the Governors had been considered in the final Soft Facilities Management contract.

Register of interests

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

New end of life initiative launched

The Trust has launched an innovative new model for enhancing end of life care.

The SWAN model was originally developed at the Salford Royal NHS Foundation Trust which maintains close links with Homerton on quality initiatives. A pilot of the model was carried out in one ward at the hospital during the first half of this year.

The SWAN model aims to:

S sign: is the patient thought to be entering the dying phase of life?

W words: sensitively communicate with the patient and their family

A actions: facilitate what is important to the patient's family

N needs: are their needs being met, documented and reviewed regularly?

Committees of the Council

Although decisions must be made by the Council of Governors as a whole, the Council has created three Committees to assist with some of the specific requirements and, on occasion, may allocate a task to an individual or a small working group to undertake more detailed work and report back to the Council.

Governor Nomination Committee for Chair and non-executive directors

The Council of Governors has responsibility for approving the reappointment or appointment of non-executive directors. This work is led by the Nomination Committee of the Council of Governors.

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

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

In 2020/21 the committee met to discuss the recruitment of three new non- executive directors to replace vacancies arising from the end of office term, and a resignation. The process was supported by Gatenby Sanderson, external search advisors.

During September 2020, a recruitment panel comprising the Chairman and five of the six other members of the Nomination Committee reviewed the short list of over 20 candidates and invited 11 to interview. Leading up to this, the Nomination Committee met and considered the desirable mix of experience and skills for the new directors, considering the future challenges, risks and opportunities facing Homerton and the skills and experience of the non-executive directors who would be remaining in post after October. Each candidate was given the opportunity to speak to the Chair, CEO and Lead Governor prior to their interview. Ten candidates for the non-executive director roles were eventually interviewed over two days.

Following extensive discussions, recommendations were made to the Council of Governors and, on 1 October 2020, the Council of Governors approved the appointment of Dr Mike Gill, Eiri Jones and Dr Mark Rickets to the Board of Directors.

Governor Remuneration Committee

The Remuneration Committee of the Council of Governors comprises public and staff governors and is chaired by the Lead Governor. Its purpose is to recommend salary and related conditions of the non-executive directors and the Chair. The committee met on one occasion during 2020/2021 to consider non-executive remuneration.

In making their decisions, the Committee considered strategic issues and commercial changes that impacted the Trust and the non-executive directors, together with central guidance from NHS England/Improvement.

Member Engagement and Communication Committee

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

During the year, Covid-19 severely restricted the Trust's ability to undertake membership activities, especially those that used to be face to face. However, it prompted an increased amount of public engagement, either directly from the Chief Executive and other directors, or because of third-party interest, such as the article in Vogue. Communication with staff, from the Chief Executive and other directors, was also enhanced during this time, with a significant increase in the levels and extent of communication.

The Committee decided that it should not progress initiatives that would need resources from amongst Homerton's over-extended staff. However, 'Memberlink' newsletters were sent to all public members providing information, election details and news about the Trust's services. The Council of Governors' meetings and the Annual Members Meeting were held online, with connection details displayed on the website so that anyone with an interest could attend. Public interest in the Soft Facilities Management contract was particularly high and the number of people attending the Council of Governors' meetings when this was discussed was amongst the highest ever.

The Member Engagement and Communication Committee is now working to update the Trust's Membership Strategy, taking into account the changes that are needed because of Covid-19, and is considering the most effective ways to reach members and the public.

Contacting the Governors

If a member of the public or patient wishes to contact a Governor they can do so by email: huh-tr.members@nhs.net or by telephone: 020 8510 5302.

Cost allocation and charging guidance

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

Political and charitable donations

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

Better payment practice code

During the financial year to 31 March 2021, the Trust paid 92.1% (2020: 94.1%) by volume and 87.6% (2020: 91.6%) by value of all non-NHS suppliers within 30 days but many are paid within 7 days. Details shown in the table below:

Better payment practice code	31/03/2021 YTD Number	31/03/2021 YTD £'000	31/03/2020 YTD Number	31/03/2020 YTD £'000
Non NHS				
Total bills paid in the year	61,851	160,462	61,950	155,269
Total bills paid within target	56,994	140,583	58,174	140,542
Percentage of bills paid within target	**92.1%**	**87.6%**	**94.1%**	**91.6%**
NHS				
Total bills paid in the year	2,446	17,064	2,295	14,763
Total bills paid within target	2,048	12,319	1,965	12,054
Percentage of bills paid within target	**83.7%**	**72.2%**	**88.6%**	**88.7%**

Better payment practice code statistics

NHS Improvement (NHSI) well-led framework

Our externally facilitated well-led assessment was scheduled for the 2020/21 reporting period but did not take place because of the significant involvement of the executive team in the response to the Covid-19 pandemic. The review is planned for the 2021/22 period. In the interim, the Board participated in a development session led by an independent facilitator to develop a targeted action programme in areas of leadership and governance for the Board to work on to deliver our vision and mission and sustain future performance. This review considered similar areas to those covered in Monitor's well-led guidance. The Board set out a series of development actions including: creating a shared learning and development programme to develop our approach to future ways of working and challenges, reviewing the role and capability of board sub committees and working groups and considering wider risks of system working not just internal risks.

Patient care activities

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

Stakeholder relations

The Trust continues to maintain and develop relationships within the NHS, the local authority, education partners and community and patient representative groups. The Trust works jointly with local commissioners and providers within City and Hackney and continues to work with health and care partners across north east London as part of the East London Health and Care Partnership, which was designated an Integrated Care System (ICS) from 1 December 2020.

The Trust is a member of the North East London Acute Alliance, along with Barts Health NHS Trust and Barking, Havering and Redbridge NHS Trust. The Acute Alliance was established in June 2020 as part of the emerging ICS to strengthen joint working and respond to immediate and longer-term plans to reduce unwarranted variation and increase standardisation across north east London. Our Director of Finance and Director of IT & Systems have additional roles within the North East London (NEL) system to improve procurement and digital and information systems.

The Trust has progressed work on the development of a Pathology Partnership with Barts Health NHS Trust and Lewisham and Greenwich NHS Trust. In July 2020, the Boards of all three organisations approved the full business case to proceed with the establishment of the Partnership, which was formed from 1 May 2021. The Partnership will be jointly owned and managed by the three partner Trusts and will enable us to invest in the development and delivery of sustainable pathology services within east London.

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

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

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

Income disclosures

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust complies with this requirement as can be seen in the following table:

	£'000
Health care income	373,651
Non-health care income	4,110
Total income	377,781

The Trust has included within "health care income" all income from contracts for patient services; Sustainability & Transformation Fund income; and income for the use of the Trust's buildings and facilities where it is from another NHS body engaged in the provision of healthcare. During the year, the Trust received a total of £10.2m funding for Covid reimbursement and top up funding.

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

Tracey Fletcher

Tracey Fletcher
Chief Executive
16 June 2021

NEW YORK, PARIS, MILAN...HACKNEY

Rachel is a Vogue cover girl

At the height of the pandemic emergency, Vogue magazine came to Homerton and took photographs of staff members. These featured in the July edition of Vogue with community midwife Rachel Millar gaining the prestigious role of cover model.

Photo by Jamie Hawkesworth

Remuneration report

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

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

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

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

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

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

The Trust currently carries a provision of £0.339m for early retirements relating to ex-members of staff.

The Trust is required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Homerton University Hospital NHS Foundation Trust in 2020/21 was £185,094 (2019/20 £185,296). This was 5.05 times (2019/20 5.21 times) the median remuneration of the workforce, which was £36,684 (2019/20 £35,561). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

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

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

The following table provides information on the remuneration of senior managers in the Trust in 2020/21.

Audited Remuneration of Senior Managers 2020/21						
Name and title	Salary (bands of £5,000)	Taxable Benefits (to the nearest £100)	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonus (bands of £5,000)	All Pension-related Benefits (bands of £2,500)	Total (bands of £5,000)
Executive Directors						
Fletcher T – Chief Executive	185-190	-	-	-	20.0-22.5	205.0-210.0
Jones D - Chief Operating Officer	135-140	-	-	-	27.5-30.0	165.0-170.0
Wells P – Director of Finance	135-140	-	-	-	27.5-30.0	160.0-165.0
Pelley C – Chief Nurse and Director of Governance	115-120	-	-	-	-	115.0-120.0
Dasgupta D – Medical Director	180-185	-	-	-	55.0-57.5	235.0-240.0
Nettel T – Director of Workforce and Organisational Development[1]	115-120	-	-	-	25.0-27.5	140.0-145.0
Gieve Sir J – Chair	40-45	-	-	-	-	40-45
Non-executive Directors						
Inko–Tariah C	10-15	-	-	-	-	10-15
Smith M [1]	5-10	-	-	-	-	5-10
Williams J [2]	5-10	-	-	-	-	5-10
Pereira R	10-15	-	-	-	-	10-15
Hudson A	10-15					10-15
Jones E [3]	5-10	-	-	-	-	5-10
Gill M [4]	5-10	-	-	-	-	5-10
Rickets M [5]	5-10	-	-	-	-	5-10

[1] Martin Smith left the Trust as a non-executive director on 31st October 2020
[2] Jude Williams left the Trust as a non-executive director on 31st October 2020
[3] Eiri Jones joined the Trust as a non-executive director on the 1st November 2020.
[4] Mike Gill joined the Trust as a non-executive director on the 1st November 2020.
[5] Mark Rickets joined the Trust as a non-executive director on the 1st November 2020.

In 2020/21 the Trust paid no (2019/20 - £212) expenses to executive and non-executive directors and there were no payments to Governors (2019/20 - nil). The Trust is well served by its Governors and volunteers who are not paid for their services.

The element of the Medical Director's salary that related to their clinical role in 2020/21 was approximately £71k.

The following table provides information on the remuneration of senior managers in the Trust in 2019/20.

Audited Remuneration of Senior Managers 2019/20						
Name and title	Salary (bands of £5,000)	Taxable Benefits (to the nearest £100)	Performance Pay and bonuses (bands of £5,000)	Long term performance pay and bonus (bands of £5,000)	All Pension-related Benefits (bands of £2,500)	Total (bands of £5,000)
Executive Directors						
Fletcher T – Chief Executive	185-190	-	-	-	27.5-30.0	210.0-215.0
Jones D - Chief Operating Officer	135-140	-	-	-	32.5-35.0	170.0-175.0
Wells P – Director of Finance	135-140	-	-	-	30.0-32.5	165.0-170.0
Pelley C – Chief Nurse and Director of Governance	115-120	-	-	-	132.5-135.0	250.0-255.0
Dasgupta D – Medical Director	175-180	-	-	-	30.0-32.5	205.0-210.0
Patterson I – Interim Director of Workforce and Organisational Development[1]	65-70	-	-	-	35.0-37.5	100.0-105.0
Nettel, T – Director of Workforce and Organisational Development[1]	45-50	-	-	-	45.0-47.5	95.0-100.0
O'Callaghan F – Director of Strategic Implementation and Partnerships [4]	95-100	-	-	-	-	95.0-100.0
Gieve Sir J – Chair	40-45	-	-	-	-	40.0-45.0
Non-executive Directors						
Treves V [2]	5-10	-	-	-	-	5.0-10.0
Williams J	10-15				-	10.0-15.0
Pereira R [3]	10-15	-	-	-	-	10.0-15.0
Smith M	10-15	-	-	-	-	10.0-15.0
Datta S [5]	5-10	-	-	-	-	5.0-10.0
Hudson A [6]	5-10	-	-	-	-	5.0-10.0
Inko–Tariah C	10-15	-	-	-	-	10.0-15.0

[1] The post of Director of Workforce and Organisational Development was covered on an interim basis by Iain Patterson until 7 November after which Tom Nettel took over on a permanent basis.

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

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

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

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

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

Pensions

Normal retirement age is dependent upon NHS Pension scheme; for the 1995 scheme normal retirement age is 60, for the 2015 scheme normal retirement age is 65. One of the Trust's directors during 2020/21 is a member of the 1995 scheme and their normal retirement age is 60. There are no additional benefits receivable in the event of early retirement and no rights under more than one pension scheme arising for the Directors.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

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

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

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

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement). The CETV at 31March 2020 is discounted by the HM treasury discount rate. A common market valuation factor is then applied to the difference between this and the CETV as at 31 March 2021 to calculate the real increase in CETV. If a director started during the year, the opening pension or cash equivalent transfer value (CETV) values will not normally be available and therefore the opening value or increase in year will be set to nil.

Audited pension benefits of senior managers

Name and title	Real increase in pension at Pension Age (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 2021 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Real Increase in Cash Equivalent Transfer Value £000
Fletcher T Chief Executive	0.0-2.5	7.5-10.0	60-65	140-150	1,127	1,054	53
Jones D Chief Operating Officer	0.0-2.5	0	30-35	55-60	464	425	12
Wells P Director of Finance	0.0-2.5	0	5-10	0	60	36	6
Pelley C Chief Nurse and Director of Governance	0.0-2.5	0.0-2.5	50-55	150-155	1,083	1,031	18
Dasgupta D Medical Director	2.5-5.0	2.5-5.0	65-70	170-175	1,485	1,353	66
Nettel T Director of Organisation Transformation	0.0-2.5	0	25-30	35-40	298	269	7

Nomination and Remuneration Committee

The Nomination and Remuneration Committee met in March 2020 to consider executive director performance and remuneration. The meeting was chaired by Sir John Gieve also present were Andrew Hudson, Cherron Inko-Tariah, Rommel Pereira, Dr Mark Rickets and Dr Mike Gill. The meeting was also part attended by the Chief Executive and fully attended by the Trust Secretary.

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

Components of Senior Management Remuneration

Salary				
Purpose	**Operation**	**Opportunity**	**Performance Measures**	**Recovery**
The Trust's strategic priorities in 2021/22 are: People, Quality: Integration and System. Executive directors are set annual performance objectives aligned to these priorities and lead on the delivery of divisional business plans structured around the same priorities.	Executive directors are on spot salaries, which are agreed upon appointment. Salaries are reviewed annually by the remuneration committee which considers the market rate for the position, any alterations to scope and the performance of the individual as assessed in their PDR*. A remuneration benchmarking report, based on a benchmark of similar trusts, is prepared for the Remuneration Committee.	Executive directors are paid a flat salary that is not linked to performance outcomes. Based on performance and benchmarking decisions are made by members of the Remuneration Committee in respect of the potential for pay awards.	Executive directors along with all staff are assessed against both what they achieve (objectives) and how they achieve it (values and behaviours) as part of their annual PDR.	There are no provisions for withholding payments.
Pension				
Purpose	**Operation**	**Opportunity**	**Performance Measures**	**Recovery**
Executive directors are eligible to join the NHS pension scheme which is linked to the director's salary.	NHS pension rules and contribution rates apply.	As above	N/A	Where dismissals are made due to misrepresentation in obtaining office, there are provisions for recovering employer pension contributions.

*PDR = performance development review

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

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

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

Policy on payment for loss of office

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

Tracey Fletcher
Chief Executive
16 June 2021

Staff report

The number of staff directly employed by the Trust increased by 157.21 full-time equivalent (FTE) from 3657.96 FTE in 2019/20 to 3,815.17 FTE in 2020/21. Excluded from these figures are pre and postgraduate health care practitioners who were placed with us for training, bank and agency employees, staff holding honorary contracts and catering and domestic personnel.

Staff costs

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	167,186	1,553	**168,739**	153,498
Social security costs	19,108	-	**19,108**	17,714
Apprenticeship levy	911	-	**911**	850
Employer's contributions to NHS pension scheme	30,857	-	**30,857**	29,258
Pension cost - other	33	-	**33**	36
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	39,628	**39,628**	36,913
Total gross staff costs	218,095	41,181	**259,276**	238,269
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	218,095	41,181	**259,276**	238,269
Of which Costs capitalised as part of assets	231	158	**389**	365

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	503	78	**580**	564
Ambulance staff	2	-	**2**	2
Administration and estates	658	145	**803**	773
Healthcare assistants and other support staff	672	131	**802**	731
Nursing, midwifery and health visiting staff	1,237	220	**1,457**	1,401
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	692	61	**753**	688
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	18
Total average numbers	3,763	634	**4,397**	4,177
Of which: Number of employees (WTE) engaged on capital projects	4	4	**8**	8

Of these staff, 71% work primarily in an acute setting, 20% primarily in a community setting and 9% in corporate functions.

Gender and Disability Analysis

Gender	2019/20	%	2020/21	%
Male	874	22%	888	21%
Female	3133	78%	3279	79%
Total	4,007		4,167	
Recorded Disability	171	4%	179	4%

In total, 79% of our staff are female which is typical of NHS organisations. This proportion has increased by 1% since last year.

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

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

Staff performance indicators

Performance against workforce indicators overall remains consistent, with the Board and Divisional Management Teams receiving monthly performance information. Vacancy rates have decreased over the last financial year from 8.76% at March 2020 to 8.33% at March 2021 although this is against a background of increasing budgeted FTE. The staff turnover rate has decreased over the last financial year by 2.84 percentage points.

NHS Workforce Statistics (NHS Digital): https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff support and wellbeing

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

The Covid-19 pandemic had a significant impact on the NHS and on our staff. Throughout the pandemic, we have worked to ensure the health and wellbeing or our staff. This included direct access to psychological support for staff, both on an individual and team basis, 'feel good trolleys' to deliver donations, information and support directly to staff, continuing to offer wellbeing activities such as Pilates and Yoga. A Remembrance event across three of our sites was held on 31 March 2021, which was live streamed and a two-minute silence observed.

The National Staff Survey 2020 results showed a significant increase in the health and wellbeing theme, up from 5.5 to 5.8; our highest score in over five years. Health and wellbeing continues to be a core strategic priority and forms part of 'Our Homerton People' plan with a focus on establishing clear pathways for support, embedding sustainable wellbeing support and upgrading staff areas. Recognising the impacts of the pandemic on our staff, we have also invested in an additional Wellbeing Day for our staff, to give time for prioritising their own wellbeing.

The Trust's sickness absence rate averaged 3.74% for the 2020/21 financial year. This is above our target of 3% and is largely attributable to the Coronavirus pandemic. The sickness management policy is widely used to ensure staff receive appropriate support and attendance is managed in the interests of service delivery.

Sickness absence rates can be found in the NHS Sickness Absence Statistics at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

The Health and Safety Team sits within the Directorate of Finance and is managed by the Head of Facilities. The team is focused on embedding a suite of revised health and safety polices, implementation of a continuous improvement plan developed in October 2020, and a formal health and safety audit programme, which is reviewed annually. The team is reasonably assured that the Trust has adequate policies, systems and procedures in place for the identification and management of health and safety issues across the organisation.

As with any large and complex healthcare organisation, events will occur and there will be areas for improvement which are being addressed through the improvement action plan monitored by the Health and Safety Committee. Additional improvements in compliance are planned over the next 12 months to further improve the Health & Safety Management system and provide greater levels of assurance to the Trust that statutory requirements are being met.

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

Influenza programme

During 20/21, the Commissioning for Quality and Innovation (CQUIN) programme was suspended due to Covid. However, it was a requirement by PHE/NHSE that the seasonal staff flu vaccination programme was to continue given the risks associated with infections of both Covid and influenza; staff at higher risk from coronavirus being more at risk from problems from flu and to reduce pressure on Homerton Hospital and wider NHS during a very challenging winter of possible further Covid-19 peaks.

The 2020/21 campaign had a target set by PHE of 90%. A total of 2,649 frontline healthcare workers at Homerton received the vaccine achieving 70% under very difficult circumstances during the second Covid peak. The staff flu programme also finished earlier than usual as the Trust had to set up and roll out the Covid vaccination programme at the same time.

Staff involvement and engagement

Throughout the Covid-19 pandemic, the Trust has worked to ensure that our staff remain involved and engaged. Regular communication channels were expanded with regular emails to all staff to ensure they remained informed of changes in the organisation. Over the summer we hosted Recognition Week; a week of events to celebrate and recognise the work of our staff. Our QI team also ran sessions with teams to identify lessons that could be learned and were share with colleagues across the organisation.

Several changes made in the pandemic have enabled greater engagement with our staff. For example, moving the monthly 'Team Brief' meeting (where the Chief Executive and senior leadership team share important messages) to being online has enabled greater attendance and participation from managers across the Trust, who can then share information to their teams. We continue to deliver an electronic weekly newsletter (HomertonLite) which shares regular updates on Trust activities, key awareness dates and Trust news.

The Trust intranet continues to act as the primary information source for staff and it is kept up to date with news items and feature articles on developments across the Trust. This

is supplemented by daily updates on the Trust Twitter feed and Facebook account. The Trust's website and intranet have been subject to review during the year to ensure they are informative, relevant and easy to use.

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

Staff survey

The 2020 Staff Survey ran between October and November 2020 and was based on a whole Trust census. The survey was reduced to 78 questions considering the Covid-19 pandemic. The benchmarking groups for acute and acute and community trusts were combined, increasing the group to 128 organisations in total.

The Trust saw a decline in response rate, with 47.6% responding, down 8.5% from 2019. Despite this, the Trust response rate remains above average compared to trusts of our type.

Despite the challenges of the pandemic, the Trust saw an increase in recommendation as a place to work, recommendation as a place to receive care and care being the top priority for the organisation; all of which form part of the staff engagement measure, which maintained at 7.1 out of 10. We also saw increases in the quality of care theme (now rated 4th of 128 acute and acute and community trusts in England for this theme) and a significant improvement in health and wellbeing, up from 5.5 to 5.8. Unfortunately we saw a decline in the equality, diversity and inclusion, from 8.5 to 8.4 out of 10. This one of our main areas of focus in 'Our Homerton People' plan.

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

- Immediate managers
- Quality of care
- Safety culture
- Staff engagement
- Team working

Our top five most improved questions were:

QUESTION	2019	2020	Change
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	61.4%	50.0%	↑ 11.4%
q26b. Has your employer made adequate adjustment(s) to enable you to carry out your work?	64.2%	70.2%	↑ 6.0%
q11a. Does your organisation take positive action on health and well-being?	27.2%	31.1%	↑ 3.9%
q4g. There are enough staff at this organisation for me to do my job properly.	36.4%	39.8%	↑ 3.4%
q5h. The opportunities for flexible working patterns.	52.5%	56.6%	↑ 3.1%

The Trust was below the average for the following themes:

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

Our bottom five scores were:

QUESTION	2019	2020	Change
q11c. In last 12 months, have felt unwell due to work related stress	43.3%	47.5%	↑ 4.2%
q8c. Immediate manager gives clear feedback on my work	64.7%	61.0%	↓ 3.7%
q11f. Felt pressure from colleagues to come to work when not feeling well enough	21.2%	24.4%	↓ 3.2%
q5g. I am satisfied with my level of pay	33.5%	30.3%	↓ 3.2%
Q4i. The team I work in often meets to discuss the team's effectiveness	63.7%	60.7%	↓ 3.0%

The Trust's overall results when benchmarked against other trusts are:

	2020-21		2019/20		2018/19	
	Trust	Benchmark Average	Trust	Benchmark Average	Trust	Benchmark Average
Equality, diversity and inclusion	8.4	9.1	8.5	9.2	8.4	9.2
Health and well being	5.8	6.1	5.6	6.0	5.7	5.9
Immediate managers	6.9	6.8	6.9	6.2	6.9	6.8
Morale	6.0	6.2	5.9	6.2	6.0	6.2
Quality of care	7.9	7.5	7.8	7.5	7.8	7.4
Safe environment – bullying & harassment	7.8	8.1	7.8	8.2	7.8	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	7.0	6.8	7.0	6.8	6.9	6.7
Staff engagement	7.1	7.0	7.1	7.1	7.2	7.0
Staff team working	6.6	6.5	6.6	6.5	6.7	6.6

Equality and diversity

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

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

Our Gender pay gap report is also on the Government website at:
https://gender-pay-gap.service.gov.uk/

Diversity data

The table over page confirms the Trust's diversity data. In total 53.7% of staff at the Trust identify as from Black, Asian and minority Ethnic (BAME) backgrounds.

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

Ethnicity	2019/20	%	2020/21	%
White	1,809	45%	1,843	44.23%
Mixed	142	4%	141	3.38%
Black or Black British	1,123	28%	1,189	28.53%
Asian or Asian British	630	16%	672	16.13%
Other Specified	213	5%	236	5.66%
Not Stated	90	2%	66	1.58%
Unspecified	0	0%	20	0.48%
Total	**4,007**		**4167**	

Over the past year we have introduced a cultural calendar, to ensure we are celebrating and sharing in dates and festivals that mean things to our people. The Trust also supports three staff networks: Together we rise (for racial heritage staff and allies), Enable (for staff who identify as having a disability or long-term condition) and LGBT (for staff who identify as lesbian, gay, bisexual or transgender, and allies).

The Trust has continued to implement 'fair recruitment standards' to help eliminate bias and maximise confidence in the Trust's recruitment processes. These standards include for all posts to be advertised for a minimum of six working days, expectations for panels to be diverse and include a minimum of one trained panel member and all decisions to be subject to review. The Trust has started rolling out independent panel members, with staff network chairs piloting this training and role.

To meet our equality objectives, 'Our Homerton People' plan sets out what the Trust will do to support the cultural transformation outlined in the NHS England Long Term Plan and to support the Trust's diversity aspirations.

The Refreshed People Plan

Following careful review of the Staff Survey results from 2020, and the impacts of the pandemic, we have updated and established 'Our Homerton People' plan and this has been reviewed by the new People and Culture Committee.

What is the Plan's Aim?

In line with the updated NHS People Plan aim to make the NHS the best place to work, the aim of the plan is to make the Homerton University Hospital NHS Foundation Trust the best place to work in the NHS.

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

Delivery of the People Plan

The plans and projects that will deliver the improvement in our people's experience will be made up of four key elements.

- Supporting the health and wellbeing of our people
- Achieving equality and inclusion for our people
- Creating a values-led organisation for all our people
- People matter at Homerton Healthcare

i Supporting the health and wellbeing of our people

Continuing the work started during the Covid-19 pandemic, the Trust has developed a comprehensive Health and wellbeing plan that is focused on the following areas:

- Wellbeing Support
- Basic Needs
- Communications
- Tertiary Psychological Support

ii Achieving equality and inclusion for our people

As referenced above, the Trust is committed to making a real difference for staff with protected characteristics. Our plan is focussed on delivering the following aspects:

- Empower our people's voice (Staff networks)
  - Develop effective support including structure, planning and objectives
- Deliver real change in real processes
  - Fair recruitment training and development
  - Just culture implementation including early informal resolutions

iii Creating a values-led organisation for all our people

The Trust values are "Personal, Safe, Responsibility and Respect". We want all of our staff to not only be aware of these but live them in their day-to-day work with each other, our patients, our communities and other colleagues who work in care. As we work to update our Trust strategy, we will embed our values our core Trust processes including appraisals and induction. We will also work to ensure our staff are recognised for their work, through introducing staff awards and long-service awards so all of our staff feel included in the Trust.

iv People matter at Homerton

Our people are our greatest asset and it is well recognised that engagement and motivation of staff leads to better outcomes for our patients. Our staff are proud to work at Homerton and as we work to update our strategy, our people will be involved in engaged in the design of this. We will work to celebrate and showcase our Homerton people and the unique talents they bring. We will also continue our work to embed a culture of civility, safety and learning, supported by our People division and our Freedom to speak up guardians."

Trade Union facility time*

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

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

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

**As a result of Covid-19 pressures the data in this section is in part an estimate based on previous years' data.*

Education and related activities

The Education and Development team have worked incredibly hard this year to support the Trust to deliver services during this exceptional time. While our routine work of Core Mandatory Training, Care Certificate, apprenticeships, and commissioning was significantly affected by Covid the team maintained the service and strived to meet the needs of our people. The requirements of our Education Centre evolved considerably over the year with regular changes implemented to keep staff safe using the site. The team has also supported with training for deployment, the vaccination programme and have aided with hosting of the vaccination programme in the Education Centre.

Core Mandatory Training

The Trust ended the year with an overall compliance rate of 84.65% against all core mandatory training requirements. Nine out of the 16 subjects ended with lower compliance than last year. The pandemic has impacted the opportunities for staff to be released to attend training and this along with some trainers and rooms being redeployed to support the Covid-19 effort has had an impact on compliance. Some topics however did see an increase in compliance from 2019/20. Level 1 topics seeing an increase included safeguarding children and adults, equality and diversity and health and safety. Moving and handling patients and safeguarding adults level 2 also saw an improvement.

All the Core Mandatory Training (CMT) topics, apart from BLS Adult and Paediatrics, can now be completed fully remotely. This work has taken significant commitment by the CMT Education Manager and subject matter experts and has helped to ensure many of our staff have maintained compliance during this challenging time.

Work is now being started to embed our learning around remote training. Booking and recording training via ESR is underway and we expect that this alongside return to normal activity will enable staff to renew their compliance.

Care Certificate

Changes have taken place over the last year to help our Health Care Support Workers complete learning despite the challenges presented by Covid. With support from the Chief Nurse staff, have embraced a blended learning approach with e-learning reducing four days of face-to-face teaching to one day. In addition, staff in the Trust before 2015 are now using a self-assessment model to complete the care certificate which recognises their experience and requires managers to confirm the practice of their staff. These decisions have meant that there have been a variety of opportunities available to for staff to continue their development despite the suspension of two cohorts during the last year.

There is now an Education Manager focussed on the Care Certificate and staff who have not been able to complete have been identified and are being followed up. The ambition is to have 75% of our Health Care Support Workers to have fully completed the Care Certificate by the end of September 2021 with action plans for the 25% not completed. To support this a remotely delivered version of the Care Certificate Training Day is being developed as a way of increasing capacity and staff and their managers are being regularly engaged with.

Apprenticeships and work experience

Homerton continues to offer apprenticeship opportunities for all our band 2 and 3 vacancies, and a wide range of apprenticeships are also available to staff as part of their personal development planning. Apprenticeships provide us a unique opportunity for staff to access education and develop that is directly relevant to their work and fully funded – something that is of great value.

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

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

Education commissioning

A variety of training programmes were delivered on site and remotely by external providers which are regularly reviewed to ensure that the training needs of the Trust are met. These include both clinical and non-clinical courses as well as bespoke training for specific staff groups.

2020/21 saw the implementation of a new way of funding education from Health Education England (HEE). The Trust now receives all our education funding directly from HEE via the Continued Professional Development (CPD) and Workforce Development (WFD) funds. The CPD money is made up of £1000 allocated for each registered AHP/ nurse and midwife across three years. This year the Trust received the first third of this money. Work was done with education leads and clinicians across these professions to allocate this money to education and we aim to continue to evolve how we plan and allocate this spend over the next year. The WFD funds are allocated for training and education for the rest of the Trust and these were fully utilised for during 2020/21.

Medical education

2020/21 was a challenging year for the delivery of Medical Education. During the first wave of the pandemic the Simulation and Clinical Skills team changed their focus from scheduled courses and local training, to deliver intensive care cross skilling and non-invasive ventilation, tracheostomy and other clinical skills training to all staff. Medical student placements were paused and following induction and upskilling, 48 volunteered to work as support staff, runners and bed buddies. Trainee and Trust doctors were redeployed to join the acute care and intensive care rosters. Some medical trainee rotations were paused by HEE but the impact on local trainees was minimised after discussion with relevant departments. The GMC allowed early graduation and pre-registration of final year medical students and 22 joined the Trust workforce earlier than planned as interim FY1s (foundation doctors). This provided valuable experience for newly qualified doctors whose training had been disrupted by the pandemic. The Newcomb Library was changed into to a wobble room to support staff wellbeing. The library staff also provided updates on the latest developments in the management of Covid.

The results of the 2020 national General Medical Council (GMC) survey of doctors in training were positive. This was a shortened survey due to the pandemic and was not compulsory. The Trust performed well overall in comparison to the national average and with other trusts in north central and east London, coming top in 14 out of 38 indicators. Areas of very good performance included communication and teamwork, curriculum delivery and education, and speaking up and voice. Training programmes which performed particularly well were Foundation, Medicine and Emergency Medicine. Training programmes which performed less well were Anaesthetics and Acute Care Common Stem (ACCS) whose trainees were largely redeployed to ITU. Following the first wave a wellbeing lead has been appointed in anaesthetics and all incoming anaesthetics trainees had a check in with the college tutor. Trust wellbeing resources are promoted to all trainees at induction and the Local Faculty Groups (for each specialty) provide a check in for trainees.

The August 2020 induction programme for incoming doctors was redesigned with social distancing in mind. Teaching, in situ simulation and courses have restarted. The Trust was able to implement a new curriculum for Year 5 medical students and accommodate increased numbers. Year 4 students returned and Year 3 students had a delayed return in January 2021. Initial feedback from the medical students has been very positive. Medical students remained on placements during the second wave and many signed up for support worker shifts. Feedback from the Barts and the London School of Medicine and Dentistry quality visit was that the Trust continues to demonstrate its commitment to the delivery of undergraduate and postgraduate medical education.

Staff policies

Raising concerns (whistleblowing)

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

Counter fraud, anti-bribery and corruption

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

Other policies

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

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

During the reporting year, the sickness policy was in place with regards to information regarding occupational health. As well as the Organisational Change Policy to support consultation with employees so that the view of employees can be considered in making decisions which are likely to affect their interests.

All People Policies will be reviewed and refreshed in 2021/22 in line with a fair and just culture working closely with staffside and our staff networks.

Consultancy expenditure

The 2020/21 expenditure on consultancy was £0.4m (2019/20 £0.5m) and this included the cost of consultancy work around organisational development and support, advice on the development of the clinical services surgical review and additional specialist procurement support.

Reporting of compensation schemes - exit packages 2020/21

Exit packages awarded in 2020/21 were as follows:

There was one compulsory redundancy and eight agreed payments in lieu of notice.

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	1	6	7
£10,000 - £25,000	-	1	1
£25,001 - 50,000	-	1	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**8**	**9**
Total cost (£)	£6,000	£71,000	£77,000

Reporting of compensation schemes - exit packages 2019/20

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	1	15	16
£10,000 - £25,000	-	6	6
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**21**	**22**
Total cost (£)	£4,000	£157,000	£161,000

Exit packages: other (non-compulsory) departure payments

	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	1	1
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	8	71	20	156
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**8**	**71**	**21**	**157**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Off-payroll engagements

The Trust has a policy that all substantive staff are paid through the payroll. No executive Board members were engaged on an off-payroll basis in 2020/21.

On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as at 31 March 2021 is shown in the tables below where daily rates exceed £245 per day and the engagement has lasted longer than six months.

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2021, for more than £245[1] per day:

	Number
Number of existing engagements as of 31 March 2021	3
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	Nil
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	Nil
for 4 or more years at the time of reporting	1

Note (1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245(1) per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	Nil
Of which...	
No. not subject to off-payroll legislation[2]	Nil
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	3
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	Nil
No. of engagements reassessed for compliance or assurance purposes during the year	Nil
Of which: no. of engagements that saw a change to IR35 status following review	Nil

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

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility during the financial year. This figure should include both off-payroll and on- payroll engagements.	9

Note (1) The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll board member/senior official engagements

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

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	Nil
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements (2)	9

Note (1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

In any cases where individuals are included within the first row of this table the department should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

Disclosures set out in the NHS Foundation Trust Code of Governance

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

For the year ending 31 March 2021 the Trust complied with all the provisions of the Code as set out in NHSI's Annual Reporting Manual 2020/21.

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

Code Reference	Annual Report Section	Page
A.1.1	Directors' Report: Trust Board and Role of the Council of Governors	16
A.1.2	Directors' Report: Trust Board, Board members, Directors' Board attendance, Board Committees, Governor Nomination Committee, Governor Remuneration Committee	16

Code Reference	Annual Report Section	Page
A.5.3	Council of Governors	30
Additional requirement	Council of Governors	30
B.1.1	Board members	16
B.1.4	Board members and Board statement on knowledge, skills, and expertise	16
Additional requirement	Non-executive directors	17
B.2.10	Remuneration and Nomination Committee and Governor Nomination Committee	36
Additional requirement	Did not apply in 2020/21	-
B.3.1	Sir John Gieve's biography	17
B.5.6	Member Engagement and Communication Committee	36
Additional requirement	Did not apply in 2020/21	-
B.6.1/B.6.2	Board statement on knowledge, skills and expertise to fulfil its function and appraisal of directors and NHSI Well-led Framework	29
C.1.1	Statement of Accounting Officer's Responsibilities and Annual Governance Statement	66
C.2.1	Annual Governance Statement	68
C.2.2	Auditors	25
C.3.5	Not applicable – external auditor recommendation accepted by the Council [TBC after 8 June]	
C.3.9	Audit and Risk Committee	24
D.1.3	Remuneration Report	40
E.1.4	Contacting the Board/Contacting the Governors	22
E.1.5	Role of the Council of Governors, Director Attendance	32
E.1.6	Member Engagement and Communication Committee	36
Additional requirement	Governors and members, Member Engagement and Communication Committee	29
Additional requirement	Board members / Register of interests	16

NHS Oversight Framework

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

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

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

Homerton was in segment 1 at the end of the reporting year, with no formal interventions introduced by NHSI/E under the legal authority as Monitor. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Statement of Accounting Officer's responsibilities

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

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

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

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

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

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

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

Tracey Fletcher
Chief Executive
16 June 2021

Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Homerton University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

The Board of Directors has overall accountability for the Trust's Risk Management Policy and established a Risk Committee to provide assurance to the Board that the Trust has effective risk management processes. Following a review of the committees of the board, it was decided to combine work on risk with the Audit Committee, and the new Audit and Risk Committee met for the first time in January 2021.

The Risk Committee met during 2020/21 to:

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

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

c) receive scrutiny reports from both internal and external sources including update on actions following the Care Quality Commission inspection in January 2020

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

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

f) Discuss, develop and agree a Trust risk appetite statement

The Board Assurance Framework (BAF) sets out the principal risks to delivery of strategic objectives and the key controls and assurances available to the Board on management of these significant areas of risk. The BAF is reviewed and updated by the executive directors and is formally reviewed by the Board of Directors and by the Risk Committee and its successor, the Audit and Risk Committee, to ensure that appropriate controls are in place and mitigating action is being taken against the key risks.

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

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

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

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

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

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

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

During the reporting year, despite the impact of Covid, we continued to operate our serious incident process which had been enhanced last year to strengthen the management of clinical incidents within the divisions. We continued to maximise the use of our risk management software system (Datix) with the aim of simplifying the reporting of incidents and to widen our understanding of particular themes and trends, and have used this to better understand risks and incidents associated with Covid.

The risk and control framework

The Risk Management Policy is approved by the Board of Directors. It describes the Trust's overall risk management approach, corporate and divisional responsibilities for risk, the risk management process and the organisation's risk appetite. The policy is available to all staff via the Trust's intranet.

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

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

During the year the Trust's BAF and BAF process were reviewed by internal audit. The review concluded that the Board could take reasonable assurance that overall, the BAF and processes for developing it were suitably designed and consistently applied. An Assurance Map has been developed which maps different sources of assurance for key process areas within the Trust, and will be updated further in the coming year.

Quality governance arrangements

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

The Trust Management Board (Quality and Operational Assurance), chaired by the Chief Executive, meets monthly and reviews and monitors quality issues for the whole Trust. The Risk Committee (the Audit and Risk Committee from January 2021), the Improving Quality Board, the Improving Patient Safety Committee, the Improving Patient Experience, and the Clinical Effectiveness Committee also have an important governance role in the oversight of quality. Non-Executive Directors began as members on some of the committees during the period.

The above committees and their supporting subgroups ensure information for decision-making flows from the wards, departments and divisions to the Board and vice versa. This approach supports delivery of improvement action at the point of care while also providing a route for escalation of concerns and mitigating actions to the Trust Board.

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

Our Trust Management Board meetings, held monthly, have been divided into a People, Performance and Assurance meeting; and a Collaboration, Integration and Systems meeting recognising the need for focus on internal governance, risk and compliance, and on developing our approach to working collaboratively within the local integrated care system.

Assessing the quality of performance information

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

- national targets, including infection control, A&E waiting times, cancer access and referral to treatment (RTT) standards. Improvement plans are included if there are concerns about specific targets
- patient safety and clinical effectiveness including the patient safety thermometer, falls and pressure ulcers, delayed transfers of care and standardised hospital mortality ratios
- exception reports from the maternity services dashboard

- patient experience data, including Friends and Family Test, PALs and complaints data. During the latter part of 2020, the ability to obtain Friends and Family Test data was limited due to Covid - wards were extremely busy and volunteers were unable to attend to support data collection due to national social distancing measures. The Trust has recommenced collection of patient experience data and is prioritising an increase in the uptake of tests in 2021/22
- key workforce metrics, such as agency spend, vacancy rates, turnover and sickness absence
- key financial performance data, including income and expenditure and a summary of cost improvement programme (CIP) performance
- progress reports on the Trust's financial plan

Dedicated central tracking and validation teams are in place for cancer and referral to treatment performance data, with local divisional arrangements for other standards. Monthly validation takes place of all key external data submissions.

Assurance on compliance with the CQC registration requirements

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

A range of mechanisms are in place to provide assurance of compliance with the CQC's registration requirements range of mechanisms are in place to provide assurance of compliance with the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2010, as set out in the CQC's guidance for providers. These include the Trust's well-established arrangements for quality governance detailed above, and the 'Perfect Ward' audits. The audits enable staff to spot and rectify issues and support a consistent evidence-based view of quality across the Trust.

In January 2020 the CQC inspected a selection of services on our acute site - maternity, end of life care and elderly care services. Homerton University Hospital's overall rating improved to 'outstanding' from the previous inspection. The Trust received improvement actions including a must-do action to address the interface between electronic patient record systems in maternity services. The Trust submitted an improvement action plan to the CQC and is implementing it. The CQC rating has remained 'good' overall following the inspection of the acute site.

The Risk Committee received regular CQC updates and reviewed CQC Insight reports to identify areas of deteriorating performance.

Major risks

The Board Assurance Framework sets out the principal risks to delivery of strategic objectives and the key controls and assurances available to the Board on management of these significant areas of risk. It incorporates three lines of assurance comprising day-to-day management controls; oversight, review and monitoring functions; and external and independent review.

In-year risks 2020/21

The Board Assurance Framework highlights areas of risk in 2020/21 where the Board has medium or limited levels of assurance. These areas remain ongoing risks, and can be summarised under the following broad themes:

- pandemic preparedness: as a result of uncertainty about the scale, severity and pattern of development of any future pandemic, the Trust may be insufficiently prepared and may not have sufficient numbers of staff and resources to provide a safe, effective and timely response to care for patients and meet our statutory and regulatory obligations
- our capacity and capability to engage and work collaboratively with partners to address population health problems including the increasing burden of ill health due to smoking related causes
- our processes to ensure patient and public engagement and inclusion is embedded in all that we do including ensuring that service provision is focussed on active personalised care as defined by patients and established through co-production
- maintaining cybersecurity in the face of increased cyber threats globally

Controls and assurances included:

- Pandemic response arrangements including the Trust Resilience Group (TRG) applying the Emergency Preparedness, Resilience and Response Policy
- Adaptable and responsive services including expansion of critical care beds, a Single Point of Access introduced as part of the Adult Neighbourhood community nursing model pilot, virtual outpatient clinics and staff redeployment
- A range of measures to protect staff including a wellbeing and vaccination programme and remote working arrangements
- Established process for learning from incidents, outbreaks and exercises which ensures continuous strengthening of response arrangements.
- Mutual aid plans especially joint working between health and social care organisations
- Covid preparedness group, oversight of outbreaks by the Infection Prevention and Control Committee and Trust participation in the local Health Protection Board
- Emergency preparedness and response arrangements tested through exercises at national, regional and local levels
- Refocusing our Trust Management Board and objectives to concentrate on integration and collaboration within our local integrated care system
- Smoking Cessation collaborative work with public health, and referral of patients to smoking cessation clinics and initiatives
- Reports to the Commissioning for Quality and Innovation Board and membership of the Clinical Commissioning Group (CCG) patient and public involvement forum
- Engagement in neighbourhoods steering group and attendance at local patient forum

- Monitoring and review by the Improving Patient Experience Committee
- Cybersecurity controls including compliance with the data security and Protection Toolkit, and the Informatics Steering Committee which oversees Cybersecurity compliance

The most significant clinical risk for the Trust remains the ability to recruit and retain medical and nursing staff to ensure the delivery of safe, harm free care for patients, an area which has been exacerbated nationally due to Covid. The Trust continues to monitor the number of clinical post vacancies. Corrective action is taken as issues are identified, and actions are also embedded within the People and Culture Strategy. Mitigation of this risk will remain a major focus in 2021/22.

Future risks 2021/22

As with all NHS organisations, we face continual challenges in balancing the delivery of high quality care with demand, rising acuity and the need to increase both productivity and efficiency. We recognise that strategic and transformational change internally and across our local health economy will be required to address risks that we identify, and that our organisation and staff will need to develop to meet obligations arising from the statutory establishment of Integrated Care Systems including the aim of improving population health.

Covid-19 has posed significant and unique operational and strategic challenges to the Trust, the National Health Service and the country. The impact will be felt across all our services and is likely to impact on achievement of the Trust's strategic objectives.

Many of the principal risks for 2021/22 arise from Covid: recovery of elective work, risk of a third wave, staff wellbeing and organisational capacity to cope.

There are also risks as we adjust to working within the new structure of the Integrated Care System and Integrated Care Partnership: ensuring we contribute and collaborate effectively as partners and maintaining our financial and waiting time standards.

Some risks remain as before for example recruiting the staff we need, cyber threats and an ageing estate infrastructure.

The Board Assurance Framework will be reassessed later in the financial year to reflect the overall impact of Covid-19 and the risks in this section on the Trust's strategic agenda.

NHS Improvement well-led framework

In 2018 the Trust received a 'good' rating following the CQC's well-led inspection. In 2020, the Trust Board completed a well-led self-assessment in line with NHS Improvement's well-led framework guidance. Our externally facilitated well-led assessment was scheduled for the 2020/21 reporting period but did not take place because of the significant involvement of the executive team in the response to the Covid-19 pandemic. The review is planned for the 2021/22 period. In the interim, the Board participated in a development session led by an independent facilitator to develop a targeted action programme in areas of leadership and governance for the Board to work on in order to deliver our vision and mission, and sustain future performance.

Risks to foundation trust governance and corporate governance statement assurance

The Board sets the vision, values and strategic direction of the Trust and is collectively responsible for its performance.

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

To assure itself of the validity of its corporate governance statement, as required under NHS Foundation Trust condition 4(8) (b), the Trust Board has assessed its compliance with the Code of Governance. The Board made a self-declaration in June 2021 that it was compliant with the conditions of the NHS provider licence and with no significant risks identified in relation to the corporate governance statement.

Embedding risk management and incident reporting

The ways in which risk management is embedded in the Trust are covered in the risk and control framework above.

All staff are encouraged to report incidents and near misses as part of an open and fair culture. Training is given to all staff at induction and the electronic incident reporting system provides feedback when an incident is investigated if the member of staff wishes to receive this. Our aim is to involve all patients and families in the serious incidents process so that they are aware of the risks identified, and those that impact on public stakeholders and staff are prompted by the incident reporting system to follow the 'duty of candour' process.

During 2020/21, the Trust has continued to demonstrate a healthy incident reporting culture with a high reporting rate but the majority of incidents reported were of no, or low, harm. In 2020/21, the Trust reported three 'never events'. All reported incidents are fully investigated to ensure the lessons are learnt and shared across the Trust. Themes are identified, so that future recurrence can be prevented.

Equality, Diversity and Inclusion

This section should be read together with the Equality and Diversity sections of the 'Staff Report'.

Control measures are in place to ensure that the Trust is compliant with equality, diversity and human rights legislation.

An equality impact assessment is completed for all new and revised policies, which is considered by the relevant committee and the Trust's Policy Group. The People and Culture Committee is responsible for progressing actions to advance equality in the Trust and meet the standards set out in the NHS Equality Delivery Systems (EDS2).

Public stakeholders' involvement in managing risk

The Trust provides information and assurance to the public on its performance against its principal risks and objectives in several different ways including:

- Homerton University Hospital NHS Foundation Trust has over 8,000 members as at the end of March 2021. They are represented by a Council of Governors that comprises public, staff and stakeholder governors
- The Council of Governors receives regular updates on clinical and financial performance, service delivery and issues raised at the Audit Committee. Meetings are held regularly and members of the public are able to raise issues directly with the Governors at these meetings and at the annual members meeting.
- Governors meet jointly with the Board to assist governors to discharge their duties to hold the non-executive directors to account for the performance of the Board
- consultation with the public is undertaken in developing new services and where key changes are proposed to existing services which may impact upon them
- the Trust has an agreed process to advise and engage with City and Hackney's overview and scrutiny sub-committees when there are proposed changes that may impact on service users
- Healthwatch Hackney is represented on the Trust's Council of Governors and are also part of the Improving Patient Safety Committee and Serious Incident Assurance Panel
- Briefings are circulated to governors and information provided at meetings on current risks including this year on the impact of Covid to patients, public and staff, and on actions being taken to mitigate risk.

Staffing assurance and compliance with Developing Workforce Safeguards recommendations

During the reporting year the Board approved a refreshed People and Culture Plan 2020-2023, which is aligned to the overarching aims of the interim NHS People Plan. One of the key aims is to prioritise urgent action on nursing shortages. A new governance structure was established to oversee and support delivery of People and Culture Plan including a People and Culture Committee which met for the first time in March 2021.

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

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

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

Compliance statements

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

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

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

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

The Trust ensures economy, efficiency and effectiveness through a variety of means, including:

- a robust pay and non-pay budgetary control system
- effective and consistently applied financial controls
- effective tendering procedures
- robust establishment controls
- annual external audit including value for money and use of resources
- divisional performance management processes including financial performance review
- identification of productivity and efficiency opportunities as part of the annual business planning process
- an efficiency programme to identify and deliver efficiencies against the Trust savings target chaired by the Chief Executive

Information governance

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

All staff receive information governance training as part of corporate induction on joining the Trust. Named Information Asset Owner (IAO) for each department, are supported by IG and information security staff. Registers of information assets, flows and uses are maintained and are reviewed and updated in-year.

Seven information governance security related incidents were reported to NHS Digital and the Information Commissioner's Office (ICO) during the reporting period. Of these, six incidents were successful phishing attacks which were risk assessed in line with Data Security and Protection Toolkit incident reporting guidance. The ICO has acknowledged receipt of these incident and no further response has been received to date. One non-phishing incident related to a letter inadvertently sent to a home address in error. It could not be established that there had been any significant impact to the rights and freedoms of the patient or if any harm occurred as a result, and the ICO decided that no further action was necessary.

The Trust uses the Data Security and Protection Toolkit, an online self-assessment tool that enables us to measure and publish our performance against the National Data Guardian's ten data security standards. We use this toolkit to provide assurance that we are practising good data security and that personal information is handled correctly.

Data quality and governance

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

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

The Data Quality Committee reports to the Trust Management Board. The Chief Operating Officer is the Trust's Senior Information Risk Officer and member of the Information Governance Committee which reports to the Risk Committee (now Audit and Risk Committee).

Using data quality indicators for both acute and community services the committee monitors data quality and promotes improvement and awareness within the Trust. The steps taken by the Trust to maintain and improve the quality of data are:

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

Data quality assurance of elective waiting time data

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

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

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

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

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

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

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

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

- The Board has been actively involved in reviewing the Trust's risk management processes and the Board Assurance Framework. The Board has played a key role in reviewing risks to the delivery of performance objectives through monitoring and discussion of the Integrated Board Report.
- The Risk Committee (now Audit and Risk Committee) has overseen the effectiveness of the Trust's risk management arrangements, the on-going development of the risk register and key clinical and non- clinical risks highlighted by other committees.
- The Audit Committee (now Audit and Risk Committee) has overseen the system of internal control, especially about corporate risk and counter fraud, and it has actively engaged in the oversight of the Trust's key financial challenges.
- Internal Audit has reviewed and reported on a number of financial and operational systems, as well as the Board Assurance Framework, based on an audit plan approved by the Audit and Risk Committee. Where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management.
- Internal Audit has reviewed the system of internal control. We do not consider any of Internal Audit findings to be significant control failings.

For the 12 months ended 31 March 2021, the Head of Internal audit opinion was that "the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified some weaknesses in the application of some internal controls. Management actions to address these weaknesses have been agreed with the Trust."

Conclusion

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

Tracey Fletcher
Chief Executive
16 June 2021

Annual Accounts

Our Values
PERSONAL
SAFE
RESPECTFUL
RESPONSIBILITY

Homerton University Hospital NHS Foundation Trust Annual Accounts 2020/21

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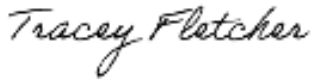
Homerton University Hospital NHS Foundation Trust Annual Accounts 2020/21

Foreword to the accounts

Homerton University Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Homerton University Hospital NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.



Signed ……

Name Tracey Fletcher

Job title Chief Executive

Date 3 June 2021

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

- Enquiring of management, the Audit Committee and internal audit as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Trust's accounting policies.

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

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

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

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals with unusual account combinations and journals with other unusual characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Identified income and expenditure invoices recognised in the period 1 March 2021 to 31 May 2021, to determine whether the income and expenditure is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties.
- Assessed the outcome of the NHS agreement of balances exercise with CCGs and other NHS providers and investigated the cause of the variances identified.

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

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

Remuneration and Staff Reports

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

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 66, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms

agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Homerton University Hospital NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Fleur Nieboer
for and on behalf of KPMG LLP
Chartered Accountants
15 Canada Square
London
E14 5GL

15 June 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3.2.	**339,017**	321,226
Other operating income	3.4.	**38,745**	32,354
Operating expenses	4&5	**(372,200)**	(342,165)
Operating surplus from continuing operations		**5,562**	11,415
Finance income	10.	**-**	390
Finance expenses	11.	**(167)**	(179)
PDC dividends payable	27.	**(3,390)**	(4,435)
Net finance costs		**(3,557)**	(4,224)
Surplus for the year		**2,005**	7,191

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	12.	**6,136**	5,106
Property, plant and equipment	13.	**166,362**	154,228
Receivables	16.2.	**519**	50
Total non-current assets		**173,017**	159,384
Current assets			
Inventories	15.	**3,736**	3,428
Receivables	16.1.	**20,380**	32,642
Cash and cash equivalents	17.	**77,687**	67,596
Total current assets		**101,803**	103,666
Current liabilities			
Trade and other payables	19.1.	**(51,495)**	(50,553)
Borrowings	22.1	**(410)**	(400)
Provisions	23.	**(3,950)**	(5,539)
Other liabilities	20.1.	**(5,502)**	(5,662)
Total current liabilities		**(61,357)**	(62,154)
Total assets less current liabilities		**213,463**	200,896
Non-current liabilities			
Borrowings	21.2.	**(4,811)**	(5,196)
Provisions	23.	**(1,426)**	(861)
Total non-current liabilities		**(6,237)**	(6,057)
Total assets employed		**207,226**	194,839
Financed by			
Public dividend capital	27.	**100,269**	92,726
Revaluation reserve	SOCTIE	**56,234**	53,395
Income and expenditure reserve	SOCTIE	**50,723**	48,718
Total taxpayers' equity		**207,226**	194,839

The notes on pages 7 to 37 form part of these accounts.

Tracey Fletcher

Name	Tracey Fletcher
Position	Chief Executive
Date	3 June 2021

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2020 - brought forward	**92,726**	**53,395**	**48,718**	**194,839**
Surplus/(deficit) for the year	**-**	**-**	**2,005**	**2,005**
Revaluations	**-**	**2,839**	**-**	**2,839**
Public dividend capital received	**7,543**	**-**	**-**	**7,543**
Taxpayers' equity at 31 March 2021	**100,269**	**56,234**	**50,723**	**207,226**

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers'equity at 1 April 2019 - brought forward	92,355	45,168	41,527	179,050
Surplus/(deficit) for the year	-	-	7,191	7,191
Revaluations	-	8,227	-	8,227
Public dividend capital received	371	-	-	371
Taxpayers' equity at 31 March 2020	92,726	53,395	48,718	194,839

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		**5,562**	11,415
Non-cash income and expense:			
Depreciation and amortisation	4.	**9,572**	9,277
Net impairments	7.	**-**	1,079
Income recognised in respect of capital donations	3.4.	**(1,448)**	-
(Increase) / decrease in receivables and other assets		**11,793**	2,262
(Increase) / decrease in inventories		**(308)**	(442)
Increase / (decrease) in payables and other liabilities		**(5,866)**	10,687
Increase / (decrease) in provisions		**(1,025)**	296
Other movements in operating cash flows		**1**	-
Net cash flows from / (used in) operating activities		**18,280**	34,574
Cash flows from investing activities			
Interest received		-	390
Purchase of intangible assets		**(1,969)**	(695)
Purchase of PPE and investment property		**(9,683)**	(10,336)
Net cash flows from / (used in) investing activities		**(11,652)**	(10,641)
Cash flows from financing activities			
Public dividend capital received		**7,543**	371
Movement on loans from DHSC		**(293)**	(292)
Movement on other loans		**(82)**	98
Interest on loans		**(166)**	(180)
PDC dividend (paid) / refunded		**(3,539)**	(3,975)
Net cash flows from / (used in) financing activities		**3,463**	(3,978)
Increase / (decrease) in cash and cash equivalents		**10,091**	19,955
Cash and cash equivalents at 1 April - brought forward		**67,596**	47,641
Unrealised gains / (losses) on foreign exchange		**-**	-
Cash and cash equivalents at 31 March	17.	**77,687**	67,596

Notes to the Accounts

1. Accounting Policies

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 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case. Provision of services by the Trust are an integral part of the overall delivery of healthcare services within North East London and the Trust has been a key partner in the planning of activity to be delivered within the North East London Integrated Care System. The Trust continues also to have a pivotal role in the development of integrated care within the City and Hackney Integrated Care Partnership.

1.2. Accounting Convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3. Basis of Consolidation

The Trust is the corporate trustee to Homerton University Hospital NHS Foundation Trust Charitable Fund, however the Charity's results have not been consolidated with those of the Trust in 2020/21 on the grounds of materiality. The Charity's accounts for 2020/21 will be published in September and can be found at www.homertonhope.org.
The Trust has no subsidiaries, associates, joint ventures or joint operations.

1.4. Critical accounting judgements and key sources of estimation of uncertainty

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

1.4.1. Critical judgements in applying accounting policies

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

● Depreciation rates applied to property, plant and equipment and valuation methodologies and external indices applied to the valuation conducted by Gerald Eve LLP (note 14 to the accounts).
● As at 31 March 2021, an assumption has been taken that there is no immediate diminution identified in the Trust's on-going requirement of its operational assets, nor a reduction in its on-going remaining economic service potential as a result of the incidence of COVID-19.

1.4.2. Sources of estimation uncertainty

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

Other sources of estimation uncertainty are the following:
● Income and expenditure accruals
● Provision for injury benefit claims, early retirements, impairments of receivables, and others (notes 16.4, 19.4 & 23 to the accounts)
● Estimates for partially completed patient episodes.

1.5. Transfer of functions

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

1.6. Pooled budgets

The Trust has not entered into any pooled budget arrangements.

1.7. Operating segments

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

1. Accounting policies (Continued)

1.8. Revenue from contracts with customers

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

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

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a [Integrated Care System/Sustainability and Transformation Partnership] level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.
The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

1.9. Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.10. NHS injury cost recovery scheme

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

1.11. Provider sustainability fund (PSF)

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration. This regime was not in place in 2020/21 due to the change in funding flows.

1.12. Other forms of income

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

1. Accounting policies (Continued)

1.13. Apprenticeship service income

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

1.14. Expenditure on Employee Benefits

1.14.1. Short-term employee benefits

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

1.14.2. Pension costs

NHS Pension Scheme

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

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

NEST Pension Scheme
Where staff are not eligible for, or choose to opt out of, the NHS Pension Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2020/21 was 3% (2019/20: 3%).

1.15. Expenditure on other goods and services

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

1.16. Value added tax

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

1.17. Corporation tax

The Trust is not liable to pay corporation tax.

1.18. Property, Plant and Equipment

1.18.1. Recognition

Property, Plant and Equipment is capitalised where:

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

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

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

1. Accounting policies (Continued)

1.18.2. Measurement

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets are measured subsequently at valuation. Assets that are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definition of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Current values in existing use are determined as follows:

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

● Specialised buildings - depreciated replacement cost on a modern equivalent asset basis.

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

Valuation guidance issued by the Royal Institution of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees, and where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

Depreciation

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

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

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

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

1. Accounting policies (Continued)

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

It is impracticable to disclose the extent of the possible effects of an assumption on another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of the Trust's land, property, plant and equipment could require a material adjustment to the carrying amount of the asset recorded in note 13.1.
Impairments

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

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

1.18.3. De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

1.18.4. Donated and grant funded assets

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

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

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

1.19. Investment properties

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

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

1.20. Intangible assets

1.20.1. Recognition

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

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

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

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

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

1. Accounting policies (Continued)

1.20.2. Measurement

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

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

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
● Information technology	-	-
● Development expenditure	-	-
● Websites	-	-
● Software licences	3	5
● Licences & trademarks	-	-
● Patents	-	-
● Other (purchased)	-	-
● Goodwill	-	-

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

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

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight line basis over the estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

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

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

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

1.22. Donated non current assets

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

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

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

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

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

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

Leases of land and buildings

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

1. Accounting policies (Continued)

The Trust as a lessor

Finance leases

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

Operating leases

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

1.24. Inventories

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

1.25. Investment properties

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

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

1.26. Cash and equivalents

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

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

1.27. Carbon Reduction Commitment scheme (CRC)

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

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

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

Allowances acquired under the scheme are recognised as intangible assets.

1.28. 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 2021:

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms. All other provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:

- A short term rate of minus 0.02 % (2019-20: -0.51%) for expected cash flows up to and including 5 years.
- A medium term rate of **0.18**% (2019-20: -0.55%) for expected cash flows over 5 years up to and including 10 years.
- A long term rate of 1.99% (2019-20 -1.99%) for expected cash flows exceeding 10 years.

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021 (GAM chapter 4 Annex 7):

Year 1 - 1.20%

Year 2 - 1.60%

Into perpetuity - 2.00%

1. Accounting policies (Continued)

1.29. 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 24 but is not recognised in the Trust's accounts.

1.30. 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.

1.31. Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, none have been disclosed.
Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

1.32. 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, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.23.

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

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

1.32.1. Financial assets and financial liabilities at amortised cost

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

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

1. Accounting policies (Continued)

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

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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

1.32.3. Financial assets and financial liabilities at fair value through income and expenditure

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

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

1.32.4. Impairment of financial assets

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

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

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

1.32.5. Derecognition

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

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

1.33. Public Dividend Capital (PDC) and PDC dividend

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

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

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

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

1. Accounting policies (Continued)

1.34. Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.35. Third party assets

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

1.36. Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.37. Gifts

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

1.38. Transfers of functions to / from other NHS bodies / local government bodies

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

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

1. Accounting policies (Continued)

1.39. Early adoption of standards, amendments and interpretations

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

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

1.40.1. IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the 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 2022, 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 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. 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.

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

1.40.2. IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

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

2. Segmental analysis

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

3. Operating income from continuing operations

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

3.1. Income from patient care activities (by nature)

	2020/21 £000	2019/20 £000
Acute services		
Block contract / system envelope income*	**305,821**	281,607
High cost drugs income from commissioners (excluding pass-through	**408**	7,462
Other NHS clinical income	**1,678**	1,742
Community services		
Block contract / system envelope income*	**-**	-
Income from other sources (e.g. local authorities)	**17,247**	19,627
All services		
Private patient income	**686**	1,122
Additional pension contribution central funding**	**9,377**	8,902
Other clinical income	**3,799**	764
Total income from activities	**339,016**	321,226

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

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

3.2. Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	**57,586**	52,577
Clinical commissioning groups	**261,518**	246,718
Department of Health and Social Care	**-**	-
Other NHS providers	**1,195**	418
NHS other	**-**	-
Local authorities	**17,247**	19,627
Non-NHS: private patients	**686**	1,122
Non-NHS: overseas patients (chargeable to patient)	**120**	92
Injury cost recovery scheme	**664**	672
Non NHS: other	**-**	-
Total income from activities	**339,016**	321,226
Of which:		
Related to continuing operations	**339,016**	321,226

3.3. Overseas visitors (relating to patients charged directly by the provider

	2020/21 £000	2019/20 £000
Income recognised this year	**120**	92
Cash payments received in-year	**122**	206
Amounts added to provision for impairment of receivables	**-**	-
Amounts written off in-year	**82**	122

3.4. Other operating income

	2020/21			2019/20		
	Contract income £000	Non-contract £000	Total £000	Contract income £000	Non-contract £000	Total £000
Research and development	**735**	**-**	**735**	1,176	-	1,176
Education and training	**13,367**	**-**	**13,367**	12,928	-	12,928
Non-patient care services to other bodies	**5,078**		**5,078**	7,505		7,505
Provider sustainability fund (2019/20 only)			**-**	4,938		4,938
Marginal rate emergency tariff funding (2019/20 only)			**-**	2,287		2,287
Reimbursement and top up funding	**10,189**		**10,189**			-
Receipt of capital grants and donations		**1,448**	**1,448**		-	-
Charitable and other contributions to expenditure		**4,504**	**4,504**		-	-
Other income	**3,424**	**-**	**3,424**	3,520	-	3,520
Total other operating income	**32,793**	**5,952**	**38,745**	**32,354**	**-**	32,354
Of which:						
Related to continuing operations			**38,745**			32,354
Related to discontinued operations			**-**			-

Charitable and other contributions to expenditure mainly relates to centrally supplied PPE Covid-19 stock at no cost and treated as a donation.

3.5. 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:

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	**261,518**	246,718
Income from services not designated as commissioner requested	**77,498**	74,508
Total	**339,016**	321,226

4. Operating expenses

4.1 Operating Expenses by type

	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies	**5,463**	5,618
Purchase of healthcare from non-NHS and non-DHSC bodies	**1,390**	1,477
Staff and executive directors costs	**258,561**	236,533
Remuneration of non-executive directors	**117**	125
Supplies and services - clinical (excluding drugs costs)	**27,422**	22,504
Supplies and services - general	**10,725**	9,376
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**14,412**	15,656
Inventories written down	**158**	-
Consultancy costs	**383**	519
Establishment	**5,419**	4,348
Premises	**20,523**	19,294
Transport (including patient travel)	**1,651**	1,970
Depreciation on property, plant and equipment	**7,888**	7,603
Amortisation on intangible assets	**1,684**	1,674
Net impairments	**-**	1,079
Movement in credit loss allowance: contract receivables / contract assets	**1,324**	-
Change in provisions discount rate(s)	**3**	4
Audit fees payable to the external auditor		
audit services- statutory audit	**77**	96
other auditor remuneration (external auditor only)	**-**	12
Internal audit costs	**164**	80
Clinical negligence	**13,625**	11,032
Research and development	**326**	1,371
Education and training	**691**	1,088
Rentals under operating leases	**170**	195
Other	**24**	511
Total	**372,200**	**342,165**
Of which:		
Related to continuing operations	**372,200**	342,165
Related to discontinued operations	-	-

5. Employee benefits

5.1. Staff costs

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	**168,739**	153,498
Social security costs	**19,108**	17,714
Apprenticeship levy	**911**	850
Employer's contributions to NHS pensions	**30,857**	29,258
Pension cost - other	**33**	36
Temporary staff (including agency)	**39,628**	36,913
Total staff costs	**259,276**	238,269
Of which		
Costs capitalised as part of assets	**389**	365

5.2. Retirements due to ill-health

During 2020/21 there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is 0k (£84k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

6. Other auditor remuneration

Other auditor remuneration paid to the external auditor:
There was no other auditor remuneration in 2020/21 and £0.012m in 2019/20 on quality report assurance.

In 2020/21 audit fees for statutory audit, and audit related assurance services (Quality Accounts), excluding VAT, were **£64,200** and nil respectively (2019/20 - £67,825 and £10,000).

Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

7. Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus / deficit resulting		
Changes in market price	-	1,079
Total net impairments	**-**	1,079

8. 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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

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

c) National Employers Saving Scheme (NEST)

This government backed pension scheme is offered by the Trust to employees as an alternative to the NHS Pension scheme.

	2020/21 £000	2019/20 £000
Employee contributions (5%)	**58**	48
Employer contributions (3%)	**43**	37
Total	**101**	85

9. Operating leases

as a lessor

Homerton University Hospital NHS Foundation Trust did not hold any lease arrangements as lessor.

as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Homerton University Hospital NHS Foundation Trust is the lessee.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	**170**	195
Total	**170**	195

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
- not later than one year;	**106**	170
- later than one year and not later than five years;	**110**	215
Total	**216**	385

10. Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21 £000	2019/20 £000
Interest on bank accounts	**-**	390
Total finance income	-	390

11. Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21 £000	2019/20 £000
Interest expense:		
Loans from the Department of Health and Social Care	**166**	179
Total interest expense	**166**	179
Unwinding of discount on provisions	**1**	-
Other finance costs	**-**	-
Total finance costs	**167**	179

12. Intangible Assets

12.1. Intangible assets - 2020/21

	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**12,178**	**-**	**-**	**21**	**12,199**
Additions	**-**	**-**	**-**	**2,787**	**2,787**
Reclassifications	**2,467**	**-**	**-**	**(2,453)**	**14**
Valuation / gross cost at 31 March 2021	**14,645**	**-**	**-**	**355**	**15,000**
Amortisation at 1 April 2020 - brought forward	**7,093**	**-**	**-**	**-**	**7,093**
Provided during the year	**1,684**	**-**	**-**	**-**	**1,684**
Reclassifications	**87**	**-**	**-**	**-**	**87**
Amortisation at 31 March 2021	**8,864**	**-**	**-**	**-**	**8,864**
Net book value at 31 March 2021	**5,781**	**-**	**-**	**355**	**6,136**
Net book value at 1 April 2020	**5,085**	**-**	**-**	**21**	**5,106**

12.2. Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Websites £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	10,470	-	-	1,034	11,504
Additions	-	-	-	695	695
Reclassifications	1,708	-	-	(1,708)	-
Valuation / gross cost at 31 March 2020	12,178	-	-	21	12,199
Amortisation at 1 April 2019 - as previously stated	**5,419**	**-**	**-**	**-**	5,419
Provided during the year	1,674	-	-	-	1,674
Reclassifications	-	-	-	-	**-**
Amortisation at 31 March 2020	7,093	-	-	-	7,093
Net book value at 31 March 2020	5,085	-	-	21	5,106
Net book value at 1 April 2019	5,051	-	-	1,034	6,085

13.

13.1. Property, plant and equipment - 2020/21

	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 2020 - brought forward	**23,940**	**111,076**	**-**	**122**	**42,287**	**118**	**10,024**	**1,891**	**189,458**
Additions	-	-	-	**15,662**	**1,448**	**-**	-	-	**17,110**
Revaluations	**1,930**	**911**	**-**	**-**	**-**	**-**	**-**	**(2)**	**2,839**
Reclassifications	**(220)**	**3,488**	**-**	**(9,435)**	**5,329**	**43**	**575**	**-**	**(220)**
Valuation/gross cost at 31 March 2021	**25,650**	**115,475**	**-**	**6,349**	**49,064**	**161**	**10,599**	**1,889**	**209,187**
Accumulated depreciation at 1 April 2020 - brought forward	**220**	**-**	**-**	**-**	**26,146**	**105**	**7,111**	**1,648**	**35,230**
Provided during the year	-	**3,288**	**-**	**-**	**3,640**	**4**	**875**	**81**	**7,888**
Revaluations	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Reclassifications	**(220)**	**-**	**-**	**-**	**(76)**	**(2)**	**(3)**	**8**	**(293)**
Accumulated depreciation at 31 March 2021	**-**	**3,288**	**-**	**-**	**29,710**	**107**	**7,983**	**1,737**	**42,825**
Net book value at 31 March 2021	**25,650**	**112,187**	**-**	**6,349**	**19,354**	**54**	**2,616**	**152**	**166,362**
Net book value at 1 April 2020	**23,720**	**111,076**	**-**	**122**	**16,141**	**13**	**2,913**	**243**	**154,228**

13.2. 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 - as previously stated	26,550	131,280	-	16	37,134	118	8,740	1,840	205,678
Additions	-	-	-	10,794	-	-	-	-	10,794
Impairments	-	-	-	-	-	-	-	-	-
Revaluations	(2,610)	(24,397)	-	-	-	-	-	(7)	(27,014)
Reclassifications	-	4,193	-	(10,688)	5,153	-	1,284	58	-
Valuation/gross cost at 31 March 2020	23,940	111,076	-	122	42,287	118	10,024	1,891	189,458
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	31,161	-	-	22,884	100	6,044	1,600	61,789
Provided during the year	-	3,273	-	-	3,204	5	1,067	54	7,603
Impairments	220	800	-	-	58	-	-	1	1,079
Revaluations	-	(35,234)	-	-	-	-	-	(7)	(35,241)
Reclassifications	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2020	220	-	-	-	26,146	105	7,111	1,648	35,230
Net book value at 31 March 2020	23,720	111,076	-	122	16,141	13	2,913	243	154,228
Net book value at 1 April 2019	26,550	100,119	-	16	14,250	18	2,696	240	143,889

13.3. Property, plant and equipment financing - 2020/21

	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
Net book value at 31 March 2021									
Owned - purchased	**25,650**	**112,187**	**-**	**6,350**	**17,872**	**54**	**2,616**	**152**	**164,880**
Owned - donated/granted	**-**	**-**	**-**	**-**	**1,482**	**-**	**-**	**-**	**1,482**
NBV total at 31 March 2021	**25,650**	**112,187**	**-**	**6,350**	**19,354**	**54**	**2,616**	**152**	**166,362**

13.4. Property, plant and equipment financing - 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
Net book value at 31 March 2020									
Owned - purchased	23,720	111,076	-	123	15,893	13	2,913	243	153,980
Owned - donated/granted	-	-	-	-	248	-	-	-	248
NBV total at 31 March 2020	23,720	111,076	-	123	16,141	13	2,913	243	154,228

13.5. Donations of property, plant and equipment

The Trust received donations of medical equipment from DHSC as a consequence of the Covid - 19 pandemic amounting to **£1.449m** (2019/20 £ nil).

13.6. Revaluations of property, plant and equipment

The buildings have been valued as at 31 March 2021 using a Modern Equivalent Asset basis of valuation, as discounted for wear and tear.

Land has been revalued at 31 March 2021 at market value for existing use.

The desktop valuation was carried out by Gerald Eve LLP whose address is 72 Welbeck Street, London. W1G 0AY.

Buildings have estimated useful economic lives ranging up to 75 years (2019/20 - 75 years).

13.7. Assets held at market value

At 31 March 2021 the Trust held land assets at market value for existing use of **£25,650,000** (31 March 2020, £23,940,000).

13.8. Investment Property

There were nil fixed asset investments held at 31 March 2021 (31 March 2020 - Nil).

13.9. Assets held under finance leases and hire purchase contracts at 31 March 2021

The Trust did not hold any finance leases or hire purchase contracts during 2020/21 (31 March 2020 - Nil).

14. Disclosure of interests in other entities

The Trust had no interests in other entities (2020 - Nil).

15. Inventories

15.1. Inventories	**31 March 2021 £000**	**31 March 2020 £000**
Drugs	**1,527**	1,637
Consumables	**1,954**	1,506
Energy	**13**	54
Other	**242**	231
Total inventories	**3,735**	3,427
of which:		
Held at fair value less costs to sell	-	-

15.2. Total Inventories recognised as an expense in the year

Inventories recognised in expenses for the year were £17,250k (2019/20: £13,730k). Write-down of inventories recognised as expenses for the year were £158k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,503k of items purchased by DHSC.

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

16. Receivables

		31 March 2021 £000	31 March 2020 £000
16.1.	**Current**		
	Contract receivables	**19,469**	30,215
	Allowance for impaired contract receivables / assets	**(4,610)**	(3,618)
	Allowance for other impaired receivables	**-**	-
	Prepayments (non-PFI)	**1,895**	2,572
	VAT receivable	**1,971**	1,062
	Other receivables	**1,655**	2,411
	Total current receivables	**20,380**	32,642
16.2.	**Non-current**		
	Other receivables	**519**	50
	Total non-current receivables	**519**	50
16.3.	**Of which receivable from NHS and DHSC group bodies:**		
	Current	**8,457**	20,727
	Non-current	**469**	-

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets.

16.4. Allowances for credit losses - 2020/21

	Contract receivables and contract assets £000
Allowances at 1 April 2020 - brought forward	3,618
New allowances arising	1,324
Utilisation of allowances (write offs)	(332)
Reversals of allowances	-
Allowances as at 31 March 2021	**4,610**

Allowances for Credit Losses by age - 2020/21	31 March 2021 £000
Up to three months old	991
In three to six months old	(54)
Over six months old	3,673
Total	**4,610**

Age analysis of unimpaired contract receivables:

	31 March 2021 £000	31 March 2020 £000
Up to three months old	**2,022**	21,473
In three to six months old	**65**	178
Over six months old	**3,348**	9,627
Total	**5,435**	31,278

16.4. Allowances for credit losses

	2020/21	2019/20
	Contract receivables and contract assets £000	Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	**3,618**	3,687
New allowances arising	**1,324**	-
Utilisation of allowances (write offs)	**(332)**	(69)
Allowances as at 31 March 2021	**4,610**	3,618

17. 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.

	2020/21 £000	2019/20 £000
At 1 April	**67,596**	47,641
Net change in year	**10,091**	19,955
At 31 March	**77,687**	67,596
Broken down into:		
Cash at commercial banks and in hand	98	54
Cash with the Government Banking Service	77,589	67,542
Total cash and cash equivalents as in SoFP	**77,687**	67,596
Total cash and cash equivalents as in SoCF	**77,687**	67,596

18. Third party assets held by the Trust

Homerton University Hospital NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021 £000	31 March 2020 £000
Bank balances	**15**	16
Monies on deposit	-	-
Total third party assets	**15**	16

19. Trade and other payables

	31 March 2021 £000	31 March 2020 £000
19.1. Current		
Trade payables	**12,051**	15,728
Capital payables	**7,677**	880
Accruals	**22,803**	24,901
Receipts in advance and payments on account	**94**	430
Social security costs	**5,939**	5,683
Other taxes payable	**2,471**	2,324
PDC dividend payable	**171**	320
Other payables	**289**	287
Total current trade and other payables	**51,495**	50,553
19.2. Non-current	**None**	**None**
19.3. Of which payables from NHS and DHSC group bodies:		
Current	**5,910**	9,980

19.4. Early retirements in NHS payables above

There are no early retirements included in the payables note above.

20. Other liabilities

		31 March 2021 £000	31 March 2020 £000
20.1.	**Current**		
	Deferred income: contract liabilities	**5,502**	5,662
	Total other current liabilities	**5,502**	5,662
20.2.	**Non-current**	**None**	**None**

21. Borrowings

		31 March 2021 £000	31 March 2020 £000
21.1.	**Current**		
	Loans from DHSC	**327**	329
	Other loans	**83**	71
	Total current borrowings	**410**	400
21.2.	**Non-current**		
	Loans from DHSC	**4,201**	4,492
	Other loans	**610**	704
	Total non-current borrowings	**4,811**	5,196

22.1. Reconciliation of liabilities arising from financing activities - 2020/21

	Loans £000	Other £000	Total £000
Carrying value at 1 April 2020	**4,821**	**775**	**5,596**
Cash movements:			
Financing cash flows - payments and receipts of principal	**(293)**	**(82)**	**(375)**
Financing cash flows - payments of interest	**(166)**	**-**	**(166)**
Non-cash movements:			
Application of effective interest rate	**166**	**-**	**166**
Carrying value at 31 March 2021	**4,528**	**693**	**5,221**

22.2. Reconciliation of liabilities arising from financing activities - 2019/2020

	Loans £000	Other £000	Total £000
Carrying value at 1 April 2019	5,115	677	5,792
Cash movements:			
Financing cash flows - payments and receipts of principal	(292)	98	(194)
Financing cash flows - payments of interest	(180)	-	(180)
Non-cash movements:			
Application of effective interest rate	178	-	178
Carrying value at 31 March 2020	4,821	775	5,596

23. Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Re-structuring £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2020	**309**	**607**	**-**	**-**	**-**	**15**	**5,469**	**6,400**
Change in the discount rate	**1**	**2**	**-**	**-**	**-**	**-**	**-**	**3**
Arising during the year	**48**	**102**	**-**	**-**	**-**	**-**	**308**	**458**
Utilised during the year	**(34)**	**(22)**	**-**	**-**	**-**	**-**	**(74)**	**(130)**
Reversed unused	**-**	**-**	**-**	**-**	**-**	**-**	**(1,356)**	**(1,356)**
Unwinding of discount	**-**	**1**	**-**	**-**	**-**	**-**	**-**	**1**
At 31 March 2021	**324**	**690**	**-**	**-**	**-**	**15**	**4,347**	**5,376**
Expected timing of cash flows:								
- not later than one year;	**35**	**22**	**-**	**-**	**-**	**15**	**3,878**	**3,950**
- later than one year and not later than five years;	**91**	**141**	**-**	**-**	**-**	**-**	**469**	**701**
- later than five years.	**198**	**527**	**-**	**-**	**-**	**0**	**(0)**	**725**
Total	**324**	**690**	**-**	**-**	**-**	**15**	**4,347**	**5,376**

Pension related provisions as at 31 March 2021 consist of £0.586m in relation to Injury Benefits and £0.371m relating to Early Retirement benefits payable to former employees of the Trust. These benefits are calculated and paid to the individuals concerned by the NHS Pensions Agency (NHSPA) and the provision represents the future liability of the Trust based on expected lifetime calculations discounted appropriately.

The Clinical Pension Tax reimbursement provision totals £0.468m and is based on the estimated liability arising in future years relating to income tax liabilities arising from clinicians' pension contributions exceeding their annual pension allowance by consultants working additional PAs. Redundancy provisions of £0.015m are based on the likely obligation of the Trust towards a small number of staff who are at risk of redundancy in the next year due to the outsourcing of certain back office administrative functions to an external provider.

The most significant elements of the other provisions figure are the following: £1.107m in respect of potential data challenges from commissioners relating to clinical contract income, £0.391m in relation to VAT review by HMRC where the Trust may be liable, £0.133m in relation to potential employment tribunal claims and £2.0m in relation to provision for future credit notes.

24. Clinical negligence liabilities

At 31 March 2021, £265,240k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Homerton University Hospital NHS Foundation Trust (31 March 2020: £251,113k).

25. Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	**7,751**	500
Intangible assets	**106**	-
Total	**7,857**	500

26. Financial instruments

26.1 Financial risk management

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

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

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

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

26.2. Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	**17,033**	-	-	**17,033**
Cash and cash equivalents	**77,687**	-	-	**77,687**
Total at 31 March 2021	**94,720**	**-**	**-**	**94,720**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	29,058	-	-	29,058
Cash and cash equivalents	67,596	-	-	67,596
Total at 31 March 2020	96,654	-	-	96,654

26.3. Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	**4,528**	-	**4,528**
Other borrowings	**693**	-	**693**
Trade and other payables excluding non financial liabilities	**42,820**	-	**42,820**
Total at 31 March 2021	**48,041**	**-**	**48,041**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	4,821	-	4,821
Other borrowings	775	-	775
Trade and other payables excluding non financial liabilities	41,796	-	41,796
Total at 31 March 2020	47,392	-	47,392

26.3. Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2021 £000	31 March 2020 Restated £000
In one year or less	43,444	42,343
In more than one year but not more than five years	1,953	2,099
In more than five years	4,040	4,538
Total	**49,437**	**48,980**

* The prior year comparator figures in this note were previously prepared on a discounted cash flow basis. In line with the recommendations of the Group Accounting Manual this has been updated to be shown on an undiscounted basis. This has no impact on the value of the liabilities within the Statement of Financial Position.

26.4. Fair values of financial assets and liabilities

The Book value (carrying value) of financial assets and liabilities is a reasonable approximation of fair value.

27. Movement in Public Dividend Capital

	31 March 2021 £000	31 March 2020 £000
Public Dividend Capital as at 1 April	**92,726**	92,355
New PDC received	**7,543**	371
Public Dividend Capital as at 31 March	**100,269**	92,726

The dividend payment for the year was **£3.390m** (2019/20 £4.435m). Further details on how the dividend was calculated are set out in note 1.33.

28. Losses and special payments

	31 March 2021 Total Number	31 March 2021 Total £000	31 March 2020 Total Number	31 March 2020 Total £000
Losses				
Cash losses	**4**	**17**	10	6
Fruitless payments and constructive losses	**-**	**-**	-	-
Bad debts and claims abandoned	**44**	**91**	57	122
Stores losses and damage to property	-	-	-	-
Total losses	**48**	**108**	67	128
Special payments				
Compensation under court order or legally binding arbitration award	**3**	**4**	5	40
Extra-contractual payments	**-**	**-**	-	-
Ex-gratia payments	**3**	**3**	14	4
Special severance payments	**-**	**-**	-	-
Extra-statutory and extra-regulatory payments	**-**	**-**	-	-
Total special payments	**6**	**7**	19	44
Total losses and special payments	**54**	**115**	86	172
Compensation payments received		-		-

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

29. Related Party Transactions

There were nil related party transactions with Executive and non-Executive Directors during the financial year (2019/20 nil).

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

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

The Trust has also received revenue and capital payments from the Homerton University Hospital NHS Foundation Trust Charitable Fund. The Charity is registered with the Charity Commission (Charity Number 1061659) and the NHS Trust acts as Corporate Trustee. The Charity operates through the Charitable Funds Committee whose members are drawn from the NHS Trust Board. It produces a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) and these documents are available on request from the Trust.

30. Private Finance Initiative Transactions

The Foundation Trust has no PFI schemes.

31. Intra-Government and Other Balances

31.1 Receivable and Payable balances	Receivables: amounts falling due within one year	Payables: amounts falling due within one year
	At 31 March 2021	At 31 March 2021
	£000	£000
English NHS Foundation Trusts	**463**	1,312
English NHS Trusts	**1,492**	2,855
Department of Health	**-**	-
Public Health England	**-**	4
Health Education England	**130**	-
NHS England & Clinical Commissioning Groups	**6,345**	45
Other NHS Whole of Government Accounts bodies	**1,998**	9,901
Other Whole of Government Accounts bodies	**6,775**	1,503
Total	**17,203**	15,620

31.2 Income and expenditure values for the year	Income Year Ended 31 March 2021 £000	Expenditure Year Ended 31 March 2021 £000
English NHS Foundation Trusts	**3,669**	2,319
English NHS Trusts	**968**	5,155
Department of Health	**-**	-
Public Health England	**1**	43
Health Education England	**13,229**	-
NHS England & Clinical Commissioning Groups	**319,916**	429
Other NHS Whole of Government Accounts bodies	**-**	71,165
Other Whole of Government Accounts bodies	**17,247**	3,364
Total	**355,030**	82,475

33. Prior period adjustments

There were no prior year adjustments other than the restatement of the holiday pay accrual brought forward figure from Provisions to Accruals as required by NHSI.

34. Events after the reporting date

34.1. Flowers legal case on inclusion of regular overtime in holiday pay entitlement

The Supreme Court appeal in respect of the Flowers case is due to be heard on 22 June 2021 but the judgement will be some time after that. It is unlikely that it will be an adjusting event after the reporting period unless information comes out in the hearing.

34.2. NHS East and South East London Pathology Partnership

Homerton University Hospital NHS Foundation Trust, Barts Health NHS Trust and Lewisham and Greenwich NHS Trust are jointly working to set up a shared pathology service from May 2021. The NHS East and South East London Pathology Partnership will be hosted by Barts Health NHS Trust, and its purpose is to provide patients and clinicians with a high-quality, cost-effective service that ensures the long-term sustainability of NHS pathology services. NHS pathology staff from Homerton and Lewisham and Greenwich will TUPE transfer to Barts Health, and existing Barts Health pathology staff will remain employed by the Trust. The Partnership will have an operating budget of c. £123m per annum, with a workforce establishment of c.900 WTE. Over the next four years, the Pathology Partnership will move to a hub and Essential Service Laboratory structure across the three Trusts.

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