The Hillingdon Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/2021

The Hillingdon Hospitals NHS Foundation Trust

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1. Performance Report

This section of the report provides an overview of the organisation, its purpose, the key risks to the achievement of its objectives, and detail on how the Trust met its performance obligations across the financial year.

1.1 Foreword

Our Annual Report this year tells a story of human endeavour and resilience. For the Trust, as well as our local community, 2020/21 was a 'challenging' year. Like many healthcare providers, the Trust has felt the impact of the Covid-19 pandemic and the subsequent pressures placed on NHS resources, but has also demonstrated innovation and achievement.

Our teams have shown impressive adaptability, creativity and resilience. They have: designed and delivered new digital services, with notable success for virtual consultations; implemented new advice and guidance services for consultation with GPs; upgraded systems that have enabled agile working, integrated with the Care Information Exchange, and the introduced new remote monitoring options for Coronary Obstructive Pulmonary Disease (COPD) and Covid-19 patients. Many of these improvements are ones we hope to retain and develop in the future.

The challenges posed by the necessary changes to patient pathways, pressures on staffing and suspensions of elective activity during the height of the pandemic, have inevitably had an impact on our ability to deliver against some objectives, including meeting some of the constitutional standards for wait times. The most significant change was seen in referral to treatment times (RTT), against which the Trust averaged 52.4% compliance in 2020/21, due to necessary suspension of elective activity. This compares with the national average of 61% for the financial year.

Despite necessary changes to service delivery, we have delivered improvements against a number of key indicators, which are outlined in this report. Plans have been put in place to support us in our recovery from the impact of Covid-19 and in achieving sustained delivery against all constitutional standards. Throughout the pandemic we have carried on caring for patients, delivering babies – 3,357 were born at Hillingdon Hospital and treating 235,091 outpatients in our clinics.

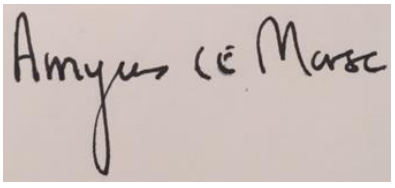
In response to the significant risk posed by the continued deterioration of the Trust's estate, we have developed an ambitious plan for the building of a new hospital on the Hillingdon site, which is referenced later in this report. We have already seen good progress in the financial year. In early 2021 the Trust was identified as one of eight priority projects that, subject to approval of the Outline Business Case and Full Business Case, will be given permission to commence work under phase one of the Government's Health Infrastructure Plan. In addition to the wider challenges posed by the pandemic, the Trust has navigated a period of significant

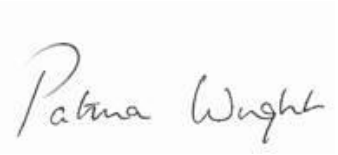
organisational change, in part precipitated by the imposition of license conditions by the CQC in response to concerns about infection, prevention and control practices across the Trust during the financial year. In response, NHS England and Improvement (NHSEI) appointed a Special Advisor (Lesley Watts, CEO of Chelsea and Westminster NHS FT) to the Board and this prompted a period of intense activity to improve practice and ensure that care was safe and effective. There were a number of new appointments to senior leadership positions, including a new Chief Executive, Chief Medical Officer, Chief Financial Officer, Chief People Officer, and Director of Nursing. The Trust has also successfully delivered a restructure of clinical services in the financial year, consolidating the four core divisions into two, (Planned and Unplanned care), to enable improved oversight and leadership.

Despite this level of change, we reviewed governance processes to ensure that there was a robust framework in place, with significant changes and improvements successfully delivered across Q3 and Q4. This stood the Trust in good stead as it responded to the second wave of the pandemic over the winter months and we are confident as we move into 2021/22 that there is a stable structure to support the Trust in improving performance.

Finally, throughout the pandemic, our local community has supported us in a myriad of ways. It is impossible to name all those who provided support, but for each and every act of kindness, however small, we are immensely grateful. Your compassion sustained us and enabled us to treat all our patients.

We, on behalf of the Board, would like to take this opportunity to thank the Trust's staff for their dedication and innovation in response to Covid-19.





Sir Amyas Morse

Trust Chair

Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

8 July 2021

1.2 Overview of performance

1.2.1 Purpose, Activities and History of the Trust

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

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

The Trust typically provides clinical services to over half a million patients a year, including over 100,000 Emergency attendances. However, these numbers changed significantly in 2020/21 due to the ongoing impact of the Covid-19 pandemic and the necessary changes in operational focus. Figures are included in section 1.4.3 of this report.

As an NHS Foundation Trust, the Trust has a Council of 25 Governors and over 6,230 public members. It employs over 3,800 permanent staff, making it one of Hillingdon's largest employers. The Board of Directors, led by Chairman Sir Amyas Morse during 2020/21, comprises seven Non-Executive (including the Chairman) and six executive directors (including the Chief Executive).

1.2.2 Overview of the Trust's Strategy and Business Model

The Trust's clinical and organisational strategy provides the framework within which the Trust Board seeks to deliver its immediate and long term operational priorities. The focus and priority of the organisation remains the provision of high quality, safe and compassionate care for the people the Trust serves and improving the health and wellbeing of our local population alongside our partners in Hillingdon and North West London.

Vision

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

Mission

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

The Trust's **vision, mission and values** have continued to inform every aspect of our work as we have progressed through our journey of improvement.

The Trust's clinical services strategy was updated in 2019/20, and approved in April 2020. The full document, which covers the period 2019-2029, can be found on The Trust's website.

Our clinicians worked in partnership with our local stakeholders to ensure that the agreed approach would inform the development of our new hospital. This strategy has been taken forward within the development of our Strategic Outline Case (SOC) and Outline Business Case (OBC) for our new hospital.

1.2.2 Objectives for 2020/21

The Trust has an established integrated performance framework in place to monitor and track performance standards, which are reviewed through the Trust Management Board, Board Assurance Committees and received at Trust Board.

The Trust's objectives for 2020/21 were framed around six key delivery areas: Quality, Workforce, Performance, Money, 'Well Led', and Partnership Working.

During the year the Covid-19 pandemic impacted the delivery of a number of these objectives and several areas were reprioritised as the impact of the pandemic unfolded. However, although not all objectives were achieved by year end, there was good progress across all areas. The Trust Board has agreed that the same objectives will be adopted for 2021/22 and a detailed business plan will be approved by the Board in July 2021.

Quality	We will deliver consistently high-quality care	2020/21 priorities: • Ensure our hospitals are safe • Deliver our key quality indicators – with a key focus on infection control • To improve patient experience/satisfaction • Improve engagement with patients and carers • Further embed change and innovation to improve quality of care • Be a learning organisation
Workforce	A great place to work	2020/21 priorities: • Improve the lived experience of our Black, Asian, Minority Ethnic (BAME) workforce • Engage with our workforce to ensure every person has a voice and we listen • Develop our workforce in line with the needs of the organisation now and in the future • Address our recruitment and retention challenges and minimise our vacancies • Create a fit for the future workforce plan that delivers new roles and different ways of working
Performance	We will deliver the right care at the right time for our patients	2020/21 priorities: • Effectively utilise resource and work with the North West London Integrated Care System (ICS) towards recovery of all constitutional standards, whilst maintaining staff and patient safety during and following Covid-19. • Constitutional standards: - Emergency and urgent care - Planned care - Cancer care - Diagnostics

		• Support the clinical teams to deliver good resource management (people, equipment and money)
Money	We will live within our means	2020/21 priorities: • Deliver updated financial plans for 2020/21 • Deliver the finance and economic case in the Hillingdon Hospital Redevelopment Strategic Outline Case and Outline Business Case • Support and develop cross system working in North West London in finance and service development • Deliver ownership of services through service line reporting and divisional service line management • Develop and enhance our finance capacity and capability
Well Led	We will empower our people to deliver	2020/21 priorities: • Update our strategies in supporting the delivery of the new Hillingdon Hospital • Embed our governance systems • Embed our new divisional structure • Continuously learn, improve, and innovate through our CARES+ transformation programme
Partnership working	We will develop sustainable models of care centred around our patients	2020/21 priorities: • Work as part of the North West London Integrated Care System and Hillingdon Health and Care Partners • Work in partnership with our local population and stakeholders, regional and national leads in finalising plans for our new Hillingdon Hospital

		• Work in partnership with the other acute providers in North West London in delivering digital care records for our patients • As part of North West London Pathology continue to improve our pathology services • Deliver improvements in care through advances in education and research with our university partners

1.3 Key issues and Risks for the Trust

The Trust Board is responsible for ensuring that effective systems are in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework (BAF) and the Corporate Risk Register. Further detail can be found in sections 3.1.4 and 3.1.5 of the annual governance statements.

The Trust identified the following as the most significant potential risks to achieving our objectives in 2020/21:

1.3.1 Principal Risks

Strategic Objective 1	**Quality – We will deliver consistent high quality care**
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor high quality care which results in consistent achievement of all relevant national and local quality standards: 1a failure to deliver safe care 1b failure to deliver good patient outcomes 1c failure to delivery good patient experience
Strategic Objective 2	**Workforce – A great place to work**
Risk	Failure to continue to build on the culture and values we have developed, meaning that we do not become the ‘Great place to work’ in a competitive labour market

Strategic Objective 3	**Performance – We will deliver the right care at the right time for our patients**
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to deliver consistent achievement of all relevant national performance and regulatory standards Failure to maintain the financial sustainability of the Trust and the services it provides
Strategic Objective 4	**Money - We will live within our means**
Risk	Failure to maintain the financial sustainability of the Trust and the services it provides
Strategic Objective 5	**Well Led – We will empower our people to deliver**
Risk	Failure to embed effective corporate and clinical governance systems and structures. Note regulatory action which took place in 2020/21 is covered here, in a section 3.2.7 and in BAF risks 1 and 6.
Strategic Objective 6	**Quality – estates related in support of quality - We will deliver consistent high quality care**
Risk	Failure to maintain safe estate in a sustainable way to support the delivery of high quality, efficient care in the short and medium term in line with the planned opening of the new hospital in 2025

1.3.2 Key issues for the Trust

The following were identified as key issues for the Trust in 2020/21 year:

Responding to and recovering from the Covid-19 pandemic	The Covid-19 pandemic is the biggest threat to the health of the population in a generation and has resulted in an unprecedented level of demand for hospital critical and medical care. The Trust has, and will continue to, respond to the pandemic in line with national and local guidance, and effectively

	deployed its pandemic flu plan and internal incident procedures operating a gold, silver and bronze command and control structure. The Trust maintains a Covid-19 risk register to support the identification, escalation and mitigation of risk associated with the pandemic.
Performance against Constitutional Standards	A key objective for the Trust was to achieve a consistent performance of 90% against the 4-hour waiting time standard for A & E by the end of March 2021 but this was not met. The Trust did however see a marginal improvement year on year, with a performance of 84.4% in 2020/21 against 82.35% in 2019/20. Delivery against all constitutional standards was significantly impacted by the Covid-19 pandemic, either due to segregation of pathways or the significant reduction or cessation of elective activity. Detail can be found in section 1.4.3.
Regulatory action by the CQC – section 31 and section 29a notices	The CQC inspected the Trust, following an outbreak of Covid-19 amongst staff. Following that inspection, the Trust received a Notice of Decision (where a condition(s) are applied to the Trust for non-compliance with its licence to operate) under Section 31 and Section 29a of the Health and Social Care Act 2008 following the August and September 2020 CQC inspections respectively. A detailed account can be found in section 3.2.7 of this report. The Trust took a robust project management approach to monitor the concerns raised by the CQC and made significant improvements in the issues that were identified. The Trust has a comprehensive action plan in place to ensure the notices are addressed and that it continues on its journey of improving care. The progress against these actions is monitored regularly and is reported to the Trust Management Executive, and at the Quality and Safety Committee and Trust Board.
Maintaining adequate nurse staffing levels	As a result of the Covid-19 pandemic and ongoing service reconfiguration, staffing models changed in line with national guidance to respond to the altered patient cohort and increased demand on services.

	In order to meet the demand placed on the trust by Covid-19, nursing student employees joined the workforce in May 2020. The Nursing and Midwifery Council (NMC) supported the approach taken nationally that student nurses could become paid employees and gain practical placement experience. The Trust has signed up to a group of incentive schemes from NHS England and Improvement (NHSEI) and Health Education England (HEE), with the aim of achieving a near zero vacancy position for healthcare assistants and qualified nurses by the end of 2021/22
Delivering high quality patient care with medical recruitment challenges and increased patient acuity	Challenges remain with regard to recruiting adequate substantive staff, in particular at consultant level in a number of medical specialities including the Emergency Department, Acute Medicine, Care of the Elderly and Endocrinology. The Trust is working closely with its People and Workforce division to refresh the workforce strategy and targeted work is taking place within these specialities. For 2021/22, the Trust will embark on a program to convert up to six of its Trust clinical fellow posts into Internal training Medicine Year 3 posts which will increase the pipeline of future Medical consultants and attract new blood to the Trust. The Trust is also collaborating with Acute Trusts in the ICS to look at sector wide approaches such as joint consultant appointments for some of the difficult to recruit specialities or cross Trust working for highly specialised services such as paediatrics orthopaedics, and haematology.
Poor condition of our estate	The level of backlog maintenance required to maintain safe and effective buildings continues to be a significant issue for the Trust. A condition survey completed in February 2017 concluded that the total cost to address the backlog was £211m for the total occupied estate. During the period of 2019/20 to 2020/21 the Trust received emergency capital funding of £16.5M to address business as usual estate statutory compliance matters, and subsequently undertook major infrastructure work to the following areas: ● Ventilation ● Asbestos ● Water

	● Electrics ● Heating and hot water ● Lifts ● Fire Compliance An Estates Risk Register is in place, which is regularly monitored through Trust governance processes, with risks escalated to the Board Assurance Framework as required. Under the Department of Health and Social Care's (DHSC) 'Health Infrastructure Plan' the Trust is seeking funding for a new hospital build. Our Strategic Outline Case (SOC), which was approved by the DHSC and NHSEI Joint Investment Committee in late 2020, evaluated a range of options. Based on a comprehensive assessment of options, a full redevelopment of Hillingdon Hospital on the current site was identified as the preferred way forward.
The scale of investment required to improve the Trust's fragile estate infrastructure	The Trust is required to comply with Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises, which covers issues around failure to maintain the estate. To support the Trust in meeting this requirement, the condition of key building systems is assessed by a five-yearly survey, and is risk assessed and rated against available capital. The annual capital investment available for the estate is targeted at addressing specific extreme risks, and has enabled risk reduction. However, the available funds are insufficient to keep pace with the scale of backlog maintenance and the Trust continues to have high-risk estates issues on its Risk Register and on the Board Assurance Framework (BAF).
Effectiveness of the financial control system or inability to achieve the financial plan	The Trust's reported financial performance has significantly improved on 2019/20; however, this is driven by the block and top up arrangements agreed for during the Covid-19 pandemic, which have guaranteed funding for the whole of the year, where the Trust was required to report a break-even position. Although the financial performance reported in 2020/21 is an improvement on 2019/20, the underlying financial

	performance and sustainability of the Trust remains a major challenge and requires significant improvement in 2021/22

1.4 Performance against objectives:

The necessary focus on responding to the Covid-19 pandemic has posed significant challenges to delivery against core objectives during 2020/21, including the constitutional standards. However, while the essential segregation of patient pathways and suspension of elective activity meant that we fell short of the maximum national waiting time targets, we have seen slight improvements in year on year performance in some areas. Further detail can be found in section 1.4.3 of this report.

The Trust was rated overall as 'Requires improvement' by the CQC in 2018, with Hillingdon Hospital receiving an overall rating of 'Inadequate', and Mount Vernon retaining an overall rating of 'requires improvement' based on an inspection in 2014. The CQC conducted additional unannounced inspections in August and September of 2020, focused on the safe and Well Led domains in the 'medical care' and 'urgent and emergency care' core services. The Trust subsequently received a Notice of Decision under Section 31 and Section 29a of the Health and Social Care Act 2008. The CQC did not issue new ratings to the Trust following these inspections. A more detailed account can be found in sections 1.6 and 3.2 of this report.

Despite the considerable disruption caused by the Covid-19 pandemic, The Trust has made good progress in delivering against several of its key objectives during 2020/21, including embedding a new divisional structure for clinical services and the introduction of a more robust and comprehensive governance framework.

1.4.1 Quality

Quality indicators

a) Infection Control

As an indication of the Trust's infection control measures, *Clostridium difficile* infection rates have reduced upon the previous year and are below the London, and national, average where an increase has been noted regionally and nationally.

In response to the CQC inspections in August and September 2020, the Trust has invested significant time and resource into improving Infection Prevention and Control (IPC) practice across the Trust: strengthening the IPC team; ensuring staff have access to appropriate personal protective equipment (PPE) and that equipment is appropriately tested; enhanced the level of cleaning in clinical areas and undertaking regular audits of practice.

b) Working to improve patient experience and engagement

In 2020/21, we continued to increase our digital capabilities to help deliver improvements to patient experience. Key achievements included: deploying video consultation technology; transforming the way we deliver outpatient care to patients; digital innovations to improve the way we communicate with patients and systems making it easier for them to tell us if they wish to cancel or change their appointments. In response to the Covid-19 pandemic we also initiated the roll out of secure handheld devices to support virtual visits, enabling relatives and friends to support patients when a face-to-face visit was not practical.

During 2020/21, the Patient Advice Liaison Service (PALS) received 1,539 contacts of which 1,215 were recorded as concern. This is a slight year on year improvement on 2019/20 where there were 1,372 contacts with 1,276 recorded concerns. The top two subjects for PALS during 2020/21, which were the same as those in the previous financial year, were around:

- Communication – information to patients
- Clinical care – appointments

The Trust received 249 complaints in 2020/21 compared to 358 in 2019/20. Between April and August 2020, the number of complaints received decreased significantly due to the likely impact of the Covid-19 pandemic. It is therefore difficult to make a direct comparison from the previous year.

Whilst NHS England announced an optional pause in the complaints process between 26 March and 30 June 2020, the Trust decided to continue with logging and responding to complaints during that period. There were unavoidable delays in the investigations, as clinical staff focused on delivering care, and this affected performance against targets. The second wave of the pandemic has seen similar pressures, but no pause was initiated by NHS England.

The top three subjects for complaints during 2020/21 were:

- Clinical care – medical staff
- Communication – information to patients
- Clinical care – nursing staff

c) Innovations to improve patient care

In 2020/21, we introduced a range of technical innovations that improved quality of care and helped mitigate some of the impact of the Covid-19 pandemic. These included:

- Replacing the system used by our radiology department to manage diagnostic tests
- Digital enablement of new models of care (remote monitoring) for Chronic Obstructive Pulmonary Disease (COPD) and Covid-19 patients
- Developing an Advice & Guidance platform that provides GPs and hospital doctors with a secure messaging system to manage patient care and determine whether a referral to secondary treatment is necessary, or whether appropriate treatment can be delivered at primary care level
- Digitised Clinical Assessment Services (CAS) card and clinical notes that are generated in the Emergency Department, ensuring that the information is available throughout the Trust
- The Hillingdon Hospitals Maternity Team was awarded the 2020 Health Service Journal (HSJ) Patient Safety Award for Maternity and Midwifery Services Initiative of the Year in collaboration with Imperial College Health Partners and a number of partner NW London Maternity Teams. The Award recognised their role in delivering the highly impactful PReCePT programme, which aims to prevent Cerebral Palsy in pre-term babies

1.4.2 Workforce

Addressing recruitment and retention challenges

In 2020/21 staffing models changed in line with National Guidelines in order respond to the altered patient cohort and the significant increase in demand for services experienced as a result of the pandemic.

The Trust has worked to reduce vacancy rates in priority areas: including participation in local, national and international recruitment drives, provided guaranteed job offers for student nurses, ran a successful Health Care Assistant recruitment campaign, and the launched of the Capital Nurse Project.

In order to help meet the additional staffing need during the pandemic, nursing student employees joined the workforce in May 2020. This was in line with the approach taken nationally and supported by the Nursing and Midwifery Council (NMC), which proved positive for the Trust, with a number progressing on to join the workforce as Registered Nurses. Nurse recruitment has been ongoing throughout 2020/21:

- April 2020 - 38 internally recruited nurses achieved registration with the NMC and joined the workforce.
- The first cohort of Nursing Associates qualified, bringing a new role and innovation to the organisation, whilst transforming the workforce.

The Trust has signed up to a group of incentive schemes from NHS England/NHS Improvement and Health Education England (HEE), with the aim of achieving a near zero vacancy position for healthcare assistants and qualified nurses by the end of 2021/22.

Since January 2020 the Trust has been able to run an additional overnight rota due to its successful overseas recruitment to a Trust Clinical Fellow program (non-consultant grade) and in August 2020 all trainee rotas were reconfigured to ensure increased staffing to support the acute medical on call rota. In 2021/22, the Trust will embark on a program to convert up to six of its Trust clinical fellow posts into Internal training Medicine Year 3 posts which will successfully increase the number of deanery[1] training posts at the Trust.

Challenges remain with regard to recruiting adequate substantive staff, in particular at consultant level in a number of medical specialities including the Emergency Department, Acute Medicine, Care of the Elderly and Endocrinology. The Trust is working to refresh the workforce strategy with targeted work against these specialities. The Trust has seen some early success including a recent appointment into Endocrinology and applicants for our Acute Medicine advert.

The Trust has collaborated with Acute Trusts in the ICS to look at a sector wide approach, including joint consultant appointments for some of the difficult to recruit specialities and cross Trust working for highly specialised services such as paediatrics, orthopaedics, and haematology.

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

1.4.3 Performance

Over 2020/21 the Trust did not consistently meet the national operational standards. Delivery was significantly impacted by the necessary segregation of pathways and the significant reduction or cessation of elective activity introduced in response to the Covid-19 pandemic.

[1] Deanery - responsible for the management and delivery of postgraduate medical education and for continued professional development

a) Emergency Care

Despite the Trust working closely with system partners and staff towards delivering sustained improvements to the 4 Hour A&E waiting time standard, performance in 2020/21 was still below the national standard of 95%. This was largely due to challenging segregation of patient pathways. The Trust has seen a marginal improvement year on year, with an overall compliance rate of 84.4% in 2020/21 against 82.35% in 2019/20 and 82.39% in 2018/19.

There were 46,611 A&E attendances in 2020/21, which is 33.1% lower than the prior year (69,659). Again, this was largely due to the impact of the Covid-19 pandemic, and is in line with national trends.

The Trust has sustained the improvement in London Ambulance Service handover times. There has also been sustained improvement in the reduction of the number of patients in hospital longer than 21 days.

b) Cancer

For four months of the year the majority of elective activity had to be paused due to the Covid-19 pandemic; essential and urgent cancer treatment continued via the RM Partners Cancer Hub & Independent Sector. The Trust was able to achieve 100% compliance with the 32 day standards, and the 62 days from NHS Cancer Screening referral standard, but the standards for two week waits and other 62 day performances were not met in the first 3 quarters.

The 93% two week waits standards were met in November and December 2020, when the Trust started activity and recovery. The second Covid-19 surge had an impact on compliance in January 2021 (82.5%), but the Trust was able to meet the threshold in February (94.6%) and March (93.4%).

c) Referral to Treatment (RTT)

In 2020/21 the Trust was not able to meet the 92% constitutional standard for treating patients within 18 weeks. This was due to the significant delays caused by reduction in, and cessation of, all elective activity during the pandemic. As a result of these disruptions the Trust was only able to achieve an average of 52.4% compliance for the year as a whole. Improvements were seen in September to December 2020, as a result of additional activity to help reduce backlogs, and the prioritisation of patients who had waited 52 weeks or more. The second surge in Quarter 4 resulted in a significant proportion of elective routine activity being paused again, which had a negative impact on waiting times. In February 2021, the Trust started to take steps towards recovery again, with a focus on its longest waiting patients.

1.4.4 Well Led

Improved Governance

A review of corporate governance arrangements at Board and sub-board level was undertaken towards the end of Quarter 1 of the financial year, and the Trust has since made significant progress in embedding a more robust governance framework. Key improvements in 2020/21 include the refinement of the Board Assurance Framework, a revised Committee structure that is more effectively aligned with strategic priorities, and strengthened arrangements with regard to Risk Management.

The Trust will review these again in 2021/22 to identify further changes required to support the organisation in attaining a CQC 'Good' rating within the next 2-3 years.

Improvements to Divisional Structure

The Trust has also successfully embedded changes to the organisational structure, with all Clinical Services consolidated into two new Divisions: Planned and Unplanned care.

Transformation

During 2020/21, the Trust made good progress in embedding its improvement methodology, CARES+, enabling and supporting staff who deliver care and services to develop and implement their own improvement plans based on patient priorities. The NHSEI Vital Signs programme team have continued to support and coach the Trust in delivering improvements in patient care and efficiency.

In the latter part of the year the CARES+ team led the systematic review of the innovations implemented within the first wave of Covid-19, with the Programme Management Officer (PMO) quantifying the financial benefits, ensuring the ongoing sustainability of the changes put in place. A particular focus in 2020/21 was the deployment of the phase 1 improvement programme in the Emergency Care department where we successfully increased efficiency, with improvements to the patient journey and to staff satisfaction. CARES+ methodology was also used to deliver improved patient pathways within the Ambulatory Emergency Care Unit.

Over 30 staff members have been accredited with the coveted Practice Coach Certification level, demonstrating development of significant skills in delivering improvement, which will be cascaded within the organisation.

1.4.5 Partnership Working

Coordinated approach to healthcare

Partnership working in Hillingdon has continued to grow through the development of Hillingdon Health and Care Partners (HHCP), a partnership of the NHS and third sector organisations in the borough[2]. During 2020/21 the partnership has focused on leading a joined up response to the Covid-19 pandemic including:

- Establishing a co-ordination hub for health and care organisations with daily reporting to manage areas of risk across the system
- Developing integrated support for clinically vulnerable residents, joining up health and care services and support to help keep people well whilst they are shielding
- Enhancing the integrated discharge work to ensure patients were discharged from the hospital without delay and into the most appropriate setting, based on clinical need and Covid-19 status
- Working together to deliver a successful Covid-19 vaccination programme that saw over 90% of residents aged 65 and over vaccinated within 10 weeks of the local programme commencing

The Trust is an active member of the North West London (NWL) Integrated Care System (ICS) which has been operating in shadow form since April 2020 and gained full approval from April 2021. The ICS is a Commissioner/Provider collaboration consisting of all of the Clinical Commissioning Groups (CCGs), acute, Mental Health and Community Providers operating within the boundaries of NWL.

Last November, NHS England and NHS Improvement invited views on strengthened proposals to put integrated care systems on a statutory footing. The responses to the November paper directly informed a set of recommendations to Government and Parliament in early February 2021 which can be accessed in the link 'Legislating for Integrated Care Systems: five recommendations to Government and Parliament'. The document sets out the five recommendations NHSEI is making, alongside principles to guide how the Government progresses this work. Based on the legislative proposals, the Department of Health and Social Care responded by setting out new proposals to streamline and update the legal framework for health and care: Integration and Innovation: working together to improve health and social care for all.

[2] HHCP partner organisations are; The Hillingdon Hospitals NHSFT, Central and North West London NHSFT, H4All and The Confederation Hillingdon CIC.

During the pandemic, the ICS was instrumental in co-ordinating the response to the pandemic ensuring incident plans and structures were activated, consistency of practice and mutual aid. The trust was an active participant in this partnership.

Moving forward into 2021/22 there will be a clear focus on recovering elective care and addressing the backlog of other unmet care needs which had to be postponed during Covid-19, as well as strengthening out of hospital care to target care to where it is needed the most.

Delivering Digital Care Records

In 2020/21 The Trust joined the Care Information Exchange, which enables our patients to sign up to access a single electronic copy of their medical records across North West London.

Partnerships to advance education and research

The Trust is a founder member of Brunel Partners Academic Centre for Health Science (BPACHS), a partnership of local health Trusts and Brunel University, London. The partnership works collaboratively in the areas of workforce supply and development, research, digital health and innovation, and quality improvement.

1.4.6 Money

Delivering the 2020/21 Financial Plan

The Trust was initially set a financial plan of a £3.3m deficit in 2020/21. The Trust has reported a £5.2m deficit in its draft financial statements. Included in that reported deficit is £5.4m of losses resulting from impairments to the value of fixed assets and investment property. The Trust's financial performance is discussed in more detail in section 1.11 of this report.

The Trust's reported financial performance has significantly improved on 2019/20; however, this is driven by the block and top up arrangements mentioned previously, which included guaranteed funding for the first half of the year, where the Trust was required to report a break-even position. Although the financial performance reported in 2020/21 is an improvement on 2019/20, the underlying financial performance and sustainability of the Trust remains a major challenge and requires significant improvement in 2021/22.

1.5 The Trust's response to the pandemic

The Covid-19 pandemic has resulted in an unprecedented level of demand for hospital critical and medical care.

The Trust has, and will continue to respond to the pandemic, in line with national and local guidance. It has effectively deployed its pandemic flu plan and internal incident procedures, operating a gold, silver and bronze command and control structure. The Trust maintains a Covid-19 risk register to support the identification, escalation and mitigation of risk associated with the pandemic.

The Trust continued to closely monitor all waiting lists and key quality and performance metrics to identify gaps in assurance and maintain patient safety and business as usual functions as far as reasonably practicable. This ensured continuous monitoring of the impact on non Covid-19 patient care and allowed the re-commencement of planned work in a flexible and timely manner as capacity and quality parameters permitted.

The Trust has worked with colleagues in the North West London Health and Care Partnership (NWL HCP), across London and beyond to enable it to manage the significant increase in caseload of Covid-19 patients and to maintain equity of access to care for all patients. This required an agile and flexible approach and rapid and significant transformation of services.

Elective inpatient and day-case services were largely paused (with the exception of some urgent critical cases including cancer services). Outpatients services were significantly reduced, with the rapid adoption of virtual clinics, where possible, and the maintenance of urgent services where required.

Plans were made in line with national and regional guidance, and with the welfare of staff and patients at their heart, with a large number of actions taken to ensure:

- Compliance with national and regional guidance
- Appropriate management of the organisation during a national incident with a gold, silver and bronze command structure in line with the internal incident and pandemic plans
- Effective communication with staff to support dissemination of information, including daily bulletins, materials for managers and Q&A sessions
- Reduction in planned care activities to manage increase in Covid-19 patients by redeploying medical and nursing teams onto the wards
- Maintenance of time critical emergency work (including cancer and urgent surgery and some diagnostics)
- Increased Intensive Care Unit (ICU) capacity in line with national and regional guidance and demand and capacity modelling, including compliance with revised national (medical and nursing) staffing ratios
- Increased availability of general medical beds so sufficient beds were available and staffed in line with demand and capacity modelling
- Creation of risk assessed and distinct areas to care for possible/definite Covid-19 cases and non-Covid-19 cases
- Safe care provided to deteriorating patients
- Consistent and ethical decision making
- Appropriate provision of PPE in line with national guidance
- Staff wellbeing was maintained
- Effective estates management and changes made in a timely manner to facilitate safe patient care

- Maintenance and improvement of governance systems to ensure safe care

The Trust developed a Covid-19 risk register to support the identification, escalation and mitigation of risks associated with the pandemic and these are reflected on the Trust Corporate Risk Register. The Trust has also developed a specific Covid-19 Board Assurance Framework to provide onward assurance to the Board on management of the risks associated with the pandemic.

1.6 Responding to regulatory action by the CQC

As part of the longer term strategy to address the issues that have resulted in poor performance in CQC inspections, the Trust established the Hillingdon Improvement Plan (HIP) in 2019. This has been used to track progress, not only against the CQC 'must' and 'should do' requirements but other self-identified areas for improvement. This plan has been overseen by a bi-monthly HIP Board chaired by the Chief Nurse, with attendees from all Trust divisions, corporate areas and from external Health Care partners including the CQC regional team, CCG colleagues, local Healthwatch colleagues and NHS Improvement (NHSI).The HIP Board reports to the Trust Management Executive, and then to the Quality and Safety Committee which is a sub-committee of the Trust Board.

Like the majority of business as usual activities, the HIP Board meetings were suspended during the Covid-19 pandemic period to ensure appropriate resource and focus was available for the safe management of staff and patients. During this period, actions arising from the focussed CQC inspections were monitored in daily CQC project management meetings, attended by clinical and corporate divisional representatives and members of executive team.

The Trust has made significant progress on these actions and has ensured that it has a robust monitoring and reporting structure in place.

The Trust also delivers a 'Ward and Department Accreditation' programme, which comprises quality and safety assessment of the clinical areas in the Trust, using a structured Trust developed assessment tool by a team of multidisciplinary stakeholders. The accreditation framework is aligned to the CQC's key lines of enquiries and five domains of quality. In November 2020, the Trust revised the accreditation tool in line with new IPC regulations related to Covid-19 safety and also streamlined the accreditation process.

Accreditation is one of the strands of measurement that aims to assure that Trust divisions and the executive team have an accurate and detailed understanding of the quality of care patients receive. The accreditation programme was temporarily suspended due to the Covid-19 pandemic and the Trust aims to recommence the schedule as soon as it is considered safe and appropriate.

Despite the comprehensive action plan in place, the Trust did not have sufficiently well embedded practices in place in some CQC domains to address the additional risks arising

from the pandemic. These were exacerbated by the poor condition of the estate. The CQC carried out a focused unannounced inspection at Hillingdon Hospital in August 2020 and a joint follow up visit with Health and Safety Executive (HSE) inspectors in September 2020. The inspections focused on the safe and Well Led domains in the 'medical care' and 'urgent and emergency care' core services, with particular attention to IPC practice.

The Trust received a Notice of Decision under Section 31 and Section 29a of the Health and Social Care Act 2008 requiring the Trust to provide the CQC with assurances of implementation of an effective system to assess, monitor, identify, mitigate and manage any risks identified in the inspection.

The Trust took a robust project management approach to monitor the concerns raised by the CQC and has a comprehensive action plan in place to ensure the issues identified in the report and notices are addressed. The progress against these actions is monitored regularly and is reported to the Trust Management Executive, and at the Quality and Safety Committee and Trust Board.

1.7 Improving the Trust's estate

The Trust has historic issues in terms of the poor condition of its estate and the level of backlog maintenance required to maintain safe and effective buildings is significant.

As a result of an audit undertaken in July 2019, the Trust has received significant investment into the estates during the last two years, including emergency capital funding of £16.5m to address business as usual estate statutory compliance matters. Major infrastructure work was undertaken in the following priority areas:

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

A programme for the upgrade of the Emergency Department (ED) at Hillingdon hospital was completed in March 2021 with a further £4.9m of improvement works delivered to support Covid-19 pathway changes in the ED department during 2020/21. Key areas of work include the following:

- A new clinical ward block has been constructed to support a new 16 bedded Intensive Care Unit (ICU), a 24 bed respiratory ward, together with a modern 28 bedded inpatient ward on the ground floor

- A further 3 levels of modular ward facilities have been installed to the south of the hospital, this included 2 floors of inpatient accommodation and a modern children's ward on the ground floor. The accommodation will be fully commissioned for use by September 2021

- Works to create a female changing facility for ED staff, which included modern changing area, shower and WC's facilities co-located with ED

- A new main boiler was installed to provide much needed resilience to support the existing fragile infrastructure. The boiler was fully commissioned and operational by January 2021

- Modern generator backup facilities have been installed to the main hospital site at Hillingdon, providing reliable electrical backup when required

Despite significant investment, the remainder of the estate has continued to deteriorate as a result of general age and obsolescence, and further backlog maintenance will be required to maintain compliance with building standards and to support business as usual (BAU) activity. The Trust has allocated £5m per annum capital allowance within the financial plan, and is now in the process of commissioning an up to date six facet survey completion for 2021, to provide an updated backlog maintenance position and cost.

Under the Department of Health and Social Care's 'Health Infrastructure Plan' the Trust is seeking funding for a new hospital build. Our Strategic Outline Case (SOC), which was approved by the DHSC and NHSEI Joint Investment Committee in late 2020, evaluated a range of options. Based on a comprehensive assessment, a full redevelopment of Hillingdon Hospital on the current site was identified as the preferred way forward.

The Trust's vision is to provide a new state of the art hospital for the residents of Hillingdon, and beyond, which supports the very best delivery of healthcare.

The new hospital will be a digitally enhanced building which is sustainable and fit for the future. It will provide the same range of services that we have now, but with improvements made possible by modern, purpose built facilities.

- Same mix of services that are currently available at Hillingdon Hospital
- Built in the same location (next to the current hospital)
- The hospital will remain open during construction to ensure no disruption to care

The development will continue as a key NHS and Trust priority in 2021/22, and the Outline Business Case is due to be delivered in autumn of 2021.

1.8 Environmental Performance

1.8.1 Sustainability and Environmental Performance

The Trust has an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, smart and efficient use of natural resources, and building healthy, resilient communities.

The NHS has recently become the world's first national health system to commit to achieving 'carbon net zero'. The Trust is working to support its commitment to mitigate the health impacts of climate change and air pollution, as well as making a significant contribution to the reduction of the UK's carbon and other noxious gas emissions, through two targets:

- NHS carbon footprint (emissions under direct control), to achieve net zero by 2040, with ambition for an interim reduction by 2028-2032

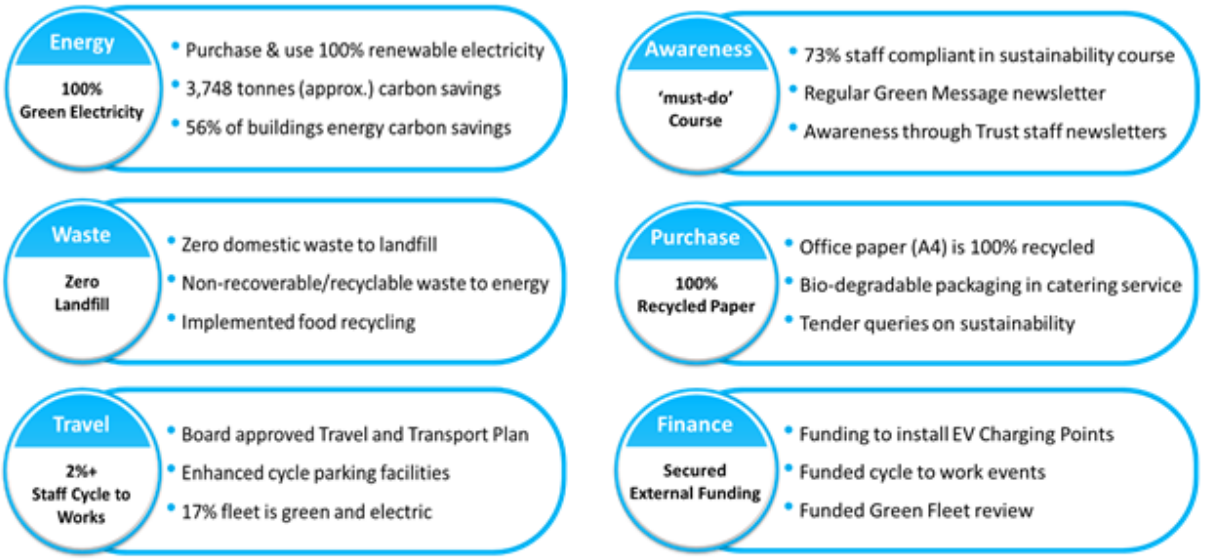
- wider NHS carbon footprint (Carbon footprint plus), which also includes the supply chain, to achieve net zero by 2045, with an ambition for an interim reduction of 80% by 2036-2039

1.8.2 Assessing Our Impact

The Trust's impact is measured using the Sustainable Development Assessment Tool (SDAT), which has been designed by the NHS Sustainability Development Unit (SDU) to:

- Help Health and Social Care organisations assess their year-on-year progress
- Support in designing and providing a focus on Sustainable Development Management
- Plan Sustainable Development Management
- Show how organisations are contributing to the United Nations Sustainable Development Goals (UNSDGs)

The Trust's assessment was completed on 28 September 2020. The overall score was 53%, lower than the average for similar acute trusts. The Trust has started contributing to some UNSDG and is making progress in most of them. The following are the key highlights of the Trust's performance in 2020/21:



1.8.3 Sustainability Initiatives

The following initiatives were delivered in 2020/21:

- Sustainability awareness course is a requirement for all staff since June 2020. The Hillingdon Hospitals NHS Foundation Trust is one of the first Trusts to implement this
- The Trust monitors its buildings energy consumption live and in real-time
- Implemented bin replacement programme to increase segregation and recycling
- New cycle compound for staff use with registered parking, lockers, changing facility, free bike pump and enhanced security. Regular 'Dr. Bike' events to support cycle to work
- Redevelopment programme and the new hospital Strategic Outline Case has sustainability assessment and net-zero carbon reduction target

1.9 Response to the potential impact of the UK's exit from the European Union (EU)

Following the no deal preparations undertaken in 2019 and a formal agreement being reached with the EU, Trusts were asked to stand down their preparations from the second week of January 2020. On 31 January 2020, the UK formally exited the EU, entering a transitional period where the rules of the EU would continue to apply whilst a negotiated settlement was reached.

During the latter months of 2020 with negotiations stalled, Trusts were asked to resume planning for a ‘no deal’ position.

Through the reconvened EU Exit Group, under the chairmanship of the Chief Operating Officer (Senior Responsible Officer for EU Exit), the Trust reviewed the activity already undertaken and used the same eight high impact areas as previously identified.

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

Risks and mitigating activities were identified for each of the high impact areas ensuring that these took account of the context of the additionality of a second pandemic wave and winter pressures.

The EU Exit Group met a number of times leading up to the end of 2020 with limited additional information available centrally. A command and control procedure was agreed that would provide an operational framework in the days leading up to and through a ‘no deal’ end of the transitional period.

Brexit reporting to the NHS nationally began on 23 December 2020 and was incorporated into the Covid-19 daily situation reports.

With a negotiated deal being announced on 28 December and agreed by parliament on 30 December 2020, the preparations and command and control was incorporated into BAU and the formal Brexit preparatory meetings were stood down.

1.10 The Trust’s Duty of Equality

The Trust’s three-year patient experience and engagement strategy, covering 2019-22, sets out the Trust’s intention to ensure the best possible experience for patients, carers, their relatives and the community. We recognise people are different and that some people will need different treatment to achieve a fair outcome, which is why we are committed to delivering healthcare around the needs of individual patients and those around them.

We seek to understand what is important to our patients, recognising that this will vary from person to person; we utilise tools such as the Learning Disability Passport and ‘This is Me’ document for people living with dementia to gain a better understanding of how to provide personalised care. Reasonable adjustments are put in place, where practicable, such as

timings of Outpatient appointments and welcoming carers throughout the 24 hour period (except during the Covid-19 pandemic). We ensure that language is not a barrier to high quality safe care through the provision of information in different languages and interpreting services.

a) Equality Act 2010

Under the Equality Act, NHS organisations have a 'general equality duty' to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by the Equality Act
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Equality and Diversity is a part of everything we do. It is our belief that we must prevent unlawful discrimination, offer equality of opportunity and provide an inclusive environment for patients, carers, visitors and staff.

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

The Trust reports a high level of compliance with making reasonable adjustments for people with a learning disability (LD) to enable them to access the appropriate healthcare and treatment they require in a timely manner, reducing health inequalities. The Trust appointed to a LD Nurse Specialist / Safeguarding Adult Clinical Nurse Specialist (CNS) role in 2019/20.

The main role of the LD CNS is to advocate for patients with LD, train staff and drive forward service improvements, to ensure quality outcomes for people with LD.

Initial data has seen increased direct support for people with LD and their families, and increased engagement with internal colleagues and external professionals to inform service developments, despite the challenges faced by the Covid-19 pandemic.

c) Engagement with seldom heard groups - Maternity services

The Trust's Maternity Voice Partnership (MVP), which includes representation from mothers and their families, has worked hard during 2020/21 to ensure engagement with women and families from all backgrounds, including hard to reach groups. During 2020/21 the MVP has been involved in:

- setting up a forum to enable fathers to discuss their experiences

- conducting a review of Covid-19 communication on maternity visiting restrictions
- running a MVP Facebook page for mothers to get involved
- reaching out to our BAME community

The MVP provides a mechanism for ongoing feedback ensuring that women and families are actively involved in service development and improvement.

d) Religion or Belief

The Trust acknowledges religion through recognition of non-religious views and diverse belief systems along with religious beliefs and practices. The Department of Spiritual and Pastoral Care fosters positive promotion of religion and belief in the hospital context. This promotion is done in various ways:

- departmental staff and volunteers responding to patient religious, spiritual, and pastoral care needs as expressed by the patient
- providing and maintaining welcoming physical space for religious observance and non-religious belief expression; including a multi-faith room, Islamic prayer room, conducting memorial services for staff and public and conducting religious services for staff and patients
- promotion of Trust-wide consideration of religious days and times; Ramadan, Christmas, Guru Nanak, Passover, etc.
- ensuring equity and regard for deceased patients and their families in relation to funerals; likewise, for the parents and families dealing with the loss of a baby.
- developed and maintained working relationships with local community faith groups.

e) Accessing the Complaints service

Patients who need support in making a complaint can access POhWER advocacy services.

Patients who require language support with providing feedback are offered an interpreter or British Sign language (BSL) translator if requested.

f) Interpreting and Translation Services

The Trust's has a contract with an external provider to deliver face-to-face, telephone interpretation, video and translation to include BSL for patients and carers across the Trust. During 2020/21 the Trust requested interpreting services on 2630 occasions supporting patients with 43 languages. These figures include requests for BSL.

The Trust's Interpretation and Translation Policy ensures that patients, relatives and carers have access to the communication tools required to allow complete understanding of their diagnosis and proposed treatment, and to ensure that each patient's communication needs are met.

g) National Inpatient Survey 2020

A survey of inpatients is part of the annual mandatory survey programme for acute services commissioned by the CQC. A Freephone helpline was available for patients who had queries or concerns about the survey. Access to Language Line was also available with interpreters in over 100 languages. The results of the 2020 national inpatient survey will not be available until later in the year. However, once received, feedback on age, gender and ethnicity of the survey population will be available to help inform a more tailored response to issues raised.

h) Patient information

Patient leaflets are available on the public website and Trust intranet. Leaflets contain a message advising patients that the leaflet can be provided in audio, large print or translated into other languages. A number of leaflets are available in 'easy read' format.

1.11 Financial performance

The Trust has reported in its financial statements a deficit of £5.2m for the 2020/21 financial year against an original plan of a £3.3m deficit. Included in that reported deficit is £5.4m of losses resulting from impairments to the value of fixed assets and investment property.

However, taking into account other movements in relation to impairments of assets and the donation of PPE and medical equipment to support the Trust's effort against Covid-19, the Trust reported a £6.4 loss against a £3.0m deficit plan.

The following table demonstrates the primary drivers behind this financial performance.

	2020/21 outturn (£m)	2020/21 plan (£m)
Operating income from patient care	258.9	246.2
Other operating income	47.8	39.9
Employee expenses	-203.9	-187.3
Other operating expenses	-97.5	-94.0
Non-operating income and expenses	-8.0	-8.1
Gains and losses relating to assets	-2.5	0.0
Surplus / (deficit) for the period	**-5.2**	**-3.3**
Other movements (described in narrative above)	-1.3	0.3
Adjusted financial performance: Surplus / (deficit) for the period	**-6.4**	**-3.0**
Year end cash	**47.4**	**1.0**

The Trust delivered £3.9m in efficiency savings during the year (1.2% of in-year expenditure).

The largest factor behind variances to plan for both income and expenditure was additional income received to cover additional costs for staff pensions and annual leave.

During the year, the balance of cash and cash equivalents increased from £9.8m at the end of 2019/20 to £47.4m at the end of 2020/21. This was as a result of the profiling of the Trust's capital programme for 2020/21; the Trust held approximately £40m in cash funding at 31 March 2021 to pay capital invoices. These cash balances have reduced significantly in April and May 2021 as these creditors are settled.

In 2020/21, the Trust invested £66.9m into its capital programme and therefore spent in line with capital forecasts agreed with NHSEI. The principal elements of the Trust's capital spend were:

- £33.2m on enabling works for the new hospital build, including the construction of two new modular ward blocks
- £8.9m on estates backlog maintenance projects, including fire remediation, lift and generator replacement, incinerator and water quality projects
- £5.0m on development work on the Trust's outline business case for the new hospital
- £3.8m on upgrading the Trust's Emergency Department, redesigning patient flows to make the department more resilient against Covid-19
- £8.1m on upgrading IT software and hardware, particularly on the Trust's Digital Care Record
- £3.2m on replacing and upgrading medical equipment.

1.12 Going Concern Disclosure

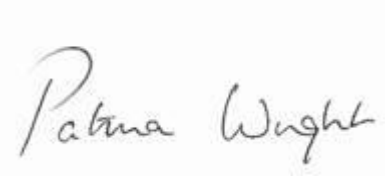
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.13 Events after the end of the reporting period

The Trust has considered whether there are any material post balance sheet events to disclose. At the end of May 2021, the Trust settled £6.1m of mutual debtor and creditor balances with Imperial College Healthcare; this reduced the Trust's debtors and creditors by this amount.

1.14 Accounting Officer approval of the Performance Report

As Accounting Officer, I am satisfied that this performance report provides a true and accurate summary of the performance of the Trust during the year 2020/21.



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

8 July 2021

2. Accountability Report

2.1 Director's Report

The Directors present their report and audited financial statement for the year to 31 March 2021.The Directors are responsible for preparing the Annual Report and Accounts, and consider the report, taken as a whole, to be a fair, balanced and understandable account of the performance of the organisation during the year 2020/21. The information within this report provides details for our stakeholders on the Trust's performance business model and strategy.

2.1.1 How we are organised

The Trust is run by a Board of Directors. The Board, led by the Chair, sets the vision, mission and values of the Trust and works to promote the success of the organisation. It is responsible for the organisation's decision-making and performance and for ensuring the Trust delivers high quality, safe and efficient services. The Board met on 21 occasions during 2020/21.

The Board of Directors comprises a Non-Executive Chair, up to seven other Non-Executive Directors, and up to seven Executive Directors one of which should be the Chief Executive. The Trust Board Secretary is an Officer of the Board, attends all meetings, and ensures provision of effective secretariat and governance services.

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

2.1.2 Board of Directors, 2020/21

Directors' details, together with their committee membership as at 31 March 2021, are outlined below. Board members declare their interests at the time of their appointment and at least annually. The register of directors' interests is available on the website on the Board of Directors' pages and is also available from the Trust Secretary.

Directors are also required to confirm they meet the 'fit and proper person' condition set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. All our directors serving across the financial year met the 'fit and proper person' test.

Arrangements for the appointment and termination of appointment of Non-Executive Directors are set out in the Trust's constitution. Non-Executive Directors are normally

appointed for a period of three years and can be re-appointed for a further period of three years. Exceptionally a third term may be agreed.

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

2.1.3 Non-Executive Directors for 2020/21

The following table lists the Non-Executive Directors for 2020/21; their full biographies can be accessed on The Trust website. Please note that all Non-Executive Directors are also members of the Nominations and Remuneration Committee.

Sir Amyas Morse: Trust Chair

Chair of the Board of Directors

Chair of the Board Nominations and Remuneration Committee and Chair of the Council of Governors and its Nominations and Remuneration Committee

Sir Amyas Morse was appointed in October 2019 and his current term of office comes to an end in September 2021. Sir Amyas has had a distinguished career in finance in both the private and public sector; recently as Comptroller and Auditor General of the National Audit Office (NAO), leaving a much-respected NAO after his 10-year tenure. Sir Amyas has worked for Coopers & Lybrand, reforming as PricewaterhouseCoopers taking on a global role. He became a member of their UK and Global boards. He joined the Ministry of Defence in July 2006 as the Defence Commercial Director, before joining the National Audit Office. Sir Amyas was Chair for the Board of Audit for the United Nations between 2011 and 2017. He currently serves as Trustee of the Royal College of Surgeons, since 2016. Since January 2020 he has also been Chair of London North West University Healthcare NHS Trust. It has been confirmed that Sir Amyas will be elevated to the House of Lords in the spring of 2021.

Richard Whittington: Non-Executive Director and Senior Independent Director

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

Richard Whittington was appointed in October 2014 and was due to step down in September 2020 having served two terms however, he agreed to extend his tenure until completion of the Annual Report and Accounts process for 2020-21 and therefore will stand down at the end of Q1 2021. Richard is a chartered accountant and was a Senior Partner at KPMG where he was latterly in charge of the Infrastructure Government and Healthcare Audit Group which provided services to the health and public sectors and building and construction companies. He has held a number of non-executive positions and is now Vice President of the Community Foundation of Surrey, a Trustee of Surrey Care Trust, a Trustee of the Gordon Foundation and Chairman of the Governors of Gordon's School Academy Trust Limited. Richard was

appointed Interim Senior Independent Director (SID) in May 2019 and acted as interim Deputy Chairman from May to October 2019. He became the substantive SID in October 2019. Richard brings senior financial, audit and corporate governance experience to the Board, together with estates and capital investment expertise.

Dr Linda Burke: Non-Executive Director

Chair of People Committee, Vice-Chair of Finance and Performance Committee and Chair of Quality and Safety Committee (from March 2020)

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

Janet Campbell: Non-Executive Director

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

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

Catherine Jervis: Non-Executive Director

Chair of Finance and Performance Committee and Vice-Chair of Quality and Safety Committee, Vice Chair of the Board of Directors (from March 2021)

Catherine Jervis was appointed in April 2019. Catherine has extensive experience of the public and not-for-profit sector organisations with a focus on governance, finance and

performance. She is a qualified accountant and started her career with the National Audit Office. She is currently also Non-Executive Director with Barnet Enfield and Haringey Mental Health NHS Trust, and Non-Executive Director with Achieving for Children (Community interest Company (CIC) and Non-Executive Director for the Independent Office for Police Conduct. She was previously Vice Chair and Non-Executive Director at First Community Health and Care (CIC). Prior to this Catherine was Strategic Advisor to the CEO of Achievement for All – (a national education charity set up to transform the lives of vulnerable children) and Director for PricewaterhouseCoopers Limited Liability Partnership where she led the Children's Services team delivering services across education, health and social care.

Simon Morris: Non-Executive Director

Chair of the Charitable Funds Committee, Vice-Chair of the People Committee (Chair from March 2021), member of the Audit and Risk Committee

Simon Morris joined the board in May 2019 following a 30-year career in the arena of health and social care. He is a qualified social worker having worked for eight years in local government, the last post being a Commissioning Manager for the London Borough of Hounslow. He then moved to the voluntary sector where he was the Chief Executive Officer (CEO) of one of the top 100 charities in the UK for 15 years. He has a degree in sociology and applied social studies and an MBA from Brunel/Henley. He now holds a number of Non-Executive Director posts in both the commercial and voluntary sector as well as being involved in a start-up using technology to reduce loneliness amongst older people. Simon is Vice Chair of the North London Hospice, since May 2019 and Non-Executive Director in Advinia Health Care (which has no care homes in Hillingdon), since December 2019. Simon was made an MBE in 2020 for services to the community.

2.1.4 Non-Executive Directors who left the Trust during 2020/21

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

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

Lis retired at the end of February 2021 having agreed to an extension of her term of office for a further year in January 2020. The Trust thanks her for bringing clinical knowledge, experience of the wider NHS and integrated care, patient engagement and leadership skills to our Board, as well as for her dedication and service. Over a career which lasted over 50 years Lis was a Consultant Rheumatologist at the Whittington Hospital for 15 years and then became Dean Director of the London Deanery, overseeing the postgraduate training of doctors. She chaired the North West London Integrated Care Programmes, later taking the lead on patient engagement for the North West London Integration Pioneer. Lis is a qualified

coach and works with London Leadership Academy to develop and deliver leadership programmes for staff and patients. She was named 'NHS Mentor of the Year' in 2010 and in 2011 received an OBE for services to Medicine.

2.1.5 Non-Executive Directors who joined the Trust after the end of the financial year 2020/21

Dr Ayesha Akbar: Non-Executive Director

Dr Ayesha Akbar was appointed in May 2021. Ayesha is a Fellow of the Royal College of Physicians employed at London North West University Healthcare NHS Trust where she is Associate Medical Director and Deputy Responsible Officer and Consultant Gastroenterologist. She has extensive knowledge of Integrated Clinical Services (ICS) in North West London, is a member of the Mount Vernon Cancer Centre Programme Board and has extensive experience of transformation.

Neville Manuel: Non-Executive Director

Neville Manuel was appointed in May 2021.Neville is currently a NED at London North West University Healthcare NHS Trust where he is chair of the Finance and Performance Committee, and comes with a personal recommendation from our Chairman. He was a NED at West London NHS Trust for 10 years, Vice Chair for 3 years, a member of the Audit and Risk and Finance and Performance Committees and involved in the re-development of Broadmoor. He spent many years in senior positions with BT before retirement.

2.1.6 Executive Directors – members of the Board

Patricia Wright – voting

Chief Executive: Executive Director from November 2020

Patricia Wright was appointed as the Chief Executive Officer of The Hillingdon Hospitals NHS Foundation Trust with effect from 30 November 2020. Patricia was previously Chief Executive of Hounslow and Richmond Community Healthcare NHS Trust and is well known within North West London (NWL) as a member of the Provider group in the NWL Health and Care System. She is an experienced CEO and comes with extensive experience within the acute sector having been Chief Executive of The Queen Elizabeth Hospital, Chief Executive of Kings Lynn FT, Director of Operations at West Middlesex University Hospital and Director of Operations, Epsom and St Helier NHS Trust.

Jason Seez – voting

Deputy Chief Executive Officer and Director of Strategy: Executive Director from February 2019. Acting Chief Executive from 15 August – 30 November 2020.

Jason joined the Trust from Barking, Havering and Redbridge University Hospitals NHS Trust where he was Executive Director of Strategy, Transformation and Infrastructure. He is an experienced NHS manager and is taking special responsibility for driving the effort to secure a new hospital, transform services, and strengthen joint working with Hillingdon Health and Care Partners and London North West University Healthcare NHS Trust. Jason is the Trust's Senior Information Risk Owner.

Ms Gubby Ayida – voting

Medical Director: Executive Director joined in October 2020 on 12 months secondment from Chelsea and Westminster

Gubby joined the Trust in October 2020 on secondment from Chelsea and Westminster where she most recently held the position of Associate Medical Director for Strategic Programmes and where she still provides advice to their Board on Equality, Diversity and Inclusion. She has held several other medical leadership roles including Divisional Medical Director across the two acute hospitals sites. Gubby is a Consultant Obstetrician with a strong background in Clinical Governance. She is passionate about women's education as well as equality and inclusion in the workplace. She is the current Responsible Officer for the Trust and the Executive Lead Maternity Safety Champion. The Caldicott Guardian is a member of her senior medical leadership team.

Melanie Van Limborgh – voting

Director of Nursing – Executive Director joined in January 2021 on 12 months secondment from Chelsea and Westminster

Melanie's career spans more than 30 years in the NHS. She started her NHS career at Hillingdon in the Theatres Team, and since then has worked at a range of acute hospitals spending 23 years at Chelsea and Westminster where Melanie was variously Theatres Manager, General Manager and Deputy Director of Nursing plus nearly two years at the Department of Health. She has developed a passion for collaborative working and driving improvement, which she is bringing to her role with the Trust with the aim of supporting it to be a better and even safer place in which to treat our patients.

Tina Benson – voting

Chief Operating Officer (COO) - Executive Director from December 2019

Tina is a qualified radiographer who got her first clinical job at Hillingdon Hospital. This was followed by a variety of clinical and managerial roles at the Royal Free Hospital, at London

North West Hospitals as a manager and Deputy COO, and then as Deputy COO, Hospital Director, at West Middlesex Hospital She brings extensive experience of operational leadership.

Jon Bell – voting

Chief Finance Officer – Executive Director from February 2021

Jon joined the Trust in February 2021. He started his career as a trainee accountant working for Hammersmith and Queen Charlotte's Special Health Authority. With more than 25 years' experience working across the acute, commissioning and community healthcare sectors in the UK (mostly in North West London) and abroad, including over 12 years as a board director, plus over four years as a management consultant with Arthur Andersen, Jon brings a wealth of experience and knowledge to the role.

Sue Smith – non voting

Chief People Officer from June 2020

Sue joined us from Wye Valley NHS Trust, a combined acute and community trust covering Herefordshire and into Powys, where she was Director of HR & OD, the trust is part of the successful Foundation Group with South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust.

Previously Sue was Deputy Director of HR & OD at Royal United Hospitals NHS Foundation Trust.

Sue has a breadth of Board experience delivering innovative HR strategies and large scale service transformations to support both efficiency and cultural change.

Tahir Ahmed – non voting

Director of Estates and Facilities - Executive Director from June 2019

Tahir has worked as a Director of Estates and Facilities in a number of London Trusts for over 20 years managing and delivering numerous large healthcare developments. He is a member of the Royal Institution of Chartered Surveyors and an active ambassador of Knowledge Transfer Partnership between academia and the industry. Tahir's central interests lie within complex healthcare construction projects, intelligent buildings and hospital innovation.

2.1.7 Executive Directors who left during 2020/21

Sarah Tedford – was voting

Chief Executive: Executive Director from November 2018 – 14 August 2020

Sarah joined the Trust from Manchester Royal Infirmary, Manchester University NHS Foundation Trust where she had been appointed Chief Executive in March 2018. She spent the six months prior to this on secondment to NHSI/NHSE as Winter Director London to provide assurance on the systems and processes in place to monitor delivery of the National A&E standard across London. Previously she was Chief Operating Officer at Barking, Havering and Redbridge University Hospitals NHS Trust, helping the Trust to exit 'Special Measures'. Before this she was at Kingston Hospital NHS Foundation Trust as Deputy Chief Executive, a position she acceded to in May 2011. Sarah brought extensive experience of NHS leadership to the role of CEO with a focus on strategy, performance and quality and a track record of achievement. Sarah stepped down from the Board in August 2020.

Dr Catherine Cale – was voting

Medical Director: Executive Director from August 2019 – 9 October 2020

Catherine joined the Trust from NHS Improvement (NHSI) London where she was the Deputy Regional Medical Director, and was GIRFT (getting it right first time) Clinical Ambassador in London. Her prior experience includes being the Medical Director of North Middlesex University Hospital and Interim Medical Director at Great Ormond Street Hospital for Children NHS Foundation Trust. Her clinical background is as a Consultant in Paediatric Immunopathology and Immunology. Catherine's areas of strength included clinical quality improvement, clinical governance and risk management and strategic experience, experience in an acute setting. She has a strong background in financial management of clinical services partnership/system working. During her time with the Trust Catherine had responsibility for Patient Safety, and was the Responsible Officer for the Trust.

Camilla Wiley – was voting

Chief Nurse and Director of Infection Prevention and Control - Executive Director from October 2019 – 8 January 2021.

Camilla joined the Trust from the Royal Free where she was Hospital Director and Divisional Operational Director, prior to this she was Director of Nursing at the Royal National Orthopedic Hospital. Camilla brings a wealth of experience having spent over 30 years in the NHS, including 18 years in Emergency Departments. One of her key priorities when she was with the Trust was to reinforce basic nursing standards, focusing on professionalism and accountability to ensure our patients receive excellent, appropriate and safe nursing care.

During her time with the Trust Camilla took a lead on developing a culture of safety in the Trust. She retired in January 2021.

David Meikle – was voting

Interim Director of Finance – Executive Director from April 2020 – 31 January 2021

David is a member of the Chartered Institute of Public Finance and Accountancy and has over 25 years of experience as a Finance Director in the NHS. David also holds an MBA. He joined the Trust from NHS Kent and Medway where was Turnaround Director. Previously he has worked in a number of organisations in Kent, Sussex and also in the east of England. After supporting the Trust over the financial year David as the Interim Director of Finance he moved away from the Board and into a role specifically supporting the New Hospital Redevelopment programme in February 2021.

Ema Ojiako – was non-voting

Acting Director of People and Organisational Development (from February 2020 – 31 May 2020)

Ema joined the Trust in February 2020 as the substantive Deputy Chief People Officer, and acted into the Chief People Officer role pending recruitment of the substantive post holder. Ema is a Fellow of the Chartered institute of Personnel and Development (FCIPD), and has held senior Human Resources roles in public and private healthcare. Alongside her full time role she is an Employment Tribunals Lay member with HMCTS, and a Trustee on the board of Directors of an international Charity. She also works with the CIPD as a schools Enterprise Advisor supporting senior leaders to enhance their career strategies and employer engagement plans. Ema left the Trust in January 2021.

Other roles

In July 2020 NHSEI appointed Lesley Watts as an unpaid Special Advisor to the Board. This is a non-voting role. Lesley is the Chief Executive of Chelsea and Westminster NHS Foundation Trust and the Chief Executive of the London North West ICS.

In addition, Pippa Nightingale was appointed as an unpaid Clinical Advisor to the Board. This is a non-voting role. Pippa is the Chief Nurse of Chelsea and Westminster NHS Foundation Trust and the Interim Chief Nurse of the London North West ICS.Trust Board Secretary

Michael Wood

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

Deborah Lawrenson

Trust Secretary (from May 2020 – 31 March 2021).

2.1.8 Executive Directors who joined the Trust after the end of the financial year 2020/21

None.

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

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

There are two Nominations and Remuneration Committees in place, one for appointments to Executive roles and the other for appointments to Non-Executive roles, which is a Council of Governors sub-committee. These committees consider the structure, size and composition of the Board in making appointments to the Board.

2.1.10 Performance evaluation of the Board and its Committees

The description of each director's experience (as described on the Trust website) demonstrates the balance and relevance of skills and expertise of the Board and in seeking new Executive Directors and Non-Executive Directors the Chief Executive and Chairman, supported by the relevant Nominations and Remuneration Committees, have taken into account the requirements of the organisation.

Work has taken place across the year, and been reported to the Audit and Risk Committee and the Board, to demonstrate progress made with 'Well Led' recommendations from the 2018/19 partial review commissioned from Deloitte in response to the 'Inadequate' rating for 'Well Led' in the CQC inspection of the Trust in 2018. Further work is planned in 2021/22 for the Board to undertake a further self-assessment against the 'Well Led' key lines of inquiry (KLOEs) and put in place a plan in response to identified gaps. Any actions not yet completed from the work undertaken in 2020/21 will be reflected in this plan.

The Board Assurance committees have undertaken reviews of effectiveness against their Terms of Reference and these have been reported to the Board via the Annual Reports from the committees.

The Chair appraises the Non-Executives and the Chief Executive. The Senior Independent Director (SID) appraises the Chair, having taken soundings from the Lead Governor, Chief

Executive and fellow Non-Executive Directors. The Council of Governors reviews the appraisals of the Chair and Non-Executives and their objectives for the year ahead. The Chief Executive appraises the Executive Directors.

The Trust Secretary undertook a review towards the end of Q1 of the financial year on the corporate governance arrangements at Board and sub board level. This resulted in reports to the Trust Management Board and Audit and Risk Committee outlining planned work in relation to the following key areas, around which good progress was made and embedded during the financial year:

- Putting in place a refreshed Board Assurance Framework developed through comprehensive Board engagement
- Aligning the committee structure and discussions at the Board and its Sub Committees more effectively with the strategic priorities and the Board Assurance Framework
- Putting in place revised templates for production of papers and their cover sheets, minutes, action logs, agendas and forward plans
- Updating Terms of Reference for all Board Sub Committees
- Rolling out templates for use at Trust Management Board and the committees and groups reporting up through the organisation, which is on-going and expected to be fully embed in 2021/22
- Developing a revised committee structure to better reflect the needs of the organisation. This will be in place from the start of the new financial year 2021/22
- Putting in place clear work plans for the Board and its Sub Committees
- Introducing a digital board and committee papers online solution
- Developing a comprehensive governance framework
- Developing a Capital Manual and associated infrastructure
- Putting in place a strengthened governance structure for digital/IT
- Putting in place strengthened arrangements with regard to Risk Management
- Introducing ‘Governance light’ arrangements in the two key phases of the Covid-19 pandemic – working in an agile way and maintaining appropriate governance and assurance processes throughout
- Alongside this, comprehensive governance arrangements have been strengthened for the Redevelopment Programme.

The Trust will undertake further work in 2021/22, under the leadership of the Chief Executive, to further embed and strengthen corporate governance arrangements and to identify any further work required to support the organisation in its improvement journey towards an improved overall CQC rating.

2.1.11 Meetings of the Board, its Committees and the Council of Governors 2020/21

The Board

The Board acts as the body which provides assurance that the Trust meets its statutory obligations and that its overall performance (including safety and quality) is of the standard required, either directly or through its Committee structure. The Board agreed the revised corporate objectives in July 2020. The annual operating plan was encompassed within the financial planning work in this financial year with the Board agreed the budget and Capital programme.

In 2020/21 the Board met 21 times, eight times in public, with a private session on each occasion to deal with confidential matters and additional private meetings held in August and December. In order to make Board meetings accessible to the public and Governors, public meetings, Governors meetings and the Annual Members meeting were conducted via Microsoft (MS) Teams. Public papers were made available via the website. The Board also held a number of seminars and additional meetings to provide oversight throughout the year on governance and regulatory issues.

Committees of the Board

The Board has six Committees, each chaired by a Non-Executive Director.

The Terms of Reference of each committee were refreshed during 2020/21:

- Audit and Risk Committee (ARC)
- Quality and Safety Committee (QSC)
- Finance and Performance Committee (FPC)
- People Committee (PC)
- Board of Directors Nomination and Remuneration Committee (RNC) - during the year the Nominations and Remuneration Committees were brought together.
- Charitable Funds Committee (CFC)

Board and Sub Committee Attendance, 2020/21

The following table outlines Board member attendance at Board and Committee meetings during 2020/21 against a total possible number of meetings for which the individual was a member of a Committee or where they are an Expected Executive Director attendee.

Board Member	Attendance 2020/21						
	Trust Board Public	ARC	QSC	FPC	Board RNC	CFC	PC
Total Meetings held in 2020/21	8	6	10	10	4	3	7
Sir Amyas Morse	8	0	2	3	4	0	1
Professor Lis Paice (last day 28/02/2021)	7	6	9/9	9	4	0	3/6
Richard Whittington	7	6	8	9	4	0	2
Dr Linda Burke	8	1	8	10	4	0	7
Simon Morris	8	6	1	3	4	3	7
Catherine Jervis	8	1	9	9	4	0	1
Janet Campbell	7	1	4	3	4	3	7
Patricia Wright (start 30/11/2020)	1/1	1/1	3/3	2/2	2/2	1/1	2/2
Sarah Tedford (last day 14/08/2020)	4/4	0/4	2/3	4/4	0	0/1	2/3

Jason Seez	7	5/6	6	9	0	3	2
Dr Catherine Cale (last day 23/10/2020)	6/6	0/5	4/6	0	0	0	3/5
Gubby Ayida (start 26/10/2020)	2/2	0/1	5/5	0	0	0/1	1/2
Tina Benson	6	4	2	8	0	0	1
Camilla Wiley (last day 11/01/2021)	8	1/5	7	1/8	0	0/2	5/6
Tahir Ahmed	8	5	2	9	0	0	1
Sue Smith	8	0	2	1	4	3	7
Lesley Watts	3	1	0	6	0	0	0
David Meikle (last day 31/01/2021)	8	6	1/8	7/8	0	1/2	1/6
Jon Bell (start 01/02/2021)	0/0	0	0/2	2/2	0	1/1	0
Deborah Lawrenson (start 01/05/2020)	7/7	5/5	9	7/9	4	3	6
Melanie van Limborgh (start 01/11/2020)	2/2	0	1/4	0	0	0/1	1/2

In response to Covid-19, and in line with other NHS bodies, 'governance light' arrangements were put in place at the outset of the pandemic and approved at the April 2020 Board meeting and revisited and approved by the Board in January 2021, when the second peak took place, to support the Trust to focus on operational pressures. This resulted in a rationalisation of meetings in terms of numbers and length of meetings and re-focussing of agendas.

2.1.12 Audit and Risk Committee (ARC)

The Audit and Risk Committee met on six occasions during 2020/21, including two special meetings**.** As at 31 March 2021, the Trust's Audit and Risk Committee comprised three Non-Executive Directors**.** The Committee meetings were attended by the internal and external auditors, the Local Counter Fraud Specialist, Finance Director, Chief Executive, Deputy Chief Executive, Director of Estates and Facilities, Chief Operating Officer, Trust Secretary and other senior staff responsible for areas under discussion.

The Committee is responsible for providing an independent and objective review of the Trust's systems of internal control (both financial and non-financial) and the underlying assurance processes in place at the Trust. The Committee is also responsible for ensuring that the Trust has independent and effective internal and external audit functions and overall responsibility for the organisation's risk management and for reviewing the effectiveness of these responsibilities. The Committee is responsible for making recommendations to the Council of Governors on the appointment and removal of the external auditor. The Trust's external auditors are Deloitte LLP, who were appointed with effect from August 2018 for a three year period (with the possibility of extending by a further two years).

The Trust's internal audit service is provided by KPMG. Internal audit provides an independent and objective opinion on risk management, control and governance by measuring and evaluating the effectiveness by which organisational objectives are achieved. Through detailed examination, evaluation and testing of the Trust's systems, internal audit plays a key role in the Trust's assurance processes. The Head of Internal Audit's overall opinion for the period 1 April 2020 to 31 March 2021 is that 'partial assurance with improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

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

The Committee received reports during the year from internal audit, local counter fraud services and external audit. They received finance reports and annual financial statements.

The Committee received reports during the year from internal audit, local counter fraud services and external audit. They received finance reports and annual financial statements. In particular in the 2020/21 year, the Committee received two reports on governance and controls around capital expenditure. This has helped to drive improvements in the control environment in the latter part of 2020/21. The Committee has also reviewed papers around changes to accounting policies in the financial year and updates to requirements around going concern. This is in addition to the regular papers that the Committee receives around aged debtors, bad debt provisions, losses and special payments, and single tender waivers. The committee received and reviewed the Annual Report and Accounts, draft Annual Governance Statements, and self-certifications.

The Committee reviewed arrangements in respect of the Board Assurance Framework (BAF) risks and review arrangements. In addition to this, the committee received: the Infection Prevention and Control BAF for assurance, noting detailed discussion was taking place on a regular basis on this at the Quality and Safety Committee; the Health and Safety progress and Annual Report; Cyber Security Assurance, which received a positive report on the Trusts approach and arrangements following a successful audit in 2019; progress with declarations of interests, gifts and hospitality and the fit and proper person's test arrangements; Corporate Governance updates, including improvements made against the recommendations in the Deloitte 'Well Led' review which took place in 2018/19. The Committee also reviewed the assurance in place in respect of data quality, information governance and health and safety. A self-assessment was carried out at the end of the financial year.

The Annual Governance Statement provides a further update on the responsibilities of the Committee.

2.1.13 Quality and Safety Committee (QSC)

The QSC met monthly during 2020/21, with the exception of January 2021 (during 'Governance Light' arrangements). The Committee provided the Board with assurance on three key areas of quality: safety, effectiveness and patient experience. QSC is responsible for ensuring appropriate arrangements are in place for measuring and monitoring quality, challenging assurance and determining what needs to be drawn to the Board's attention.

The QSC identifies and escalates potential risks to the quality of services, shares learning from serious incidents and deaths, and ensures that agreed actions are implemented. The Committee reviews compliance and receives assurance on meeting regulatory standards set by the CQC. In particular during 2020/21 the Committee monitored progress with the Covid-19 response; CQC regulatory response action plans; the organisation's response to the Ockenden Report on Maternity services; plus, other Maternity services required reports; End of Life Care and Safeguarding annual reports.

A self- assessment was carried out at the end of the financial year.

2.1.14 Finance and Performance Committee (FPC)

The FPC met monthly throughout the year with the exception of January 2021 (during 'Governance Light' arrangements) and provided advice, oversight and scrutiny of all aspects of financial strategy and planning and operational performance of the Trust, and on commercial strategy, strategic investments and the development of Trust infrastructure. In relation to operational performance, the Committee scrutinised the Trust's performance against operational constitution standards and, where trajectories were not being met, the Committee sought assurance that clear plans were in place to recover the position. This Committee examines key aspects of financial and operational performance and reviews costing and benchmarking work and provides assurance to the Board on the management of financial and operational risk.

The Committee also reviews the annual capital programme and reports to the Board on major capital investments and programmes including the redevelopment of the Hillingdon Hospital. In addition, the Committee oversees the development and delivery of the digital strategy, including digital, cyber and data security. A self-assessment was carried out at the end of the financial year.

2.1.15 People Committee (PC)

The People Committee has met seven times in 2020/21. It provides oversight and scrutiny on issues related to recruitment, retention, health & wellbeing and learning & development. Key issues have included responding to the health and wellbeing needs of staff through the Covid-19 pandemic; considering findings of the national staff survey; addressing equality, diversity, inclusion, recruitment and retention and looking at new ways of working. A self-assessment was carried out at the end of the financial year.

2.1.16 Charitable Funds Committee (CFC)

The CFC provides oversight and direction to the Hillingdon Hospital Charitable Trust. The Trustee of the charity is the Trust Board. During 2020/21, the Committee met three times. The Committee looked at the development of the charity to ensure its objectives and work supports the work of the Trust. Significant and varied donations were made to the hospital as a response to Covid-19, which were provided in such a way which made formal capturing of all donations difficult. However, appropriate arrangements were put in place to ensure distribution in a structured and managed way.

The Trust received money via the 'Captain Tom' fundraising initiative, shared via the NHS Charity which was used to provide staff with a thank you gift card, letter and badge to acknowledge the contribution of all staff during the pandemic. The Annual Report and Accounts were approved by the Board and submitted in advance of the required deadline. A self-assessment was carried out at the end of the financial year.

2.1.17 Board of Directors Nominations and Remuneration Committee

The Board of Directors Nominations and Remuneration Committee met four times during 2020/21 and comprises all Non-Executive Directors and the Chief Executive except where it is dealing with the appointment or removal of the Chief Executive. The Committee is chaired by the Chair of the Trust Board. The Chief People Officer and the Trust Secretary are in attendance. The committee leads the process for Executive Board appointments; Non-Executive and Executive succession planning (working with the Governors Nominations and Remuneration Committee) and evaluation to ensure the Board has the right skills mix to effectively lead the organisation. The Committee agrees Non-Executive annual objectives, reviews performance and appraisal of performance and remuneration arrangements. A self-assessment was carried out at the end of the financial year.

2.2 Governor's Report

2.2.1 Council of Governors

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

- To hold the Non-Executive Directors to account for the performance of the Board
- Appoint the Non-Executive Directors of the Trust, including the Chair and agree their remuneration
- Approve the appointment of the CEO as recommended to them
- Appoint the Trust's Auditors
- Approve changes to the Trust Constitution
- Receive the Trust's Annual Report and Accounts
- Approve 'significant transactions' and may choose to set out the definition(s) of this in the Trust's Constitution

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

The Constitution determines the following composition of the Council of Governors:

Public Governors (elected)

North Constituency	4
Central Constituency	4
South Constituency	4
Rest of England Constituency	1
Sub total	13
Staff Governors (elected)	
Doctors and dentists	1
Nurses and midwives (including health care assistants)	3
Allied Health Professionals	1
Support staff	2
Sub total	7
Partner Governors (appointed)	
Hillingdon Clinical Commissioning Group	1
London Borough of Hillingdon	1
Joint Negotiating & Consultative Committee	1
London Ambulance Service	1
Health watch Hillingdon	1
Sub total	5
Total	25

Governor elections were held in 2020 and as at 31 March 2021, there were 23 members of the Council of Governors:

- 12 elected to represent the public members (with 1 vacancy remaining in the Rest of England Constituency)

- 6 elected to represent the staff members (with 1 vacancy remaining in Nurses, Midwives and HCAs Staff Constituency)
- 5 appointed by partner organisations (Hillingdon Local Authority, Hillingdon CCG, the London Ambulance Service, Hillingdon Healthwatch and Trust's Joint Negotiating & Consultative Committee)

Governors are normally appointed for a term of three years. By having publically-elected and appointed Governors representing the local area, the Trust ensures the public interests of patients and the community are represented. In 2020/21 the Council of Governors met three times in public and one private session held on 3 November 2020 to discuss the objectives and appraisal of Non-Executive Directors.

Name	Type	Meetings attended 2020-21
Graham Bartram	Public Governor	3/3
Ian Bendall	Public Governor	3/3
Desmond Brown	Public Governor	3/3
Ian Burnell	Public Governor	2/3
Tony Ellis	Public Governor	3/3
Rosemary Jenkins	Public Governor	3/3
Robin Launder	Public Governor (to 03.11.2020)	1/3
Ahmet Moustafa	Public Governor	3/3
Kamran Qureshi	Public Governor (to 03.11.2020)	2/3
Mohan Sharma	Public Governor	2/3
Rekha Wadhwani	Public Governor (to 03.11.2020)	3/3
Marian Thompson	Public Governor	1/3
Beulah Mary East	Public Governor (from 03.11.2020)	1/1
Harjinder Singh Hoonjan	Public Governor (from 03.11.2020)	1/1
John Philip Clark	Public Governor (from 03.11.2020)	1/1
Amanda O'Brien	Rest of England Public Governor (to 03.11.2020)	1/3

Dr Arindam Basu	Staff Governor (to 03.11.2020)	0/3
Jack Creagh	Staff Governor	3/3
Lubna Hussain	Staff Governor	2/3
Stephen Ihuanne	Staff Governor (to 03.11.2020)	0/3
Sheila Kehoe	Staff Governor (to 03.11.2020)	0/3
Liz Bunker	Staff Governor (to 03.11.2020)	0/3
Gillian Pearce	Staff Governor	3/3
Mildred Neale	Staff Governor (from 03.11.2020)	1/1
Arun Natarajan	Staff Governor (from 03.11.2020)	1/1
Stefan Krok-Paszkowski	Staff Governor (from 03.11.2020)	1/1
Vacant	Staff Governor: Nurses, Midwives and Healthcare Assistants	-
Lynn Hill	Appointed Governor (Hillingdon Healthwatch)	3/3
Dr Angela Joseph	Appointed Governor (Hillingdon CCG)	2/3
Mary O'Connor	Appointed Governor (Hillingdon Local Authority)	2/3
Natasha Wills	Appointed Governor (London Ambulance Service)	2/3
Nicole Rennison	Appointed Governor (from November 2020) (Trust's Joint Negotiating & Consultative Committee representative)	-
Vacant	Rest of England	-

Governors are required to declare any relevant interests which are then entered into the publicly available Register of Governors' Interests. The Register is formally reviewed by the Council of Governors annually and is made available on the Trust website. Contact with

individual Governors can be made by request through the Trust Secretary or the Assistant Trust Secretary.

b) Meetings of the Council of Governors

The Council of Governors normally meets four times a year. The meetings are held in public, and, given Covid-19 restrictions, have been held virtually via Microsoft (MS) Teams throughout the year (with a telephone dial-in facility also provided). The meetings are followed, where necessary, by a private session to discuss matters of a confidential nature. At the end of the public session, members of the public are invited to ask questions and papers are made available in advance via the website. In addition, the Trust held five briefing sessions for Governors where they were updated on important matters and to allow Governors the opportunity to raise issues of concern with the Chair. In 2020/21, the briefing sessions covered topics such as new hospital redevelopment, CQC inspection and implications, future ICS changes and the role of the Governors and of Non-Executive Directors. The briefing and training sessions have been well attended and appreciated by Governors.

Ordinarily, Governors are invited to accompany Non-Executives on safety walkabouts to clinical areas of the Trust, so that they may observe the Non-Executives in action and form a view on how they interact with frontline staff. Given Covid-19, this has not been possible during the financial year. However, Governors have been encouraged to provide feedback on their experience, or that of their constituents, in the regular meetings which have continued throughout. Communications with Governors have also been enhanced during the year with the addition of a weekly Governor e-newsletter and provision of materials and messages to share with their constituents.

Governor Observer roles for Board Sub Committees have remained in place throughout the year (with committees held via MS Teams and observers asked for their reflections at the end of each meeting). The Governor Observer role is formally recognised in the Terms of Reference and following elections the Governor Observer roles were reviewed and changes agreed at the Council of Governors meeting held in November 2020.

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

Non-Executive Board Member	Council of Governors meetings attended in 2020/21
Sir Amyas Morse	3/3
Professor Lis Paice	2/3

Richard Whittington	3/3
Dr Linda Burke	3/3
Simon Morris	3/3
Catherine Jervis	3/3
Janet Campbell	3/3

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

d) Lead Governor

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

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

Tony Ellis was Lead Governor for the whole of 2020/21 and was re-elected to the role in November 2020. Throughout the year the Lead Governor has held regular individual meetings with the Chair, Vice Chair, Chief Executive and Trust Secretary. In this role, he has agreed the agenda for Council of Governors and the Governors' briefings and training sessions and attended bimonthly meetings of staff Governors with the Vice Chair.

e) Council of Governors Nominations & Remuneration Committee

The Nominations and Remuneration Committee met four times during 2020/21. The Membership is listed below:

- the Chairman of the Trust
- three public Governors

- two staff Governors
- the Senior Independent Director (SID)
- the Chief People Officer is in attendance
- the Trust Secretary is in attendance

The Committee leads the process for appointing the Chairman and all Non-Executive Directors, making recommendations to the full Council of Governors; it is also responsible for recommending their remuneration, appraising their performance and approving objectives as recommended by the Chair or in the case of the Chair the Senior Independent Director.

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

- approve arrangements for recruitment to Non-Executive Director posts
- appoint two new Non-Executive Directors
- recommend to the Council of Governors the Chair and Non-Executive Director appraisals 2019/20 and their objectives for 2020/21 and approve succession arrangements for departing Non-Executive Directors including approving the appointment at the end of the financial year of a new Vice Chair

When considering the appointment or reappointment of Non-Executive Directors, the Council of Governors takes into account the qualifications, skills, and experience required for each position.

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

2.2.2 Membership

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

a) Public Membership

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

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

Public Membership at 31st March 2021

At 31st March 2021, the Trust had 6,213 public members. The table illustrates the number of public members for each constituency compared to the total population. The objective is to achieve a membership broadly equal to the population base.

	31 March 2021	% of membership	Population base	% of area
Hillingdon Central	2,315	37.3	196,708	39.2
Hillingdon North	1,163	18.7	106,275	21.2
Hillingdon South	2,455	39.5	198,469	39.6
Rest of England	280	4.5	0	0
Total	6,213	100	501,452	100

Membership is open to all those eligible to be a member, regardless of gender, race, disability, ethnicity, religion or any other groups covered under the Equality Act 2010. An analysis of the current composition of public membership can be found in the table below:

Analysis of current membership		
Public constituency	Number of members	Eligible membership

Age (years):		
0-16	1	116,918
17-21	21	28,662
22+	5,702	355,873
Ethnicity:		
White	3,878	245,741
Mixed	194	16,929
Asian or Asian British	1,267	141,803
Black or Black British	310	36,872
Other	64	14,674
Socio-economic groupings*:		
AB	1,755	41,959
C1	1,837	56,711
C2	1,233	34,895
DE	1,377	41,564
Gender analysis		
Male	2,352	251,833
Female	3,852	249,619
Total	6,204*	501,452

***NB. The analysis section of this report excludes:**

- 9 members with no stated gender, 488 public members with no dates of birth, and 499 members with no stated ethnicity

b) Staff membership

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

- Doctors and dentists

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

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

Staff Membership at 31 March 2021

At 31 March 2021, the Trust had 3,589 staff members. Staff membership is validated once a year in Quarter 1. An additional validation process was undertaken in 2020 to ensure data was up to date in advance of the Staff Governor elections. This looked at staff on permanent contracts, who are on fixed terms for one year, or who have been on the bank for a year.

Staff Class	Number of Members
Doctors and Dentists	327
Nurses, Midwives and Healthcare Assistants	1,624
Professional, Scientific and Technical	497
Support Staff	1,141
Grand Total	**3,589**

c) Membership Development and Engagement

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

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

- Governors were encouraged to participate in community groups and events (e.g. Resident Associations) to engage with the public and recruit new members
- The Trust supported fund-raising events organised by the Trust or other local organisations
- Governors and members were encouraged to sign up family, friends and members of the public
- Ex-staff, their family and friends were invited to become public members
- All volunteers were encouraged to sign up as public members
- The Trust used digital marketing, including our website and social media

d) Summary of Stakeholder Relations

Hillingdon Hospital's 'People in Partnership' meetings open to the public and advertised to members of the Trust, continued via online platforms during 2020/21.

During 2020/21, a weekly electronic newsletter providing focused updates on the Trust's activities, alongside information and resources that were marked for sharing with the wider community, was introduced for Governors. This enabled them to be more effective in communicating with their constituencies and they have reported the benefit of the regular communication in respect of Covid-19.

Public governors continued to engage with local community groups, including residents' associations, where they talked with local stakeholders. Feedback from members and the public was reported to the Chair and/or Directors.

2.3 Governance Disclosures

2.3.1 Details of any political donations

The Trust did not make any political donations during 2020/21.

2.3.2 Better payment practice code performance

The Trust aims to comply with the Better Payment Practice Code, which requires Trusts to pay 95% of invoices (volume and value) by the due date of payment (or within 30 days of receipt of goods or a valid invoice). The table below shows that the Trust has noticeably improved performance against the target between 2019/20 and 2020/21; but is still significantly below the 95% target. The Trust's performance against the target is limited by its underlying challenging financial position, but funding underpinning a balanced financial plan for the first half of 2021/22 should allow the Trust to continue on its journey of improvement.

	Actual 31/03/2021 YTD Number	Actual 31/03/2021 YTD £'000	Actual 31/03/2020 YTD Number	Actual 31/03/2020 YTD £'000
Non NHS				
Total bills paid in the year	62,391	192,962	92,233	189,454
Total bills paid within target	47,706	161,634	33,864	123,671
Percentage of bills paid within target	**76.5%**	**83.8%**	**36.7%**	**65.3%**
NHS				
Total bills paid in the year	2,561	29,342	2,291	30,727
Total bills paid within target	1,301	14,131	399	12,482
Percentage of bills paid within target	**50.8%**	**48.2%**	**17.4%**	**40.6%**
Total				
Total bills paid in the year	**64,952**	**222,304**	**94,524**	**220,181**
Total bills paid within target	**49,007**	**175,765**	**34,263**	**136,153**
Percentage of bills paid within target	**75.5%**	**79.1%**	**36.2%**	**61.8%**

2.3.3 Statement of compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

2.3.4 Income disclosures as required by section 43(2A) of the NHS Act 2006

The Trust has met the requirement of Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), in that its income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provisions of goods and services from other purposes. The impact of other income which the Trust has received has been invested in the provision of goods and services for the purposes of the health service in England.

2.4 Well Led framework

2.4.1 Well Led Framework

The Trust has had regard to NHS Improvement's Well Led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, its board assurance framework and the governance of quality. Further details are provided below and in the Annual Governance Statement. No material inconsistencies have been identified between the Annual Governance Statement, Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any subsequent action plans. During the year the Trust received unannounced visits from the CQC and Health and Safety Executive (HSE) which resulted in regulatory action. Regular reports have been provided to the CQC and HSE to demonstrate traction against issues raised and regular reports provided to Assurance Committees and the Board. Work is underway within the Trust to prepare for the next CQC visit, which it is anticipated will take place in 2021/22.

In July 2020, January 2021 and March 2021 the Audit and Risk Committee and the Board received updates on progress against recommendations in the 'Well-Led' external governance review undertaken by Deloitte in 2019; this was commissioned by the Trust in 2018 after the CQC identified weaknesses in arrangements during their inspections. A further update on progress was received at the January and March 2021 Audit and Risk Committee. The Executive can confirm that the majority of recommendations have been addressed and are either closed or close to finalisation.

Any outstanding actions will be reflected in planning being taken forward early in the new financial year which will include the Board undertaking a self-assessment against the Well Led Key Lines of Enquiry (KLOEs), to outline the current position, to identify any gaps and plan any actions required.

Over the financial year: a new divisional structure was put in place. Work has taken place to:

- further strengthen clinical governance, corporate governance and risk management arrangements

- focus on encouraging and supporting staff to take local ownership and responsibility; to further refine the Board Assurance Framework to meet new organisational objectives and to reflect current strategic challenges and high-level risks

- further develop integrated performance reporting and assurance provided to the Board and its Sub-Committees; to improve internal and external communication and to ensure increased visibility of the Executive leadership team. Given the Covid-19 pandemic it has not been possible for Non-Executive Directors and Governors to regularly attend the Trust and as a result there has been an increase in engagement via virtual and electronic methods.

Significant progress has been made in respect of the Hospital Redevelopment Programme and its associated governance infrastructure. The Strategic Outline Case for a new hospital was approved in November 2020 and work is progressing on the Outline Business Case. The Trust has been successful in securing Health Infrastructure Partnership (HIP) accelerator capital funding which has supported the Trust to move forward at pace with key areas of work required to improve the estate infrastructure as the hospital decant programme, required to support the building of new facilities, progresses.

Throughout the year, the risks identified in the Board Assurance Framework (BAF) have supported forward planning and agenda setting for the Board and its assurance Committees and cover sheets for papers received have been updated to include relevant BAF references. In developing the refreshed BAF the Executive Team and then the Board participated in facilitated workshops to reshape the document taking a lead from the approach at CQC rated Outstanding Trusts, and to identify current risks to the Trust in meeting its strategic objectives. Given this was a year in which regulatory action was taken, this included some key operational in-year actions. The updated BAF was approved by the Board in November 2020 and progress against it received at assurance Committees.

2.5 Remuneration Report

2.5.1 Annual Statement on Remuneration

The Nominations and Remuneration Committee is a Committee of the Board, appointed in accordance with the Trust's constitution, and is responsible for determining remuneration and terms of service for the Executive Directors.

It provides recommendations to the Board with regard to:

- All aspects of salary, including bonuses and any performance related elements
- Provision for other benefits including pensions
- Arrangements for the termination of employment and other contractual terms, including associated risks

The Board of Directors Nominations and Remuneration Committee met four times during 2020/21. It comprises all Non-Executive Directors and the Chief Executive, except where it is dealing with the appointment or removal of the Chief Executive. The Committee is chaired by the Chair of the Trust Board. The Chief People Officer and the Trust Secretary are in attendance.

The Committee does not determine the terms and conditions of office of the Chairman and Non-Executive directors. These are decided by the Council of Governors.

Service contracts

Name	**Role**	**Term of Office**
Sir Amyas Morse	Chairman	Appointed October 2019 to September 2021
Prof Elisabeth Paice	Deputy Chairman	Appointed February 2014 - retired end of February 2021
Richard Whittington	Non-Executive Director and Senior Independent Director	Appointed October 2014 to September 2020, extended to end of June 2021
Dr Linda Burke	Non-Executive Director	Appointed April 2019 to March 2022
Janet Campbell	Non-Executive Director	Appointed August 2019 to July 2022
Catherine Jervis	Non-Executive Director	Appointed April 2019 to March 2022
Simon Morris	Non-Executive Director	Appointed May 2019 to April 2022

Name	Role	Date of appointment
Sarah Tedford	Chief Executive	In post during 2020/21 until 14 August 2020
Jason Seez	Deputy Chief Executive	In post throughout 2020/21 – was acting CEO from 15 August to 29 November 2020
Dr Catherine Cale	Medical Director	In post until 9 October 2020
Patricia Wright	Chief Executive	In post from 30 November 2020
Camilla Wiley	Chief Nurse	In post until 8 January 2021
David Meikle	Interim Director of Finance	In post until 31 January 2021
Tina Benson	Chief Operating Officer	In post throughout 2020/21
Tahir Ahmed	Director of Estates & Facilities	In post throughout 2020/21
Ema Ojiako	Internal Director of HR and Organisational Development	Acting up until 1 June 2020
Sue Smith	Chief People Officer	In post from 1 June 2020
Ms Gubby Ayida	Medical Director	In post from 14 October 2020 on 12-month secondment from Chelsea and Westminster NHS Foundation Trust
Melanie van Limborgh	Director of Nursing	In post from November 2020 on 12-month secondment from Chelsea and Westminster NHS Foundation Trust
Jon Bell	Chief Finance Officer	In post from 1 February 2021

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

Information to support discussion and decisions around Senior Managers' (i.e. Executives') pay is taken from benchmarking exercises undertaken by NHS Providers and information received from NHSEI. This data looks at roles in relation to headcount

and turnover of NHS and Foundation Trusts. The Nomination and Remuneration Committee uses data from Trusts of a similar size as a benchmark for these discussions.

Senior Managers Remuneration Policy

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

Chairman and Non-Executive Director Remuneration Policy

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

Expenses

No material expenses were paid to governors during the year 2020/21. Expenses paid to Non-Executives and Executives are shown in the senior managers' remuneration table within section 2.5.3.

2.5.2 Senior Managers' Remuneration

The Nominations and Remuneration Committee sets pay and employment terms for the Executive Directors and other senior staff designated by the Board.

In its assessment, the Trust follows guidance from NHSEI, and benchmarks against organisations with similar services and income.

Salaries are awarded on an individual basis, taking into account the skills and experience of the post holder and comparable salaries for similar posts elsewhere. Pay is also compared with that of other staff on nationally agreed agenda for Change terms.

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

2.5.3 Report on remuneration in 2020/21:

See tables below:

Single total figure table[3]

	Current financial year 2020-21						Previous financial year 2019-20					
Name and title	Salary and fees (in bands of £5,000)	Taxable benefits (total to the nearest £100)	Performance-related bonuses (in bands of £5,000)	Long-term performance-related bonuses (in bands of £5,000)	Pension-related benefits (in bands of £2,500)	Total	Salary and fees (in bands of £5,000)	Taxable benefits (total to the nearest £100)	Performance-related bonuses (in bands of £5,000)	Long-term performance-related bonuses (in bands of £5,000)	Pension-related benefits (in bands of £2,500)	Total
Sarah Tedford, Chief Executive (to August 2020)	190-195	500	0	0	0	190-195	200-205	0	0	0	95-97.5	295-300
Patricia Wright, Chief Executive (from November 2020)	60-65	0	0	0	122.5-125	185-190	N/A	N/A	N/A	N/A	N/A	N/A
Jason Seez, Deputy Chief Executive (to August 2020 and from November 2020); Acting Chief Executive between August - November 2020)	155-160	9,700	0	0	65-67.5	230-235	145-150	8300	0	0	137.5-140	295-300
Catherine Cale, Medical Director (to October 2020)	85-90	0	0	0	17.5-20	105-110	165-170	0	0	0	60-62.5	225-230
Gubby Ayida, Medical Director (from October 2020)	85-90	0	0	0	0	85-90	N/A	N/A	N/A	N/A	N/A	N/A
Tina Benson, Chief Operating Officer	135-140	0	0	0	87.5-90	220-225	35-40	0	0	0	87.5-90	125-130
Camilla Wiley, Chief Nurse (to January 2021)	100-105	0	0	0	72.5-75	170-175	55-60	0	0	0	85-87.5	140-145
Melanie van Limborgh, Director of Nursing (from November 2020)	40-45	0	0	0	90-92.5	130-135	N/A	N/A	N/A	N/A	N/A	N/A
David Meikle, Interim Director of Finance (to January 2021)	220-225	0	0	0	0	220-225	N/A	N/A	N/A	N/A	N/A	N/A
Jon Bell, Chief Finance Officer (from February 2021)	25-30	0	0	0	0	25-30	N/A	N/A	N/A	N/A	N/A	N/A
Ema Ojiako, Acting Chief People Officer (to May 2020)	15-20	0	0	0	0	15-20	15-20	0	0	0	32.5-35	45-50
Sue Smith, Chief People Officer (from June 2020)	75-80	0	0	0	155-157.5	230-235	N/A	N/A	N/A	N/A	N/A	N/A
Tahir Ahmed, Estates Director	140-145	0	0	0	12.5-15	150-155	115-120	0	0	0	0	115-120
Terry Roberts, Director of People (to February 2020)	N/A	N/A	N/A	N/A	N/A	N/A	90-95	5000	0	0	32.5-35	125-130
Dean Spencer, Chief Operating Officer (to June 2019)	N/A	N/A	N/A	N/A	N/A	N/A	30-35	0	0	0	0	30-35
Melissa Mellett, Chief Operating Officer (September 2019 to December 2019)	N/A	N/A	N/A	N/A	N/A	N/A	30-35	0	0	0	55-57.5	85-90
Jenny Greenshields, Chief Finance Officer (to March 2020)	N/A	N/A	N/A	N/A	N/A	N/A	125-130	0	0	0	75-77.5	200-205
Siobhan Gregory, Interim Chief Nurse (May 2019 to August 2019)	N/A	N/A	N/A	N/A	N/A	N/A	30-35	0	0	0	0	30-35

[3] 1. Does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table below provides further information on the pension benefits accruing to the individual. 2. The salary for the former Chief Executive contains a payment for lieu of notice. £101k was paid to cover a six month notice period. 3The Medical Director and Director of Nursing are on secondment from Chelsea and Westminster NHS Foundation Trust. The Chief People Officer has been recharged at 50% to Chelsea and Westminster since November 2020. Her total salary is £101,030. 4. Non-Executive Directors do not accrue pension benefits for their role.5. The interim Director of Finance was employed through the agency route. The cost here is the cost to the Trust, but includes agency fee and VAT.

Sir Amyas Morse, Chair	45-50	0	0	0	0	45-50	20-25	0	0	0	0	20-25
Prof Lis Paice, Non-Executive Director and Deputy Chair (to February 2021)	15-20	0	0	0	0	15-20	25-30	0	0	0	0	25-30
Linda Burke, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Janet Campbell, Non-Executive Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Catherine Jervis, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Simon Morris, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Richard Whittington, Non-Executive Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Richard Sumray, Chair (to July 2019)	N/A	N/A	N/A	N/A	N/A	N/A	15-20	0	0	0	0	15-20
Soraya Dhillon, Non-Executive Director (to December 2019)	N/A	N/A	N/A	N/A	N/A	N/A	5-10	0	0	0	0	5-10
Rima Makarem, Non-Executive Director (to May 2019)	N/A	N/A	N/A	N/A	N/A	N/A	0-5	0	0	0	0	0-5
Carl Powell, Non-Executive Director (to April 2019)	N/A	N/A	N/A	N/A	N/A	N/A	0-5	0	0	0	0	0-5

Total pension entitlement table[4]

[4] Executives marked as N/A in all columns are not members of the NHS pension scheme.
The former Chief Executive and former Chief Nurse took retirement in 2020/21, hence their Cash Equivalent Transfer Value (CETV) is zero.
A CETV for the current Chief Executive was requested from NHS Pensions, but is not available.
The Trust has not made contributions in respect of directors to any stakeholder pension schemes, hence this is not applicable.

	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 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
Sarah Tedford, Chief Executive (to August 2020)	0	0	45-50	140-145	1154	0	0	N/A
Patricia Wright, Chief Executive (from November 2020)	5-7.5	17.5-20	65-70	200-205	1511	0	0	N/A
Jason Seez, Deputy Chief Executive (to August 2020 and from November 2020);	2.5-5	2.5-5	60-65	125-130	958	82	1051	N/A
Catherine Cale, Medical Director (to October 2020)	0-2.5	0	70-75	160-165	1195	21	1230	N/A
Gubby Ayida, Medical Director (from October 2020)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tina Benson, Chief Operating Officer	5-7.5	5-7.5	50-55	105-110	785	95	890	N/A
Camilla Wiley, Chief Nurse (to January 2021)	2.5-5	15-17.5	50-55	170-175	1111	0	0	N/A
Melanie van Limborgh, Director of Nursing (from November 2020)	2.5-5	12.5-15	35-40	105-110	752	122	883	N/A
David Meikle, Interim Director of Finance (to January 2021)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jon Bell, Chief Finance Officer (from February 2021)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ema Ojiako, Acting Chief People Officer (to May 2020)	0-2.5	N/A	0-2.5	N/A	1	0	1	N/A
Sue Smith, Chief People Officer (from June 2020)	5-7.5	15-17.5	35-40	90-95	763	189	961	N/A
Tahir Ahmed, Estates Director	0-2.5	0	30-35	55-60	488	25	518	N/A

Fair Pay multiple

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

	2020/21	2019/20
Band of highest paid director's remuneration	220-225k	200-205k
Median remuneration	28,793	27,636
Ratio	7.73	7.33

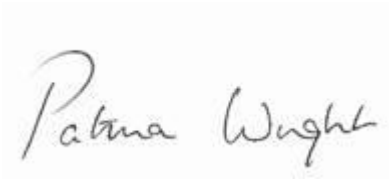
The banded remuneration of the highest paid director in the Trust in the financial year 2020/21 was £220k - £225k (2019/20, £200k - £205k). This was 7.73 times (2019/20, 7.33 times) the median remuneration of the workforce, which was £28,793 (2019/20, £27,636). The increase in multiple resulted from an agency director being paid at a higher band than the highest paid director in 2019/20.

In 2020/21 no (2019/20, none) employees received remuneration in excess of the highest-paid director.

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.

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

Signed,



Patricia Wright 8 July 2021

Chief Executive

The Hillingdon Hospitals NHS
Foundation Trust

2.6 Staff Report

2.6.1 Staff costs

	2020/21			2019/20
Pay element	**Permanent (£k)**	**Other (£k)**	**Total (£k)**	**Total (£k)**
Salaries and wages	135,857	16,899	152,756	146,442
Social security costs	14,635	1,414	16,049	15,302
Apprenticeship levy	648	97	745	719
Employer contributions to NHS Pension Scheme	16,334	546	16,880	16,156
Additional contributions to NHS Pensions funded by NHS England	7,282	240	7,522	7,188
Pension costs - other	52	-	52	51
Termination benefits	-	-	-	-
Temporary staff costs	-	13,439	13,439	9,697
Total gross staff costs	**174,808**	**32,635**	**207,443**	**195,555**
Less recoveries in respect of seconded staff	- 1,811	-	- 1,811	- 1,751
Total staff costs	**172,997**	**32,635**	**205,632**	**193,804**

2.6.2 Average staff numbers

	2020/21			2019/20
Staff group	**Permanent**	**Other**	**Total**	**Total**
Medical and dental	483	60	543	541
Administration and estates	739	95	834	801
Healthcare assistants and other suppory staff	617	85	702	732
Nursing, midwifery and health visiting staff	943	111	1,054	1,062
Scientific, therapeutic and technical staff	312	27	339	347
Healthcare science staff	55	8	63	64
Total staff numbers	**3,149**	**386**	**3,535**	**3,547**

2.6.3 Exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	0	1	1
£10,000 - £25,000	0	0	0
£25,001 - £50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	1	1
Total number of exit packages by type		2	
Total resource cost		105,439	

As stated in the table below, both exit packages settled by the Trust in year were contractual payments in lieu of notice.

	Number of agreements	Total value of agreement (£k)
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	105
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**2**	**105**
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

2.6.4 Off-payroll engagements

The Trust's policy is that off payroll arrangements should only be used on rare occasions where recruitment to key/specialist roles has not been possible. The use of any off-payroll arrangements are regularly reviewed to ensure that they are used for the shortest period of time possible. There were no individuals within the scope if IR35 in 2020/21.

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2021, earning £245 per day or greater	
Number of existing engagements as of 31 March 2021	2
of which	
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater	
Number of off-payroll workers engaged during the year ended 31 March 2021	2
of which	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in-scope of IR35	0
Subject to off-payroll legislation and determined as out of scope of IR35	2
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021	
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	20

2.6.5 Expenditure on consultancy

The Trust's expenditure on consultancy during 2020/21 was £6.5m compared with £4.2m in 2019/20. The amount of consultancy cost charged to revenue was significantly lower than in 2019/20 (only £16,000), as the Trust's Board composition was much more stable than in the prior year; but the amount charged to capital expenditure is significantly higher in year. The majority of these fees are for consultants and other advisers working on preparation of the Trust's outline business case for the new hospital development.

2.6.6 Recruitment and retention

The Trust has continued with a number of activities to reduce vacancy rates. This has included: several initiatives to maximise opportunities such as local, national and international recruitment drives, as well as guaranteed job offers for student nurses; a successful Health Care Assistant recruitment campaign and the launch of the Capital Nurse Project. The main focus has been to reduce the qualified nursing vacancy rate to 10% which, as at 31 March 2020, was 8.2 % with an overall Trust vacancy rate of 8.6%.

Recruitment time to hire has continued to reduce across all non-medical staff groups from 35.4 working days last year to an average 33.5 working days as of March 2021, which is just outside the Trust target of 33 working days.

Further plans are being developed to improve the candidate recruitment journey through better engagement during the on-boarding stage and also to work with the relevant departments to streamline the new starter processes in order to ensure 'day one readiness' for all new staff.

Retention of our staff remains one of the key priorities for the Trust. The Trust is putting actions in place to reduce turnover to 10%. This focuses on the following key themes:

- Improving training, career development and enhancing support from managers

- Creating advanced scope roles to provide attractive career pathways
- Improving how we gather feedback from new staff and staff who leave the Trust so we can understand and act on it better
- Widening and communicating our health, wellbeing and benefits offering
- Increasing the opportunities for working flexibly

As at the end of March 2021 the Trust had reduced voluntary turnover in the year from 13.3% to 11.7%.

Information on staff turnover:

Information on the Trust's workforce, including staff turnover, is available on the NHS Digital website.

2.6.7 Equality, Diversity & Inclusion

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

Work is continuing to progress in this area:

- Board oversight – a Non-Executive Director has been designated to work with the Chief People Officer
- Structure – a Black, Asian, Minority Ethic (BAME) Staff Group has been established, sponsored by the Chief Executive. It is chaired by a member of our BAME workforce
- Training – Equality, Diversity & Inclusion training, which incorporates the Equality Act legislation, is compulsory for all staff
- Reporting – the Trust complied with all national reporting (e.g. Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender pay equality) as well as taking part in the WRES data collection and processes across London
- Staff Support – in addition to the Freedom to Speak Up Guardian, the Trust has established a diverse range of staff who are designated Freedom To Speak Up (FTSU) Champions and CARES Ambassadors offering support to other staff members to address issues within the workplace
- Interpreting Service – the Trust has an Interpreting Policy and uses language line for its interpretation and translation services. The interpreting services ensure staff members meet the needs of clients whose first language is not English or who have sight or hearing impairment

- Chaplaincy Services – the Chaplaincy Department seeks to offer high quality pastoral and spiritual care to all patients, carers and staff within the Trust. It is available to all and welcomes referrals from colleagues and carers alike. The Trust also has a designated staff chaplain and prayer room facilities
- Equality Impact Assessments – a policy and associated processes are in place, along with a staff training programme, that can be accessed for anyone who is not sure on how to conduct these
- Positive about Disability – in line with the Workforce Disability Equality Standard

Workforce gender split

Gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

The Trust's gender pay gap information for 2020/21 is published in this annual report and the annual report summary, which can be found on the Trust's website.

As at 31 March 2021 the total relevant paid workforce was 3,500 staff across all sites and staff groups.

Gender	Number of Staff	% split of the workforce
Male	827	23.6%
Female	2673	76.4%

Senior Managers

	Female	Male
Directors	5	3
Senior Managers (Band 8a+)	51	35

Average and median hourly rates

Gender	Average hourly rate	Median hourly rate
Male	£23.00	£17.88
Female	£18.96	£16.47
Difference	£4.04	£1.41
Pay gap %	17.57%	7.87%

The gender pay gap when expressed as a mean average shows that female staff earn 17.57% less than male staff. This equates to a difference of £4.04 per hour. The gender pay gap when expressed as a median average shows that female staff earn 7.87% less than male staff. This equates to a difference of £1.41 per hour.

Bonus gender pay gap by hourly rate

For the purpose of this report the bonus payments referred to are those made to consultants in the form of clinical excellence awards (CEAs). As at 31 March 2021 there were 193 consultants at the Trust of which 50.8% were male and 49.2% female.

Gender	Average bonus pay	Median bonus pay
Male	£14,149.22	£8,143.20
Female	£7,917.73	£6,032.03
Difference	£6,231.50	£2,111.17
Pay gap %	44.0%	25.9%

Proportion of males and females when divided into four groups ordered from lowest to highest pay

Quartile	Female	Male	Female %	Male %
1 (Low)	681	183	78.8%	21.2%
2	684	182	79.0%	21.0%
3	717	147	83.0%	17.0%
4 (High)	587	281	67.6%	32.4%

2.6.8 Performance and development

a) Performance and development reviews (PDRs)

During the year, staff have, where possible, had their PDRs completed and we are currently at 82.5% compliance. Work is underway to include Health and Wellbeing in the PDRs for the coming year.

Under guidance from the General Medical Council and Health Education England, Medical staff appraisals at the Trust were placed on hold from mid-March to September 2020. Throughout the period of the pandemic, the Trust sought to offer a supportive and non-pressurised approach to the completion of appraisals. Once the programme was re-started, doctors were encouraged to complete an appraisal if possible, but it was understood that due to Covid-19 this may be difficult. It was communicated that it was acceptable to have the meeting without the normal amount of supporting information, and to look at it as opportunity to reflect and discuss with the appraiser how Covid-19 has, and continues to have, an effect on personal performance and the delivery of care.

If doctors felt they were unable to complete an appraisal, they were asked to let us know so that it could be recorded accurately on the appraisal system and our records. These appraisals are marked as cancelled/approved due to Covid-19.

b) Professional development

In response to Covid-19, all core skills training (statutory and mandatory) was moved to on line delivery, with the exception of Moving & Handling and Basic Life Support. Compliance was 89% overall as at the end of March 2021 compared to the required target of 90% with 16 of the 20 core skills within their respective targets. Additional (non-core) topics have also been made available via our eLearning platform over the past year with positive feedback from staff regarding flexibility of access.

In support of the Trust's Wellbeing strategy, the Trust also launched resilience training utilising the Insights Discovery model. This training is now integral to the

leadership and preceptorship programmes with additional provision made for team-specific interventions.

See Transformation section (section 1.4.4) for further detail on Cares + and training.

c) Leadership development

We launched our Senior and Top leaders' programmes with HULT Ashridge Executive Business School and currently have five staff undertaking an MBA and 15 staff undertaking an MSc in Leadership.

In addition to beginning to scope our new Talent management strategy, we also developed two new leadership programmes, linked to our Trust priorities and aimed at multidisciplinary cohorts. Both courses - Emerging Leaders and Established Leaders - were placed on hold during the second wave of Covid-19, but we are now arranging to run these as virtual sessions when possible. These programmes are designed to support participants to implement transformation projects combined with learning around leadership principles.

We have also been using this time to scope a new Management Fundamentals programme, utilising the Apprenticeship Levy, to ensure new and existing managers are equipped with the necessary skills and knowledge at the earliest opportunity.

d) Recognition schemes

Throughout the pandemic, we have recognised staff demonstrating our CARES values and going above and beyond in their contribution to the Trust, through our Star of the Week awards. In addition, members of staff have received a personal Thankyou card and NHS Heroes badge plus a small token of appreciation from the Chairman and Executive Team in recognition of the challenges they have faced and overcome during the Covid-19 pandemic.

e) Apprenticeships

Clinical and non-clinical apprenticeships continue to be used in the Trust to support and develop staff in their roles. As at 31 March 2021, there are 51 'live' apprenticeships. Additional work is being conducted in partnership with Chelsea and Westminster NHS Foundation Trust to explore further opportunities on how to expand the range of apprenticeships available to junior staff in the Trust.

f) Work experience

Work Experience was put on hold during 2020/21 for students coming into the hospital. We have, however, worked across the North West London system to develop a virtual work experience programme in partnership with ‘Springpod’ –

which comprises ten hours of interactive online learning and webinars to enable students to understand different careers in the NHS. The initial areas have been Nursing & Midwifery, and Allied Health Professionals, and this year we are adding in Medicine and Support Staff.

2.6.9 Staff Engagement

Staff engagement is a key priority for the Trust and we recognise that ensuring our workforce is informed, consulted and empowered, will ultimately deliver improvements in the quality of patient care.

One of the Trust's core values is communication, and this has been particularly important in helping us to meet the challenges raised by Covid-19. Our range of well-established communications channels was expanded in 2020/21 to meet the increased need for guidance during the global pandemic and included: a daily all staff electronic newsletter that is linked to our intranet's news section; executive led briefings; an extensive intranet; use of social media platforms and a weekly blog.

The Trust launched a Covid-19 specific all staff newsletter distributed twice a day, Monday to Friday, and once a day on Saturday and Sunday during Q1 and into Q2 2020/21. This was to ensure that everyone working at the Trust had consistent access to the latest and most accurate information and employees were empowered to make any necessary adjustments to working practices. The Trust also embraced the opportunities afforded by technology to increase the reach and impact of existing engagement activity. The monthly Team Brief meeting is now run virtually, allowing the Trust to open it up to all staff members and to enable senior managers to discuss key updates on strategic priorities and organisational performance with all colleagues. As a result, attendance figures have significantly increased.

In 2020, the Trust launched a weekly virtual Q&A forum, offering staff an opportunity to speak directly with senior leaders, to raise any concerns and to discuss any decisions that may affect their interests. As Trust members, staff are invited to participate in the Annual General and Annual Members meetings. We also run an anonymous dialogue system called "SpeakInConfidence", which can also be used for the purposes of raising concerns.

In addition to activity open to all staff, The Trust runs a range of engagement events and forums for specific initiatives, which facilitate cross-departmental discussion and allow for focused feedback. For example: The Health & Wellbeing Forum.

The Partnership Agreement sets out the Trust's commitment to communicate, consult and negotiate with staff and their representatives on matters that affect their interests. The Trust has formal mechanisms in place to facilitate these processes including the

Trust Partnership Forum, the Joint Local Negotiating Committee for Doctors, and the Junior Doctors Forum.

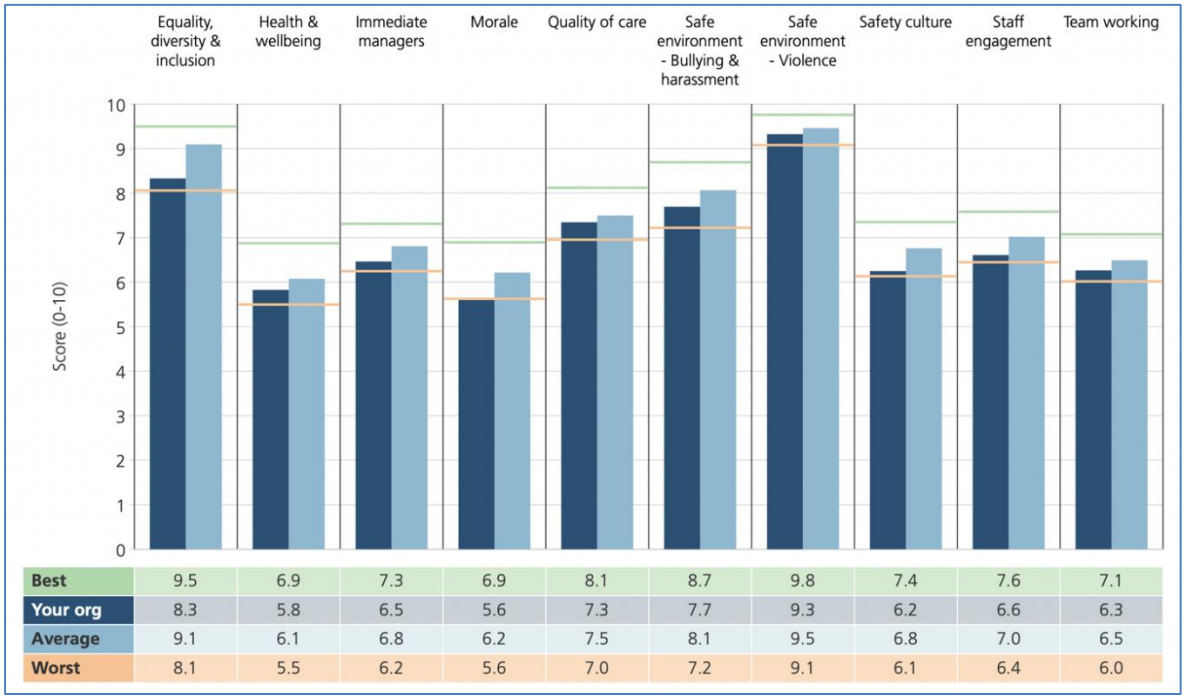
Staff Survey 2020

Towards the end of 2020, questionnaires were sent to the 3,388 staff who met the eligibility criteria set out by the NHS staff survey coordination centre. 1,457 staff took part in this survey, giving us a response rate of 43%.

The 10 key themes are listed below:

- Equality, diversity and inclusion
- Health and Wellbeing
- Immediate managers
- Morale
- Quality of care
- Safe environment (bullying and harassment)
- Safe environment (violence)
- Safety culture
- Staff engagement
- Team working

The following table shows the Trust and the average scores in 2020.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	8.3	5.8	6.5	5.6	7.3	7.7	9.3	6.2	6.6	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0

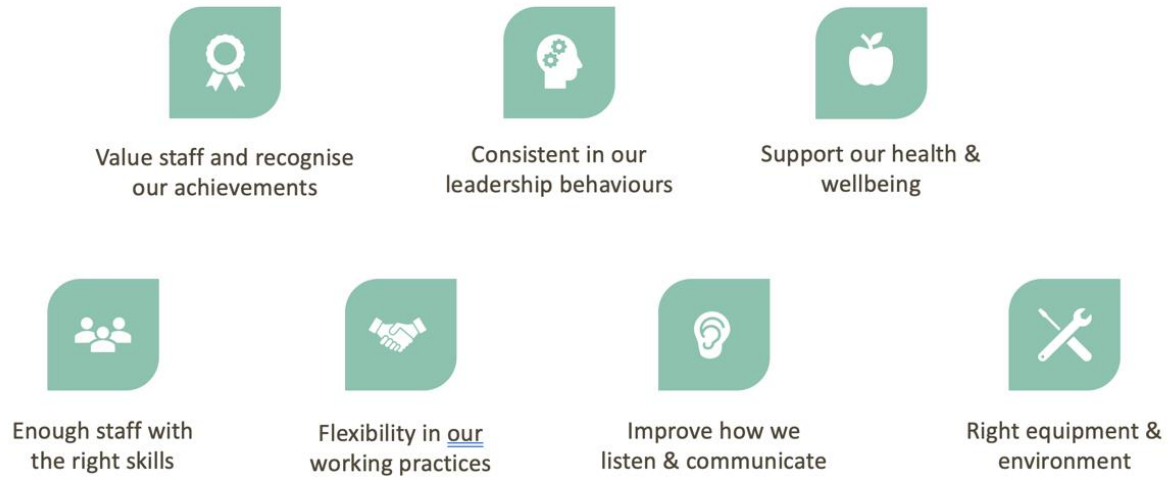
The detailed results of the 2020 staff survey show that the Trust position has deteriorated year on year across seven of the ten themes, with the exception of Health & Wellbeing, Immediate Managers, and Safe Environment (bullying and harassment).

Areas for improvements

An initial assessment of our results indicated the following five areas as focus for improvement:

- Equality, diversity & inclusion
- Health & Wellbeing
- Morale
- Safe environment (bullying & harassment)
- Safety culture

Staff engagement sessions in March 2021 confirmed the following areas for action, which will be developed into "*You said … We did*" actions plans:



Further engagement sessions were held in April 2021; feedback received will inform the development of a comprehensive action plan to address the issues raised.

2.6.10 Staff health and wellbeing

The Trust recognises that there is clear evidence supporting the link between staff health and wellbeing and safe patient care and is committed to continually working to improve the health and wellbeing of staff.

We believe individuals should be treated fairly in all aspects of their employment, including training, career development and promotion, regardless of disability or any

other protected characteristic. We aim to create a culture which respects and values individual differences and encourages individuals to develop and maximise their true potential.

As part of our response to Covid-19, we have worked in collaboration with the North West London system to develop a range of health and wellbeing interventions that address both the physical and psychological challenges facing our workforce.

These interventions and the personal risk assessment process in support of all staff, in particular those most vulnerable to the impact of Covid-19, have been overseen by our in-house Occupational Health and Wellbeing department which is in place to support both managers and staff by providing the full remit of occupational health services.

In accordance with the Trust policies on sickness absence and Equality and Diversity, the Occupational Health department offers advice to both managers and staff on appropriate working arrangements, which may include reasonable adjustment or modifications to working hours to accommodate a medical condition. Reasonable adjustments are specific to individuals and could include making adjustments to premises, duties, working hours or acquiring or modifying equipment. The Trust also seeks guidance from specialist external agencies, such as Access to Work, where necessary. The Trust is recognised as a disability confident employer and is committed to promoting equality of access, opportunity and treatment for candidates and employees.

The Trust's recruitment and selection policy ensures that all applicants who declare a disability and who meet the essential criteria are offered an interview, and adjustments are made as part of the selection and/or interview process. The Trust also has specific guidance for line managers to support staff who acquire a long-term medical condition or disability during their employment.

Sickness absence data

A full breakdown of sickness absence data is available via the NHS Digital website

2.6.11 Health & Safety

During this reporting period Health & Safety at the Trust experienced some notable progress in further developing its strategic agenda. Undoubtedly though, focus for the greatest part of the year, has been on the Covid-19 pandemic response, disrupting some of the more traditional Health & Safety work streams.

a) Health & Safety governance

The Trust Health & Safety Committee was relaunched on 4 March 2020, chaired by the then Trust Chief Executive Officer. From 1 April 2020, the Committee

thereafter has met on seven occasions to drive the pace of the Health & Safety agenda. Reports were provided to the Audit and Risk Committee on 16 July 2020, 20 October 2020, and 26 January 2021.

A large part of the Committee's focus since the relaunch, has been on improving engagement, reporting and getting the basic functions of Health & Safety across the organisation to a more stable place. Notwithstanding Covid-19 pressures, Committee attendance has been very positive, with good representation from divisions, support functions and specialist leads.

b) Health & Safety Training

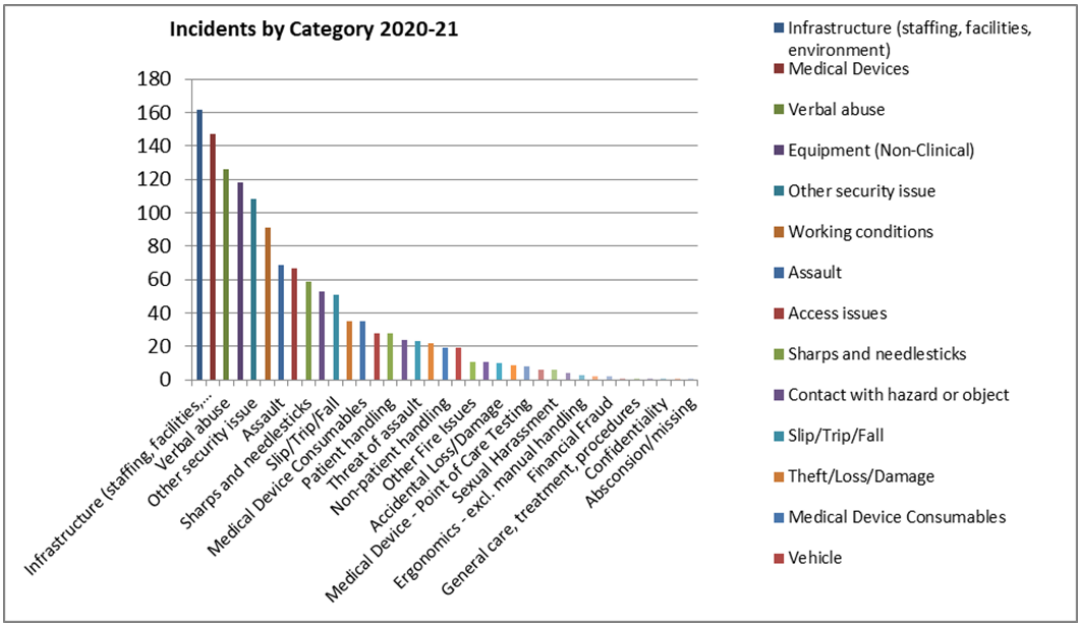
Among a range of other Health & Safety related training, the Committee closely monitors the key Statutory Mandatory (STaM) subjects of 'Health, Safety and Welfare', 'Manual Handling' and 'Fire Safety'.

Health, Safety and Welfare continued to meet the Trust's target of 90% throughout the year. However, both Manual Handling and Fire Safety training experienced temporary drops in face to face delivered training compliance, due to classroom restrictions and shielding staff throughout the pandemic. Once appropriate solutions were implemented, compliance was restored to over 90% and 80% respectively.

Work is still underway to implement and monitor Health & Safety training for departmental safety representatives, and improve Health & Safety responsibility awareness among line managers. Additionally, Health & Safety training for the Board was scheduled for and delivered in April 2021.

c) Health & Safety Related Incidents

With the exception of 'Equipment (Non-Clinical)' the top five categories of Health & Safety incidents reported have remained in line with 2019/20 trends. Other notable trends include a reduction in reported Assaults, Verbal Abuse and Medical Devices incidents, but a rise in reported incidents related to Infrastructure (staffing, facilities, and environment).



32 incidents (compared to 11 for all of the previous year), were reported to the Health & Safety Executive (HSE) under the Injuries Diseases and Dangerous Occurrences Regulation (RIDDOR) 2013. Of these, 23 were directly related to Covid-19.

d) Challenges and Highlights

At the start of the Covid-19 pandemic, the Trust took a proactive approach to setting up its Covid-19 environmental risk assessment programme and advancing its Fit Mask Testing efforts. The CQC's unannounced inspection in August in 2020 and CQC/HSE joint inspection in September 2020, which identified failings in IPC and Health & Safety practice, only served to strengthen the Trust's resolve to improve: to do better by our staff, patients and visitors during the pandemic.

The Trust has already satisfied the HSE and the CQC on a number of fronts, via tangible evidence of improvements in safety arrangements, and in compliance performance. Our approach included:

- Revising our standard operating procedures to ensure they are more robust in regard to our fit testing processes and reusable respiratory protective equipment (RPE) maintenance

- Setting up systems and processes in which we can more effectively undertake, record, monitor and report on reusable RPE maintenance compliance

- Improving storage facilities for reusable RPE in the Emergency Department, so that they can be kept more safely (minimising the risk of damage and cross contamination) when not in use

The ambition is not only to further improve, but to set the standards for our sector neighbours, and further afield.

Similarly, work is ongoing to improve the standard of fire safety across the Trust, and meet the expectations set out by the London Fire Brigade in January 2020.

Overall, there is ongoing work to identify, monitor and address Health & Safety gaps and provide improved assurance. The Trust recognises that a greater level of robustness is needed in particular areas such as, but not limited to, risk assessments, contractor management and monitoring and compliance reporting. However, in the coming year there will also be a greater emphasis on empowering new and existing managers, to confidently and competently discharge their Health & Safety duties.

2.6.12 Freedom to Speak Up

The Trust follows the National standard integrated 'Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS' issued by NHS Improvement and NHS England in 2016. The Trust has undertaken a review of this policy and revised processes making this clearer and easy to follow.

Speaking up is about anything that gets in the way of delivering safe, excellent care. Workers wellbeing and their concerns about colleagues and patient safety; potential fraud; individual or systemic bullying as well as ideas for improvement are all included.

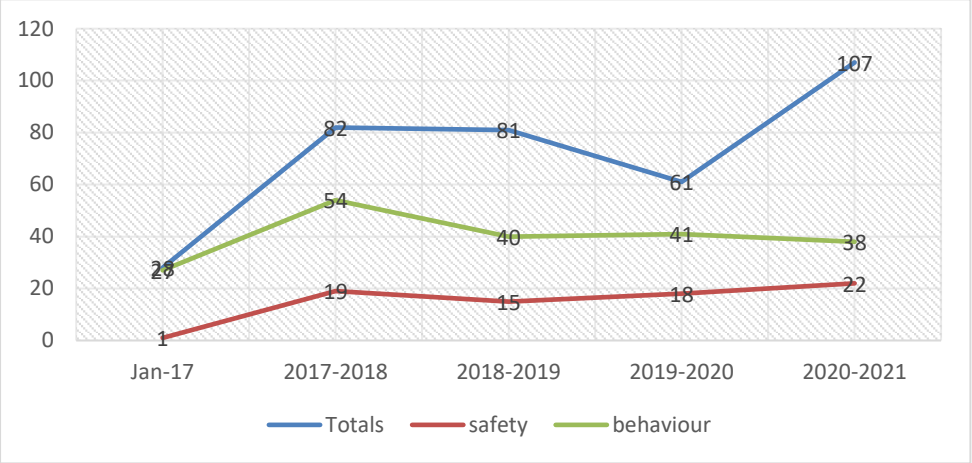
A positive speaking up culture leads to better care for patients and improves workers' wellbeing. The Hillingdon Hospitals NHS Foundation Hospitals Trust Board is committed to an open and honest culture and recognises the importance of enabling staff to speak up about any concerns at work, in order to improve services for all patients and the working environment for staff.

The culture and processes that make speaking up possible must be underpinned by the knowledge of how to speak up and how to respond when someone does. To ensure that Freedom to Speak Up is embedded in every service, every team and every worker, the Trust is dedicated to providing the level of knowledge to all workers through training modules, in accordance to national directive (2019).

In most circumstances, concerns are raised and resolved informally through the management structure of the Trust. A number of other options are available to staff who do not feel able to raise concerns in this way, including access to the Trust appointed Freedom to Speak Up Guardian (FTSUG) and visible Champions.

The FTSUG has handled over 360 concerns raised by members of staff since January 2017, from a variety of professional backgrounds and professional levels. Year on year comparison and the main category of concerns raised are detailed in the graph

below. It is worth noting that about 30% of the cases during 2020/21 were related to the Covid-19 pandemic.



This graph shows **total concerns** year on year, elements of **patient safety** and **behaviours** not in line with Trust

The FTSUG acts as an independent and impartial source of advice to staff at any stage of raising a concern, and has access to anyone in the organisation, including the Chief Executive, or if necessary, outside the organisation. The FTSUG operates both locally and regionally on behalf of the Trust - this includes awareness presentations and planned events during speaking up months locally and participating in regional and national events.

2.6.13 Trade Union Facility Time

The Trust acknowledges the importance of partnership working between management and recognised Trade Unions. Partnership working provides a clear framework for consultation, negotiation and decision-making where our Trade Unions can have a proactive role in matters of strategic importance that affect the workforce.

It also enables joint ownership of problems and solutions to get the best outcome for the Trust, patients and our people to ensure delivery of high-quality patient care and a positive working environment for staff.

In line with the Trade Union (Facility Time Publication Requirements) Regulations, which came into force on 1 April 2017, Trade Union representatives are required to record their paid time off to carry out Trade Union duties and the Trust is required to publish this information on an annual basis. To comply with the regulations the Trust is required to publish the data included in the following four tables. This data relates to facility time recorded between the period of 1 April 2020 to 31 March 2021.

Number of employees who were relevant union officials during the relevant period, and the number of full-time equivalent employees

	2020/21
Number of employees who were relevant union officials during the relevant period	7
Number of full-time equivalent employees as at 31 March 2021	3,173

Percentage of time spent on facility time for each relevant union official*

	2020-2021
0%	
1 - 50%	7
51 – 100%	

*Where no information on facility time has been provided by a Trade Union representative this has been included in those recorded as 0% of time spent on facility.

Percentage of pay bill spent on facility time

	2020/21
Total cost of facility time	£5451.23
Total pay bill	£343,088.63
% of total pay bill spent on facility time (total costs of facility time/total pay bill x100)	1.6%

2.6.14 Countering fraud and corruption

The Trust has an approved counter-fraud and corruption policy and does not tolerate any form of fraud, bribery or corruption by its employees, partners or third parties acting on its behalf. We investigate allegations fully and apply sanctions to those found to have committed a fraud, bribery or corruption offence.

The Trust's local counter-fraud specialist (LCFS) services are provided by a shared service (jointly between Guy's and St. Thomas's and South London and Maudsley Trusts) in accordance with Secretary of State directions. The Audit and Risk Committee formally approves the counter fraud annual work plan and progress reports are provided to the Committee at each of its meetings.

2.7 NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework considers 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 1–4, where 1 reflects providers with maximum autonomy and 4 reflects providers receiving the most support. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Trust has been placed in segment 3. This segmentation information is the Trust's position as at 27 May 2021. Current segmentation information for all NHS providers is published on the NHS Improvement website at NHS England » Single Oversight Framework: segmentation.

The NHS Oversight Framework disclosure has been simplified for 2020/21; there is no requirement to disclose use of resources ratings for the year. As such, the table containing statistics for 2019/20 has been removed.

3. Annual Governance Statement

3.1.1 Scope of responsibility

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

3.1.2 The purpose of the system of internal control

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

3.1.3 Capacity to handle risk

The Trust is committed to a Risk Management Strategy and Policy which minimises risk to all of its stakeholders through a comprehensive system of internal controls, based upon the support and leadership offered by the Board of Directors, Committees, Trust Executive Management Board and Risk Management Group.

The Risk Management Strategy and Policy provides a framework for taking this forward. This is through internal controls and procedures which encompass strategic, financial, quality, reputational, compliance and Health & Safety risks. The aim is to ensure the safety of patients, staff and the public and to deliver quality, patient-centred services that achieve excellent results and promote the best possible use of public resources, through an integrated approach to managing risks from all sources. The strategy and policy also seeks to support consistency and standardisation through the gathering and dissemination of intelligence on risks and mitigation control measures amongst all staff.

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

The Board discharges its overall responsibilities for risk management through the assurances of its Audit and Risk, Quality and Safety, Finance and Performance, and People Committees as outlined in section 2.1 of this report. The Trust also has the following operational Committees in place:

Trust Management Board

The Trust Management Board (TMB) has been established by the Trust Board and is the executive decision-making Committee of the Trust, chaired by the Chief Executive. It is authorised to:

- investigate any activities within its Terms of Reference and to seek any information it requires from any member of staff to support it in fulfilling its duties. All members of staff are directed to co-operate with any request made by the Committee
- obtain outside legal or other independent professional advise as required, and to secure the attendance of outsiders with relevant experience and expertise that it considers necessary
- provide the Board with assurance concerning all aspects of setting and delivering the strategic direction for the Trust, and its associated clinical strategies
- ensure that there is appropriate integration, connection and liaison between individual clinical services, between clinical and corporate functions and between strategic and operational matters - within the Trust and between the Trust's academic partners
- support individual Directors and members of the Senior Leadership Team to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support and resolution of issues
- make management decisions on issues with the remit of the Trust Management Board (TMB)
- provide assurance to the Board, through consultation with appropriate other subcommittees as necessary, that the structures, systems and processes are in place and functioning to support the work of TMB as set out in its Terms of Reference

Risk Management Group

The Risk Management Group is responsible for ensuring, on behalf of the Trust Management Executive:

- that the risk management policy and processes are being followed
- risk management conforms with best practice standards
- risks are appropriately and consistently described, scored with actions in place to address any gaps in controls or assurances
- risks that meet the defined criteria are recommended for escalation onto the Corporate Risk Register
- advice and support on risk management is provided to divisions and corporate directorates

Divisional Governance Groups

The Divisional Governance Groups are responsible for:

- The risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks
- Developing, populating and reviewing their risks, drawing on risk processes within the services, to ensure that Service, Directorate and Divisional Risk Registers are kept up to date through regular review

The Risk Management Strategy ensures that risks are identified from the bottom up: risk registers are managed within each service line and corporate area. Risk identification, assessment and control is carried out locally with accountability through divisional Directors and review by the Risk Management Group (RMG).

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

Risks within the Board Assurance Framework and the Corporate Risk Register are aligned to the Sub-Committees of the Board and reported to these Committees at least quarterly as per the Committee's cycle of business.

Staff are trained and supported to manage risk in a way appropriate to their authority and duties through targeted training of individuals and access to the Trust's Patient

Safety, Health & Safety, and Governance Systems team. Guidance is provided in writing through the Risk Management Strategy and Policy. This includes the process to identify and manage local risks, the systematic means by which these local risks are escalated to Board level attention through the Corporate Risk Register and how risks are controlled and monitored. Further operational procedures for risk and incident management are referenced in the Risk Management Strategy and Policy which is available to all staff through the Trust's policy management system.

3.1.4 Risk Control Framework

Risk Management Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Appetite Levels

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

Risk Tolerance

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

The Board have agreed that all risks with a total risk score of 15 or above, have a consequence score of 5, could significantly impact the Trust strategic objectives or

cannot be mitigated solely by the division or corporate directorates will be considered for defining as Corporate Risks and as such require executive oversight. These will be agreed by the Risk Management Group for ratification by the Trust Management Board (TMB). The Risk Management Group is responsible for ensuring that Corporate Risks are managed and controlled in accordance with the Trust's risk appetite defined by the Board and within the Risk Management Policy.

3.1.5 The organisation's major risks

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

Against each of the strategic risks a responsible Executive Director is assigned to the risk and is tasked with identifying cause, impact, key control measures to mitigate the risk, means of assurance, actions to close any gaps and action review dates. Progress is reviewed at relevant assigned assurance Committees and the Board.

In 2020/21 the Trust identified six key strategic risks which could impact on the delivery of the Trust's strategic objectives and their supporting priorities as follows:

Strategic Objective 1	Quality – We will deliver consistent High-quality care
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor high quality care which results in consistent achievement of all relevant national and local quality standards: 1a failure to deliver safe care 1b failure to deliver good patient outcomes 1c failure to deliver good patient experience Note – key issues for the Trust in section 1.3 related to: • Maintaining adequate nurse staffing levels • Delivering high quality patient care with medical recruitment challenges and increased patient acuity
Strategic Objective 2	Workforce - Great Place to Work
Risk	Failure to continue to build on the culture and values we have developed, meaning that we do not become the 'Great Place to Work' in a competitive labour market

Strategic Objective 3	Performance – We will deliver the right care at the right time for our patients
Risk	Failure to ensure systems are in place to effectively plan, deliver and monitor service delivery in order to deliver consistent achievement of all relevant national performance and regulatory standards Note – key issues for the Trust in section 1.3 related to: • Performance against Constitutional Standards
Strategic Objective 4	Money - We will live within our means
Risk	Failure to maintain the financial sustainability of the Trust and the services it provides Note – key issues for the Trust in section 1.3 related to: • the scale of investment required to improve the Trust's fragile estate infrastructure • effectiveness of the financial control system or inability to achieve the financial plan
Strategic Objective 5	Well Led – We will empower our people to deliver
Risk	Failure to embed effective corporate and clinical governance systems and structures Note regulatory action which took place in 2020/21 is covered here, in annual report section 3.2.7 and in BAF risks 1 and 6
Strategic Objective 6	Quality – estates related in support of quality - We will deliver consistent high-quality care
Risk	Failure to maintain safe estate in a sustainable way to support the delivery of high quality, efficient care in the short and medium term in line with the planned opening of the new hospital in 2025 Note – key issues for the Trust in section 1.3 related to: • Poor condition of our estate

3.1.6 Quality Governance Arrangements

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

- monthly reporting to the Board in the form of an integrated quality and performance report with exception narrative
- presentations on clinical and quality governance issues (including discussion on risk areas, performance reviews against key quality indicators and progress of work in relation to learning from clinical incidents and clinical audit) are considered at every Quality and Safety Committee (QSC) meeting
- detailed discussions took place at QSC meeting on key issues during the year including those related to Covid-19 response, and the aims of the Quality and Safety Improvement (QSI) Strategy. Any external quality and safety intelligence is presented at the QSC, and a summary of performance against the QSI strategy annual action plan is also reported
- clinical divisional governance boards review quality data in relation to patient safety, patient experience and clinical effectiveness on a monthly basis
- a process of reporting the investigation of Serious Incidents (SIs) and the related follow up of outcomes and action plans via a weekly Serious Incident Review Group (SIRG). Root cause analysis is used and forms the basis of SI reports together with the creation of action plans which are monitored by divisional governance boards through to completion.
- the Trust is reviewing the system of complaints management, with the aim of instituting auditable and proven learning where complaints are received. This will be related to other forms of patient feedback
- the Executive and Senior Management Team make regular visits to clinical departments where they have the opportunity to talk to staff and patients about their experiences
- a robust framework is in place to ensure that all service changes are subject to a Quality Impact Assessment (QIA) which is reviewed and signed off by the Medical Director and Director of Nursing to ensure appropriate actions are being taken to mitigate any associated risks to quality
- listening to patients and Governors: A range of opportunities exist to support patients in providing feedback and raising their concerns. This is welcomed by the Trust as a learning organisation striving for quality improvement
- opportunities exist for patients and members of the public to attend the Council of Governors and Trust Board meetings. Patients have been involved in reviewing patient information leaflets and Trust publications. The Hospital Redevelopment Public Partnership Forum (HRPPF) ensures that the patient voice is a central part of shaping the plans to build a new hospital. Members attend virtual meetings and are an active member of the Forum, bringing their

experience and ensuring that the public voice is represented and considered as part of our decision making.

3.1.7 Incident Reporting

Structured processes and systems are in place in respect of incident reporting, the investigation of Serious Incidents and following up outcomes from Board commissioned external reports. The Board, through the Risk Management Strategy and Policy and the Incident Policy, promotes open and honest reporting of incidents, risks and hazards. The Trust has a positive culture of reporting incidents enhanced by accessible online reporting systems available across the organisation. The latest available National Reporting Learning System (NRLS) report (covering October 2019 to March 2020) does not indicate any evidence of potential under-reporting at the Trust.

3.1.8 Serious Incidents

There is universal agreement across the Trust around the importance of protecting patients from avoidable harm. The Trust has clearly defined processes and procedures to follow which help to reduce the risk of these events occurring and recurring. However, where a Serious Incident (SI) does occur, the incident is investigated thoroughly through a process of root cause analysis (RCA). The RCA investigation leads to the development of associated and appropriate learning resulting in recommendations and actions identified to prevent reoccurrence.

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

The Hillingdon Hospitals Learning and Improvement programme (HiHLS) programme consists of a Safety Summit, and a monthly bulletin. The learning summit is held once a month and is open to all staff. There is a dedicated theme where staff will present SI and complaint cases. This is followed up by an open discussion into the cases presented and how the learning can be applied and cascaded throughout the Trust.

The monthly learning bulletin is cascaded to all staff and includes learning from the learning summit, SIs, complaints, claims and inquests, clinical audit and mortality reviews. The Trust also produces a quarterly consolidated learning report in order to triangulate themes which are presented to the Quality and Safety Committee.

3.1.9 Ensuring Safe Staffing

The Trust has a Safe Staffing policy in place, and workforce plans are developed at a Trust level on an annual basis. This process ensures input from relevant clinical, operational and corporate teams, making plans reflective of the clinical environment and issues affecting the Trust as a whole.

Workforce plans form part of divisional business plans and are reviewed as part of the quarterly divisional review process. Progress with achievement of the deliverable outcomes of the workforce plan (and the overarching Trust People Strategy) is reported via the People Committee and direct to the Trust Board. Workforce development and performance is also assured through the Board Assurance Framework.

Nursing establishments are set using evidence based tools, as presented in the National Quality Board (NQB) guidance. A real time electronic tool – 'SafeCare' supports the dynamic assessment of staffing demand and capacity taking into account patient acuity and dependency. This system is used daily to facilitate the effective use of the nursing resource, safeguarding patient safety and allowing redeployment of staff in response to patient demand. As a result of the Covid-19 pandemic and ongoing service reconfigurations, staffing models changed in line with national guidance to respond to the altered patient cohort and increased demand on services.

The Quality and Safety Committee and the Trust Board receive a monthly paper reviewing average shift fill rates and care hours per patient day. These metrics are triangulated against patient centred outcome indicators such as falls, pressure ulcers and sub-optimal staffing incidents, in line with National Quality Board (NQB) guidance.

The Trust has continued to further strengthen the implementation of its e-rostering system to expand both e-job planning and e-rostering for all medical and clinical staff.

3.1.10 Engagement with Stakeholders

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

- Engagement with the local Healthwatch
- The Council of Governors, who are an integral part of our governance infrastructure as a Foundation Trust, are consulted throughout the year on key issues and risks as part of the annual operational planning process.
- Annual Members' Meeting
- Public members and local stakeholders are invited to join Trust staff to agree priorities for the Quality Report

- engagement with user and support groups, including the Maternity Voices Partnership, Patient-led Assessment of the Care Environment, and Stroke Forum
- Patients and members of the public are offered opportunities to attend the virtual Council of Governors and Trust Board meetings
- Patients are invited to review patient information leaflets and trust publications.
- The Trust continues to engage with patients and the public in respect of the patient safety and quality agenda and service improvement through CARES+

In 2020/21 the necessary operational focus on responding to the Covid-19 Pandemic resulted in the scaling back of some business as usual activity including temporary suspension of the Lay Strategic Partnership Forum. This will resume in 2021/22.

3.1.11 Emergency Preparedness Resilience and Response (EPRR)

This year has been like no other from a Major Incident perspective with the NHS as a whole responding to the single biggest challenge since its inception.

Throughout 2020 the Trust has re-focussed all operational areas to manage the reality of the Covid-19 virus with changes to clinical pathways, operational activity, workforce management and practice and Command and Control. EPRR has been central to this response.

The Trust recruited a full time Emergency Planning Lead at the end of 2019 with the new person starting on 6 April 2020. This resource has been focused upon the Covid-19 response during the peak of the first wave and following into the second, as well as improvements in the Trust Major Incident Plan, EPRR Assurance process and Vaccination Centre preparedness and operations.

The Trust was externally assessed against the 64 NHS EPRR Core Standards. The Trust was able to demonstrate a significant improvement from 2019 with a full level of compliance against 60 of the standards and a partial level of compliance against the remaining 4. This was an improvement from 78% to 94% compliant. There were no standards where a non-compliant rating was noted. The Trust was overall rated as having a Substantial level of compliance by NHS England a position that was welcomed by the Trust given the significant efforts taken and additional Covid-19 pressures experienced in 2020.

In 2021 the focus for EPRR activity within the Trust will be continuing to learn from the current pandemic and planning for future surges, expanding the training programme in place as well as reviewing core plans and Business Continuity arrangements.

3.1.12 Responding and recovering from the Covid-19 pandemic

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

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

The Trust also assessed and mitigated the risks associated with the impact of the Covid-19 pandemic on its strategic objectives via the Boards Assurance Framework and Corporate Risk Register.

The Trust maintained Mount Vernon Hospital as a 'green' site throughout the pandemic, which has greatly supported this approach.

3.1.13 Well Led Framework

The Trust has had regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance and in developing its approach to internal control, board assurance framework and the governance of quality. Further details are provided below. No material inconsistencies have been identified between the Annual Governance Statement, Corporate Governance Statement, the Annual Report and reports arising from CQC planned and responsive reviews of the Trust and any subsequent action plans. Work is underway within the Trust to prepare for the next CQC visit, which it is anticipated will take place in 2021/22.

In July 2020, the Audit and Risk Committee and the Board received an update against the action plan put in place to address recommendations from an external governance review commissioned by the Trust and undertaken in 2018/19. This confirmed all actions had been either been addressed or were significantly in progress. A further update on progress was received at the Audit and Risk Committee in January 2021 and the Board in March. This work, on historic issues, will now be closed down and outstanding actions reflected in next steps being taken forward by the Chief Executive in 2021/22, which will include undertaking a current self-assessment against the 'Well Led' Key Lines of Enquiry (KLOES), and in order to put in place refreshed actions to support the organisation to move to at least 'good' in this CQC domain.

The Trust took a robust project management approach to monitor the concerns raised by the CQC following its unannounced inspections in August and September 2020, and has a comprehensive action plan in place to ensure the issues identified in the report and notices are addressed. The progress against these actions is monitored regularly and is reported to at the Trust Management Executive, and at the Quality and Safety Committee and Trust Board.

Topics covered which have supported the Trust in the Well Led area across the year have included:

- further refinement of the Board Assurance Framework; review of Board sub-committee Terms of Reference
- standardisation of agendas, minutes, actions logs and forward planning, templates for cover sheets and papers for Board and Sub Committee meetings and work underway to refresh the committee and governance structures below board sub-committee level and to embed this standardisation
- approval of a refreshed clinical services strategy at the start of the financial year
- ongoing clinical engagement and pan organisation engagement in the hospital redevelopment programme which has passed strategic outline phase and is well on the way with the Outline Business Case; extensive work around the health and wellbeing agenda in support of staff
- detailed oversight of Covid-19 governance arrangements in the Board Sub Committees as required and in line with their respective remits
- strengthening financial controls: ownership and grip; provision of additional support to leaders and budget managers throughout the Trust via the introduction of tools such as the Capital manual and guidance and service line reporting, ensuring robust assurance arrangements throughout the year, whilst in response to Covid-19, and in line with national guidance; implementing 'governance light' arrangements at the outset of the pandemic and approved arrangements at the April 2020 Board meeting, revised and approved by the Board in January 2021. This resulted in some reduction of meetings and associated papers during phase 1 and 2 of the pandemic; however, scrutiny on key issues and assurance continued to be provided throughout this time with additional arrangements put in place

Areas that will be taken forward in 2021/22 include:

- Board and Executive development given changes which have taken place in the leadership team and the difficulties there have been with taking that work forward during 2020/21 given the pandemic
- work around Leadership, training and development across the organisation and responding to feedback from the staff survey which is beginning with a wide range of staff engagement events in April 2021

- developing a refreshed communications and stakeholder engagement strategy; addressing perceptions in some parts of the organisation around visibility of the Board and senior leadership team
- further development of our risk management systems and processes consolidating systems around risk management and compliance, our Quality Improvement Programme, and our strategic planning with the updating of our clinical services strategy and the development of plans for our new hospital as well as putting in place the new divisional structure
- strengthening the Trust's approach to addressing inequalities through appointments of an Electronic Data Interchange (EDI) lead, responding to the London WRES strategy, active involvement in the NWL inequalities programme of work and a review of, and re-energising of, the trust approach to the Diversity agenda

3.1.14 Care Quality Commission: compliance with registration requirements

The Trust is fully compliant with the Care Quality Commission registration requirements and has been issued with its certificate for 2020/21. The CQC has imposed conditions on the Trust's registration in respect of a regulated activity 'Treatment of disease, disorder or injury' as a consequence of issuing the Trust with a notice of decision under Section 31 of the Health and Social Care Act 2008.

The actions taken by The Trust to meet the requirements of the additional licence condition are described in detail in section 3.2.

3.1.15 Compliance with NHS Foundation Trust condition 4 (FT Governance)

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

3.1.16 Compliance with the Code of Governance

The Hillingdon Hospitals 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.

3.1.17 Information Governance

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

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

The Trust reported four incidents to the Information Commissioners Office (ICO) in 2020/21. Below are details together with the respective ICO's decisions:

a) April 2020 – Where there was water leakage from a floor above into the medical records library which resulted in damage to a number of patient files. The ICO has closed the case and advised that no further action would be taken
b) April 2020 - The Trust sent a centrally defined letter to a cohort of 4,808 patients who had been identified as high risk in relation to Covid-19. The letters went to the correct patients based on their names and addresses, however, a mail merge error resulted in all the letters having the NHS number and the salutation (i.e. Dear xxx) of the first patient on the list. The ICO has closed the case and advised that no further action would be taken
c) August 2020 - Parents of a baby (Baby A) found the discharge summary of another baby (Baby B) in their baby's red book. The discharge summary contained safeguarding information about the mother of Baby B. The ICO has closed the case and advised that no further action would be taken
d) December 2020 - A letter containing clinical patient data was sent to a wrong address, and was later delivered opened by an unknown party. Experian later contacted the patient informing them that they were at risk of identity fraud due to compromised personal data. ICO's action is still pending

In 2019/20 due to the Covid-19 pandemic, the submission date for the DSPT was extended from 31 March 2020 to 30 September 2020 for organisations which required it. The Trust had satisfactorily met all but one assertion and made its submission on 30 April 2020 with an Improvement Plan for the outstanding item. This was a significant improvement over the previous year's assessment. This year, NHS Digital has extended the submission deadline of the 2020/21 DSPT from 31 March 2021 to 30 June 2021. The Trust is working towards meeting all the requirements for the DSPT.

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

We have reported on the Trust's financial performance elsewhere in this Annual Report, and how the block funding arrangements in place during 2020/21 have allowed the Trust to report an improved financial position when compared with 2019/20. However, we need to recognise that the Trust still has financial challenges – and the Trust's historic financial performance evidences this.

Block and top up funding was paid in advance in months up to and including February 2021. This meant that the Trust was also relatively cash healthy for the majority of the year. However, as the effect of these advance payments has unwound during the year, the nature of the Trust's underlying cash flow issues has become clear. Reports to the Trust Board and Finance and Performance Committee (FPC) through the year flagged the likely need for emergency cash funding in March 2021 to cover the period when no contract payment was made by commissioners. The Trust received £10m to ensure that revenue creditors and staff were paid in a timely way in this period.

The Trust Board receives a monthly overview of the Trust's use of resources through the monthly finance report, allowing grip and control on financial performance and cost-effectiveness. Covid-19 withstanding, during 2020/21 the Trust has increasingly used various benchmarking sources and the improvement board to identify efficiency opportunities including Model Hospital, Getting it Right First time (GIRFT), Carter and local benchmarking across the system.

Where the Trust Board identifies key risks and issues in relation to the Trust's use of resources, it can instruct the FPC to undertake 'deep dive' reviews of such concerns to ensure that a sufficient degree of assurance exists. The oversight roles of the Trust Board and FPC are supplemented by the annual internal audit programme, which includes a comprehensive review of the Trust's financial systems and controls. The governance structure below the Trust Management Board provides opportunities through divisional meetings for teams to be challenged on their use of resources within the respective clinical services they provide.

3.1.19 Data Quality Governance

Pre-pandemic, the Trust had begun reviewing its data quality governance structure to replace the Data Quality Improvement Steering Group (DQISG) with a more agile approach to managing existing and emerging data quality issues. The pandemic accelerated that requirement and the data quality policy was updated in 2020/21 accordingly. The objective in setting up the new structure was to support 'data owners' to manage the data that they have responsibility for to improve data quality and for them to be able to provide assurance around any data that is reported either internally or externally as part of business as usual activity. A relevant executive lead has overall responsibility depending on the data reported.

Through this new structure, a number of data quality initiatives have already taken place on existing datasets improving data entry and flow around diagnostic waiting times (radiology and endoscopy pathways), maternity activity (Maternity Services Dataset, or MSDS, which underpins the now annual Clinical Negligence Scheme for Trusts Incentive Scheme) and Referral to Treatment.

During the pandemic however, a number of new local, regional and national reporting requirements have emerged and as knowledge about Covid-19 has developed over the year, those reporting requirements have been rapidly evolving. The more agile approach to data quality adopted in the new data quality policy allowed the Trust to respond to these new requirements in a timely manner. Key examples include the management of three daily national Situation Reports (Emergency Care, Covid-19 and Discharges) to support daily monitoring and the weekly Covid-19 Activity Return to support elective recovery.

New areas of data for the information team including staff testing, fit mask testing and vaccinations for Covid-19 have grown over the year too. Focus has been on creating a robust set of data flow and operational processes in order to provide accurate information, recognising that new digital systems needed to be implemented at pace to respond to imminent safety risks posed by the pandemic. These are regularly reviewed and improved upon as part of business as usual to fit the changing national circumstances and Trust needs.

Data Quality for the constitutional standards (A&E, elective and cancer pathways) remained a priority during the pandemic. Regional governance structures were put in place as part of a national pandemic response programme to ensure patient safety and reduction of hospital infection rates.

The Trust reports to the North West London (NWL) Elective Programme Board providing weekly standardised RTT Patient Treatment Lists (PTLs) for regional performance, decision making and data quality monitoring. Queries raised through this group are investigated and appropriately processed. Patient pathways are clinically risk assessed based on nationally agreed standards. Source Systems (including the main patient access system) are updated to allow recording and monitoring of new requirements.

Cancer pathways are closely scrutinised and risk assessed in line with their own national standards beyond those undertaken as part of RTT. The Trust is part of the West London Cancer Alliance hosted by the Royal Marsden NHS Foundation Trust, which provides support to the Trust and conducts benchmarking and data quality analyses. Queries are investigated to ensure data flow is accurate and any variance can be reasonably explained.

Data Quality within A&E is monitored through the national daily Urgent and Emergency Care Situation Reports, which are reviewed internally and regionally though the NWL

working Group and internal daily Emergency Care Data Set (ECDS) reports. Automated data flow procedures and Standard Operating Procedure documents have been reviewed this year, with a focus on reducing single points of failure and improving reporting consistency.

The scope of the 2020/21 internal Data Quality Audit has been agreed with the Trusts' internal auditors KPMG and is due to be submitted to the Audit and Risk Committee in June 2021. The Trust will work through the recommendations from this audit and will provide onward assurance that the Trust has implemented the actions required to address any recommendations.

3.1.20 Data Security

The Trust has committed to a series of cyber security projects to protect its data networks, clinical devices and the computing infrastructure. This programme of works has enabled the Trust to obtained Cyber Essentials Plus certification and compliance with the Data Security Protection toolkit.

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

The Trust received an Information Notice issued under the Network and Information Systems (NIS) Regulations 2018 in relation to the proportion of the device estate that was running the Windows 7 operating system. A project is underway to remove or upgrade all Windows 7 machines.

3.1.21 Register of interests for decision-making staff

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

3.1.22 Bribery

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

3.1.23 Equality, Diversity and Human Rights

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

3.1.24 Pension Scheme Regulations

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.

3.1.25 Modern Slavery

The Trust has a modern slavery statement on its website as required which is reviewed annually. At its meeting in March 2021, it was agreed that the statement required some additional focus on ethical procurement and a revised statement will be published following approval at the April 2021 Board meeting.

3.1.26 Overseas operations

The Trust does not have any overseas operations. The Trust has been preparing throughout the year for the eventuality of a no-deal Brexit through the Brexit steering group. On 24 December, the Trust received from Department of Health and Social Care (DHSC) details of the deal reached between the UK and the European Union; as well as some of the practical implications on Trust operations. This clarified the direction of travel on Brexit- related work streams across the Trust. The steering group continues to meet to manage the ongoing impact of Brexit.

3.1.27 Assessing our Impact on the environment

The Trust will continue to develop its sustainable management plans in line with the Climate Change Act and with regard to UK Climate Projections 2018.

The Trust is working to support the wider NHS in its commitment to making a significant contribution to the reduction of the UK's carbon and other noxious gas emissions, through two targets:

- NHS carbon footprint (emissions under direct control), to achieve net zero by 2040, with ambition for an interim reduction by 2028-2032
- wider NHS carbon footprint (Carbon footprint plus), which also includes the supply chain, to achieve net zero by 2045, with an ambition for an interim reduction of 80% by 2036-2039

The Trust assesses progress using the Sustainable Development Assessment Tool (SDAT) designed by the NHS Sustainability Development Unit (SDU). An initial report was completed on 28 September 2020; results show that the Trust has started contributing to some United Nations Sustainable Development Goals (UNSDG) and is making progress in most of them. Performance will continue to be assessed annually.

3.2 Update against the significant weaknesses identified in 2019/20 and 2020/21 review processes

The following potential weaknesses in arrangements have been identified through the Trust's 2020/21 review process and in response to issues raised through the 2019/20 audit. All risks arising are reflected on the Board Assurance Framework and regularly monitored through the Board Assurance Committees and Trust Board.

A number of these weaknesses were addressed in last year's annual reporting process, but significant disruptions to business as usual activity during the Covid-19 pandemic have impacted the organisation's ability to close some outstanding actions. Detailed updates are provided below.

Good progress has been made towards addressing the following weaknesses in arrangements during 2020/21; the Trust no longer considers them to be 'significant weaknesses' as at March 31 2021.

3.2.1 Fire Safety Enforcement Notice

The London Fire Brigade issued the Trust with an Enforcement Notice on 30 January 2020 due to several failures to comply with fire safety requirements. The notice was still in force at 31 March 2021.

An action plan has been agreed in consultation with London Fire Brigade and good progress has been made in the 2020/21 financial year; the enforcement notice is expected to be removed in December 2021 upon completion of the improvement works.

Update

Following receipt of the Enforcement Notice action, the Trust was asked to provide further detail on specific issues, including: fire risk assessments, means of detection and warning, equipment and clear access in corridors. These requirements were incorporated into one integrated action plan for fire safety, and significant progress against delivery has been made throughout the financial year.

- Meetings have taken place with the London Fire Brigade to develop a partnership approach and to review the action plan. A two-year programme of works was agreed and is due for completion by December 2021
- A Trust-wide Fire Safety Group, with wide membership, is in place. This reports into the Health & Safety Committee, who monitor the action plan, with regular updates received at Trust Management Board, Finance and Performance Committee and the Board
- A new electronic system for fire safety management, risk management and audit (British Approvals For Fire Equipment accredited) has been installed to support the actions needed to improve fire safety and fire training across the Trust sites
- The Trust was successful in its request to NHSEI for capital funding for fire precautionary works
- Refreshed fire marshal training was put in place during 2020 with an updated list of marshals and locations. Key Performance Indicators (KPIs) are recorded centrally by the training department
- Statutory and Mandatory training (level- 2 Fire Safety training) has been updated and delivered via e-learning. The level 2 course includes all necessary evacuation procedures required by Trust staff.
- During the year the fire suppression system to catering facilities was installed, a new mains dry riser system was also installed into the hospital's tower (wards) to enable London Fire Brigade sufficient water connections at all levels from either end of the tower, this enabled lift seven to be utilised as a firefighting lift. Desk top training exercises and planned evacuation routes and signage updated in April 2020, continued to be updated throughout the year.
- The Trust was successful in bidding for, and receiving £3m in 2020/21 to address fire safety requirements in the tower (which houses wards).

In accordance with the two-year action plan agreed with the London Fire Brigade the Trust is continuing to deliver the improvement programme. The delivery timelines will be dependent on a series of ward decants, but based on current projections, works are on track to be completed by December 2021.

The works specifically focus on maintaining:

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

3.2.2 Quality of performance data

The 2018/19 external audit value for money conclusion identified weaknesses in the Trust's arrangements to ensure the quality of performance data. The 2019/20 and 2020/21 assurance requirements on the quality report have been removed so there has not been a subsequent external audit assessment of improvements made in this area.

As part of its actions to address these issues pre-pandemic, the Trust had begun reviewing its data quality governance structure to replace the Data Quality Improvement Steering Group (DQISG) with a more agile approach to managing existing and emerging data quality issues. The pandemic accelerated that requirement and the data quality policy was updated in 2020/21 accordingly.

Update

The objective in setting up the new data quality governance structure was to support 'data owners' to manage the data that they have responsibility for, to improve data quality, and for them to be able to provide assurance around any data that is reported either internally or externally as part of business as usual activity. A relevant executive lead has overall responsibility depending on the data reported.

Through this new structure, a number of data quality initiatives have already taken place on existing datasets improving data entry and flow around diagnostic waiting times (radiology and endoscopy pathways), maternity activity (Maternity Services Dataset, or MSDS, which underpins the now annual Clinical Negligence Scheme for Trusts Incentive Scheme, and Referral to Treatment. Detailed information on the Trust's approach can be found in section 3.1.19.

The Integrated Performance Report has been continuously refined throughout the year and reviewed at Trust Management Board, the Assurance Committees and Board.

The scope of the 2020/21 internal Data Quality Audit has been agreed with the Trust's internal auditors KPMG and is due to be submitted to the Audit and Risk Committee in June 2021. The Trust will work through the recommendations from this audit and will

provide onward assurance that the Trust has implemented the actions required to address any recommendations.

The template, KPIs and performance reporting arrangements used within the Integrated Performance Report have been updated for re-launch at the start of 2021/22.

3.2.3 Financial Risk

The 2019/20 external audit conclusion identified pressures on financial sustainability that were not entirely within the control of the Trust, including the significant deficit that was incurred due to failure to secure sufficient Provider Sustainability Funding.

Update

The Trust has submitted a draft financial plan to NHSEI for the first six months of the financial year; this plan includes a breakeven position. The Trust received £10m in working capital support in 2020/21 to maintain cash balances and to pay creditors within agreed timeframes. If the Trust is able to deliver a breakeven plan, then it should not require further financial support in 2021/22.

3.2.4 Financial Management Arrangements

The 2019/20 external audit conclusion found evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Update

The Trust is undertaking a detailed planning process, within the parameters set out by NHSEI and in conjunction with its NWL ICS system partners, to ensure that the Trust and divisional plans are aligned and are consistent with the assumptions for service delivery during 2021/22. There has been considerable engagement with all the divisional teams to ensure the plans are robust and deliverable and delivery will be monitored through weekly and monthly divisional and Trust Committee meetings.

3.2.5 Condition of the Estates

The Trust is exposed to risks related to the age and condition of the estate that could impact levels of service provision.

A condition survey completed in February 2017, concluded that the cost to address the backlog was £211m for the total occupied estate (the second highest in England). The six-facet survey highlighted that 81% of the Hillingdon estate and 51% of the

Mount Vernon estate was in a condition that was ‘operational but major repair or replacement will be needed soon’. Therefore, the replacement of the hospital asset remains a key issue.

Due to limitations in available funding, the Trust has allocated only limited funding to capital developments. The Trust had capital additions in 2020/21 of £62.2m and plans capital expenditure of £57.2m in the 2021/22 financial year.

Actions

An Estates Risk Register is in place, which is monitored through Trust governance processes, with risks escalated to the Board Assurance Framework as required.

As a result of an audit undertaken in July 2019, the Trust received significant investment into the estates during the period of 2019-2021, including emergency capital funding of £16.5m to address business as usual estate statutory compliance matters. This lead to undertaking major infrastructure work to the following areas:

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

A programme of works for the upgrade of the Emergency Department at Hillingdon hospital started in 2018 and was completed by March 2021.

A further £4.9m improvement works programme was delivered to support Covid-19 pathway changes in the ED department during 2020/21. Key areas of work included the following:

- A new clinical ward block has been constructed to support a new 16 bedded ITU, a 24 bed respiratory ward, together with a modern 28 bedded inpatient ward on the ground floor
- A further 3 levels of modular ward facilities have been installed to the south of the hospital, this included 2 floors of inpatient accommodation and a modern children’s ward on the ground floor. The accommodation will be fully commissioned for use by September 2021
- Works to create a female changing facility for ED staff, which included modern changing area, shower and WC’s facilities co-located with ED

- A new main boiler was installed to provide much needed resilience to support the existing fragile infrastructure. The boiler was fully commissioned and operational by January 2020
- Modern generator backup facilities have been installed to the main hospital site at Hillingdon, providing reliable electrical backup if required

The Trust is now in the process of procuring and commissioning an up to date six facet survey for completion in 2021, to provide an update backlog maintenance position and cost.

In light of the significant challenges posed by the condition of the estate, the Trust has developed an ambitious plan for the construction of a new hospital building on the site under the Department of Health and Social Care's 'Health Infrastructure Plan'. The Trust's project plan has been identified as one of eight considered to be sufficiently developed in order to get the full go ahead in Phase 1, subject to successful completion of Outline Business Case (OBC) and Full Business Case (FBC) approvals.

The development of the new hospital will continue as a key NHS and Trust priority in 2021/22, with the OBC due for submission by the autumn of 2021.

The following areas continue to be regarded as significant weaknesses in arrangements as at 31 March 2021

3.2.6 Arrangements to ensure compliance with 2018 Enforcement Actions

In 2018 NHS Improvement issued The Trust with two Enforcement actions, detailed below. These enforcement actions continued to be in place throughout the 2020/21 period.

Whilst progress has been made against all key areas, the pace of rollout and the significant disruptions caused by the necessary focus on the pandemic meant that some weaknesses in arrangements were present for at least part of year.

Enforcement Action – June 2018

In June 2018, the Foundation Trust undertook enforcement actions issued by NHS Improvement (NHSI) under section 106 of the Health and Social Care Act 2012. NHSI stated that it had reasonable grounds to suspect that the Foundation Trust has provided and is providing health services for the purpose of the health service in England while failing to comply with the following conditions of its Licence: FT4 (5) (d) (f) (g) and FT4 (7), with regard to governance arrangements and financial control mechanisms.

Key areas particularly flagged at that time included, but were not limited to:

- A&E performance (see i)
- delivery of cost improvement plans (see ii)
- weaknesses in the Project Management Office team (see v)

Enforcement Action – October 2018

Following publication of the CQC's report in July 2018, NHSI issued further enforcement actions in relation to the delivery of quality.

Undertakings required to meet the conditions addressed in the additional enforcement actions included, but were not limited to:

- a review to determine reasons why lack of progress against CQC targets was not identified (see iii)
- development of an assurance framework (see iv)
- deploying a framework to ensure patient safety issues are escalated
- a review of risk management policies
- Improvements to medical engagement.

Overview

Progress against the key areas raised in NHS Improvement's 2018 enforcement actions is detailed in the following subsections.

i) Performance against the A&E Standard

The Emergency Care transit time standard is monitored and The Trust has worked closely with system partners and staff towards delivering sustained improvements in this key delivery area.

The necessary response to the Covid-19 pandemic had an impact on performance in 2020/21, which was still below the national standard of 95%. This was largely due to challenging segregation of patient pathways. However, the Trust has seen a marginal improvement year on year, with an overall compliance rate of 84.4% against 82.35% in 2019/2020 and 82.39% in 2018/2019.

The Trust's performance was also in line with the overall compliance rate reported for the NHS in England during the 2020/21 financial year. As a comparator, national compliance was at 90.4% in April 2020, 84.4% in October 2020, 78.5% in January 2021, and 86.1% in March 2021.

Update

The performance for this standard is being monitored through the monthly, HHCP chaired A&E Delivery Board which has representation from the whole care system leads, highlighting the dependency of achievement across all the agencies involved in providing emergency care for the residents of Hillingdon and the neighbouring boroughs.

The Trust worked collaboratively with system partners to try and recover as much activity as possible, whilst following social distancing and IPC guidance.

The Trust is now also working with North West London ICS to complete a recovery plan, which through a transformation programme, will ensure that the Trust starts to see an improvement in the waiting times for our patients, across all elective and non-elective pathways.

ii) Delivery of Cost Improvement Plans

As one of the eight trusts selected in England to be part of the national Vital Signs Programme, NHSI have continued to support and coach the Trust in delivering improvements in patient care, whilst also improving its efficiency.

Update

In 2020/21 the Trust continued to make progress in embedding its improvement methodology, CARES+. The application of standard work processes has supported several teams in establishing a more efficient and effective approach. These processes supported the organisation in managing the unprecedented situation, particularly in:

- the coordination and control of the Trusts response
- managing staff sickness and welfare
- facilitating communication with patients and their families.

In the latter part of the year the Cares + team led the systematic review of the innovations implemented within the first wave of Covid-19, with the Programme Management Officer (PMO) quantifying the financial benefits, ensuring the ongoing sustainability of the changes put in place.

A particular focus in the year was within the Emergency Care department, where significant efficiency improvements were identified and delivered, resulting in both improved patient experience and staff satisfaction.

Furthermore, CARES+ methodology was also used to deliver improved patient pathways within the Ambulatory Emergency Care Unit. Focusing on the high value

pathways, the practice coaches worked with the team to improve both impact and effectiveness within key areas.

Over 30 plus staff have been accredited with the Practice Coach Certification level, demonstrating development of significant skills to deliver improvements that can be cascaded within the organisation.

iii) Performance against CQC targets

The CQC inspected all eight core services provided by the Trust at the Hillingdon Hospital site in March and April 2018. NHSI visited the Trust in May 2018 to conduct a 'Use of Resources' assessment as part of the revised inspection regime. Overall, the CQC rated the Trust as 'Requires Improvement'. The Safety and Well Led domains for the Hillingdon Hospital site were rated as 'Inadequate' resulting in the Hillingdon Hospital site receiving an overall rating of 'Inadequate'. The Mount Vernon site did not form part of the 2018 inspection and the CQC took into account the previous 2014 'Good' rating of the core services at this site in issuing Mount Vernon with an overall rating of 'Requires Improvement'.

This risk remains; the Trust received focused CQC visits in Q2 of 2020/21 following infection prevention and control issues which emerged during phase 1 of the Covid-19 pandemic. These resulted in additional regulatory action. Further detail on the Trust's response can be found in section 3.2.7. The visit did not result in changes to the overall ratings and the Trust remains 'Requires improvement'.

Update

In order to effectively manage and control all the elements of change required and to ensure the delivery of required improvements, the Trust established a holistic Hillingdon Improvement Plan (HIP) in 2019. This has been used to track our progress, not only against the CQC 'must' and 'should do' requirements but other self-identified areas for improvement. This plan has been overseen by a bi-monthly HIP Board chaired by the Chief Nurse, with attendees from all Trust divisions, corporate areas, and from external Health Care partners including the CQC regional team, Clinical Commissioning Groups (CCG) colleagues, local Healthwatch colleagues and NHS Improvement. The HIP Board reports to the Trust Management Board and onwards to the Quality and Safety Committee and the Board.

A number of the Trust's business as usual activities, including HIP Board meetings, had to be temporarily suspended in the financial year 2020/21. This was to ensure appropriate resource and focus was available for the safe management of staff and patients during the Covid-19 pandemic.

Whilst the HIP Board meetings were suspended, the actions that arose from the focussed CQC inspections were monitored in daily CQC project management

meetings, which were attended by clinical and corporate divisional representatives and members of Executive team. The Trust has made significant progress on these actions and has a robust monitoring and reporting structure in place.

The Trust also delivers a 'Ward and Department Accreditation' programme, which comprises quality and safety assessment of the clinical areas in the Trust, undertaken on a structured Trust developed assessment tool by a team of multidisciplinary stakeholders. The accreditation framework is aligned to the CQC's key lines of enquiries and five domains of quality. In November 2020, the Trust revised the accreditation tool in line with new IPC regulations related to Covid-19 safety and also streamlined the accreditation process.

Accreditation is one of the strands of measurement that aim to assure that Trust divisions and the Executive team have an accurate and detailed understanding of the quality of care patients receive.

iv) Risk management and Board Assurance Framework

The 2018/19 external audit conclusion identified weaknesses in the Trust's risk management arrangements and Board Assurance Framework. Significant progress was made in 2019/20, but as improvements were rolled out during the year and older risk management arrangements continued to be in place for a substantial length of time within the period, this was raised again in the 2019/20 external audit conclusion.

The reformulated BAF, which was reviewed by internal auditors in the 2019/20 financial year, received a 'substantial assurance with limited improvements required' rating. In 2020/21 the Trust has focused resources on further improvements to arrangements.

Update

The BAF was updated in the summer of 2020 by the Executive team and then by the Board and challenged through the Assurance Committees in the autumn. Throughout the financial year the BAF has driven the agendas of assurance Committees and the Board. The BAF is treated as a live tool and is subject to regular review to ensure that it is current.

The refreshed BAF, which reflected the risk status for the organisation following the 2020 regulatory action, was approved by the Board in November 2020 and updates received at Assurance Committees. An end of year BAF report was received by the Board in April 2021.

The Risk Register processes continued in 2020/21, however, work was required to continuously reflect the impact of Covid-19 and knock on effect of this and other challenges on risks, and management of these, throughout the year.

The BAF is a live document which will be updated again in early 2021/22, as is appropriate for the new financial year, to reflect current business needs and to provide more differentiation between strategic and operational risks. Any further improvements suggested in the next internal audit of the BAF and Risk Management process will be reflected in 2021/22 planning.

v) Addressing weaknesses in Project Management Office and Governance Arrangements

As reported in 2019/20, the external governance review, which was commissioned in 2018 and released in January 2019, indicated that improvements were required with regards to:

- capacity and capability within the Foundation Trust's leadership team and Project Management Office
- development of Foundation Trust strategy
- governance structures and membership of groups within those structures
- arrangements for moderation and escalation of risk, performance reporting, data quality arrangements, and stakeholder relationship management.

In July 2020 and January and March 2021 the Audit and Risk Committee and Board reviewed progress against the 2018/19 external governance review, and determined that the majority of recommendations had been addressed. The Trust requested an internal audit on corporate governance in 2020/21, which began in the latter stages of 2020/21. The last internal audit on the BAF and Risk Management processes was received in April 2020 and provided significant assurance with some recommended improvements. These have been taken forward in a further refinement of the BAF in 2020.

Update

The Trust Secretary undertook a review towards the end of Q1 of the financial year on the corporate governance arrangements at Board and sub board level. This resulted in reports to the Trust Management Board, and Audit and Risk Committee, outlining planned work in relation to the following key areas, which were embedded during the financial year:

- Putting in place a refreshed Board Assurance Framework developed through comprehensive Board engagement
- Aligning the Committee structure and discussions at the Board and its Sub Committees more effectively with the strategic priorities and the Board Assurance Framework
- Approval of a refreshed clinical services strategy at the start of the financial year

- Putting in place strengthened arrangements with regard to Risk Management
- Introducing 'Governance light' arrangements in the two key phases of the Covid-19 pandemic – working in an agile way and maintaining appropriate governance and assurance processes throughout

Any outstanding actions will be reflected in work planned to take place under the direction of the Chief Executive in Q1 of the new financial year to undertake a refreshed self-assessment against the Well-Led Key Lines of Enquiry. The outcome of the internal audit on corporate governance will also inform any further action needed in the new financial year.

3.2.7 Additional Licence Condition - September 2020

Following the focused CQC inspections in August and September 2020 the Trust received a Notice of Decision under Section 31 and Section 29a of the Health and Social Care Act 2008, imposing an additional licence condition for governance arrangements. The CQC did not issue new ratings to the Trust following these inspections.

The Board put in place an extraordinary meeting in August 2020 to receive and consider the regulatory requirements and to agree immediate actions to address them. A comprehensive action plan has been put in place to ensure the issues identified in the report and notices are addressed.

Progress against these actions is monitored regularly and is reported to at the Trust Management Executive, and at the Quality and Safety Committee and Trust Board.

Update

Governance arrangements were put in place to ensure progress was monitored on a weekly basis through Executive Team meetings, regularly received and challenged at Assurance Committee meetings and Board meetings, as well as with the sector and regulators via Sector Oversight Meetings, and via additional assurance opportunities put in place with Non-Executive Directors.

The Trust received 17 'must do' actions and eight 'should do' actions from the two inspections in 2020 which have been embedded in its improvement processes. The Trust has a CQC quality improvement plan in place.

The progress against each of the actions was monitored in daily, which later changed to biweekly, CQC PMO update meetings with representatives from clinical divisions, corporate services such as estates, HR, Health & Safety and members of Executive team. The CQC PMO meetings were discontinued in October 2020 when reasonable assurance was obtained on the progress of the actions. The compliance against action is now monitored bi-monthly at Hillingdon Improvement Plan (HIP) Board meetings

which were reinstated in October 2020. The progress report on actions is reported to the Trust Management Board, and then to the Quality and Safety Committee.

Over the Covid-19 period, whilst the HIP Board was suspended, there continued to be two presentations per week in the CQC PMO meetings from the CQC work stream leads to senior leaders in the organisation, to give assurance on progress against all CQC actions from the 2018 inspection. These meetings posed appropriate challenge and scrutiny of evidence, both qualitative and quantitative, along with the offer of support.

The Trust continues to comply with the conditions imposed on the Trust's registration in the Section 31 and Section 29a improvement notices including weekly submission of any monitoring data and audits undertaken in connection with the action plan to the CQC.

Support was provided via the Integrated Care System and through managed services arrangements with Chelsea and Westminster to strengthen the IPC team arrangements and to provide additional senior support to Executive leads. The arrangements the Trust now has in place are significantly strengthened, have been shown to be well regarded via ICS peer review processes and by its regulators, and have been used to support other Trusts to strengthen their own responses in respect to infection prevention and control.

3.2.8 Progress against weaknesses identified in the Internal Audit Report

Of the outstanding recommendations from past periods, 47 were implemented in 2020/21 and 25 remain outstanding.

Update:

The Trust's internal auditor has identified some weaknesses in the internal control environment, including arrangements in relation to: Capital purchasing and procurement; Core financial systems: Accounts receivable and General Ledger, Standing Financial Instructions (SFI) waivers and budget holder survey, and Capital Governance. 37 new recommendations have been made in response to reviews delivered in 2020/21.

3.3 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments

made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee, the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides the Board of Directors with an opinion about the effectiveness of the assurance framework and internal controls as part of the internal audit work plan. The Head of Internal Audit Opinion for the 2020/21 financial year gave an overall opinion of Partial Assurance with improvements required on the overall adequacy and effectiveness of the organisations framework of governance, risk management and control. In issuing their opinion Internal Audit have recognised that the organisation has implemented the recommendations raised as a result of their work to address issues identified within agreed timeframes and have also seen improvements in audit work undertaken toward the latter part of the year.

The table below summarises the assurances ratings for internal audit work undertaken in 2020/21.

			Recommendations Accepted			
#	Review	Assurance	H	M	L	Total
1	Capital Purchasing and Procurement	Partial assurance with improvements required	3	2	2	7
2	Financial Controls	Partial assurance with improvements required	-	3	3	6
3	SFI Waiver Processes	Partial assurance with improvements required	-	5	4	9
4	Capital Governance and Purchasing and Procurement follow up	Partial assurance with improvements required	2	4	3	9
5	Safeguarding	Significant assurance with minor improvements	-	4	2	6
6	Data Quality and Assurance	Partial assurance with improvements required	2	4	1	7
7	Governance of THH Board	Significant assurance with minor improvements	-	4	4	8
8	Risk Management	Significant assurance with minor improvements	-	4	3	7
Total			7	30	22	59

As at the time of publication of this report, eight internal audit reports had been received out of eight planned. This includes financial reviews submitted at the April 2021 Audit and Risk Committee, covering the Trust's Corporate Governance arrangements:

- Core Financial Systems: Capital Purchasing (partial assurance with improvements required)

- Core Financial Controls (partial assurance with improvements required)
- SFI Waiver Processes (partial assurance with improvements required)
- Capital Governance and Purchasing and Procurement follow up (partial assurance with improvements required)

This review of effectiveness is also informed by the external audit opinion, which concluded an adverse opinion in 2019/20 with regard to the Trust's use of resources to secure economy, efficiency and effectiveness in its use of resources, inspections carried out by the CQC and other external agencies. The external audit opinion is included in the appendix to the annual accounts.

The Trust took a robust project management approach to address and monitor the concerns raised by the CQC through their focused unannounced inspections on the safe and well-led domains in the 'medical care' and 'urgent and emergency care' core services, in August 2020; and in response to the Section 31 and Section 29a notices issued and on the findings from the joint CQC and Health and Safety Executive (HSE) follow up visit in September. The comprehensive action plan put in place was closely monitored at the Trust Management Board, Quality and Safety Committee and Trust Board.

The CQC did not issue new ratings to the Trust following these inspections.

The Covid-19 pandemic is the biggest threat to the health of the population in a generation. It has resulted in an unprecedented level of demand for hospital critical and medical care. The Trust has, and will continue, to respond to the pandemic in line with national and local guidance. It effectively deployed its pandemic flu plan and internal incident procedures operating a gold, silver and bronze command and control structure. Throughout the year risks have been monitored via the Covid-19 risk register to support the identification, escalation and mitigation of risk associated with the pandemic.

As well as responding to the pandemic the Trust has continued to closely monitor all waiting lists and key quality and performance metrics to identify gaps in assurance and to maintain patient safety and business as usual functions as far as reasonably practicable. This ensured continuous monitoring of the impact of Covid-19 patient care and allowed the commencement of planned work in a flexible and timely manner as capacity and quality parameters permitted.

The Trust has worked with colleagues in the North West London Health and Care Partnership (NWL HCP), across London and beyond to enable it to manage the significant increase in caseload of Covid-19 patients and to maintain equity of access to care for all patients. This required an agile and flexible approach, rapid and significant transformation of services.

The Board has updated and refreshed the Board Assurance Framework to reflect the key risks to delivering its strategic objectives and this has continued to drive reporting and assurance through the Board Sub Committees.

As a result of Covid-19 elective inpatient and day-case services were largely paused (with the exception of some urgent critical cases including cancer services). Outpatient services were significantly reduced, with the rapid adoption of virtual clinics where possible but they maintained urgent services where required. Plans have been made in line with national and regional guidance with the welfare of staff and patients at the heart of decision making.

The Trust developed a Covid-19 risk register to support the identification, escalation and mitigation of risks associated with the pandemic and these are reflected in the Risk Register and on the Board Assurance Framework. A Covid-19 specific BAF was also produced to provide onward assurance to the Board on management of risks.

Further detail on how the Trust has managed the impact of the pandemic is provided across the document.

The Trust has described in this Annual Governance Statement the financial challenges it faces and the pressures on financial sustainability including matters which are not wholly within the control of the Trust. To address these challenges the Trust is undertaking a detailed planning process within the parameters set out by NHSI and in conjunction with its NWL ICS system partners to ensure that the Trust and divisional plans are aligned and are consistent the assumptions for service delivery during 2021/22. The Trust has submitted a draft financial plan to NHSEI for the first six months of the financial year; this plan includes a breakeven position. The Trust received £10m in working capital support in 2020/21 to maintain cash balances and to pay creditors within agreed timeframes. If the Trust is able to deliver a breakeven plan, then it should not require further financial support in 2021/22.

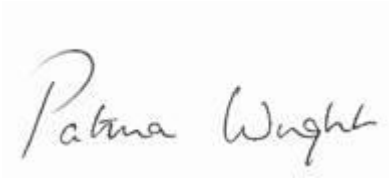
The Trust Estate also continues to present a significant challenge. As outlined in detail in the Annual Report and in the Annual Governance Statement, the Trust has been successful in accessing additional funds to support it to address backlog maintenance issues and decant requirements to enable it to take forward its new build hospital plans at pace and it remains on track for delivery by 2025. The Finance and Performance Committee and Trust Board have kept these under close review.

It was reported in the 2019/20 Annual Report, that the Trust had an Enforcement Notice received in January 2020 from London Fire Brigade due to several failures to comply with fire safety requirements. Significant progress has been made in addressing issues supported by emergency capital funding as outlined in this report. The Trust has an outcome rating of ‘Reasonable Assurance’ from the ALFOR (Authorised Engineer) report into fire safety and an action plan was developed to address improvement measures around fire safety and requirements from the

enforcement notice are reflected in this. The two-year programme of works agreed with the London Fire Brigade in March 2020 is underway with many areas already addressed, and the remainder due for completion by December 2021.

3.4 Conclusion

Significant internal control issues have been identified through: review by the CQC which found weaknesses in financial control mechanisms and arrangements to support delivery of quality; consideration of the NHSI enforcement undertakings which identified that the Trust was not meeting its licence requirements and was required to improve governance systems and processes to address weaknesses in infection control processes, and A&E waiting time performance; quality issues raised in past inspections and underlying financial deficit, and through internal audit which identified high priority recommendations in respect of capital purchasing and procurement, and data quality and assurance.



Patricia Wright

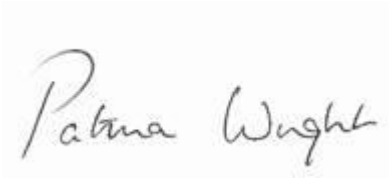
Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

8 July 2021

Accounting Officer approval of the Accountability Report

As Accounting Officer, I am satisfied that this accountability report provides a true and accurate summary of the performance of the Trust during the year 2020/21.



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

8 July 2021

Statement of the Chief Executive's responsibilities as the Accounting Officer of The Hillingdon Hospitals NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Hillingdon Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Hillingdon Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

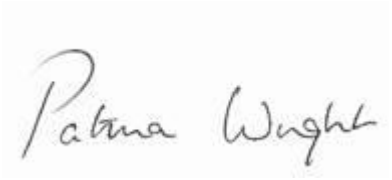
- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the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

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the

assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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



Patricia Wright

Chief Executive

The Hillingdon Hospitals NHS Foundation Trust

8 July 2021

Appendix

The Hillingdon Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

The Hillingdon Hospitals NHS Foundation Trust

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

Signed 

Name **Patricia Wright**
Job title **Chief Executive**
Date **8 July 2021**

Independent auditor's report to the board of governors and board of directors of The Hillingdon Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

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

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

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

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes in section 2.5.3;
- the table of pension benefits of senior managers and related narrative notes in section 2.5.3;
- the table of pay multiples and related narrative notes in section 2.5.3;
- the table on staff costs in section 2.6.1;
- the table on average staff numbers in section 2.6.2; and
- the table of exit packages cost band in section 2.6.3.

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

Basis for opinion

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

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

The going concern basis of accounting for the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts , which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

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

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

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

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

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

or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the foundation trust and its control environment, and reviewed the foundation trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, those charged with governance, internal audit and local counter fraud about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the foundation trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team, including relevant internal specialists such as valuations, IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.
As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following area, and our specific procedures performed to address it are described below:

- determination of whether an item of expenditure is capital in nature: we tested the capitalised expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature.
- the judgemental nature of key assumptions used in property valuations: we engaged our property specialists to assess the assumptions and methodology used to value the estate.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;

- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance,
- and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

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

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 , we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

On 1 June 2021, we reported to the foundation trust significant weaknesses in the foundation trust's governance arrangements. The significant weaknesses reported were as follows:

- Significant governance weaknesses were identified by the CQC in December 2020 as a result of their inspections in August and September 2020 focusing on infection, prevention and control. The results of the inspection led to a Section 111 Notice from NHS Improvement and additional enforcement undertakings. We recommended the trust implements the recommendations from the CQC report and continues with its action plan.
- The foundation trust received an opinion from its head of internal audit for 2020/21 of "Partial Assurance with some improvements required". The significant areas of weakness identified were in respect of Capital Purchasing and Procurement, Capital Governance and Data Quality and Assurance. We recommended that management addresses the recommendations made by internal audit in line with the agreed timeframe for remediation.
- In our audit report dated 24 June 2020 on the 2019/20 financial statements, we reported a significant weakness in the foundation trust's governance arrangements. The significant weakness reported was in relation to enforcement undertakings from NHS Improvement. These undertakings remained in force throughout the year to 31 March 2021, therefore, this weakness has not yet been addressed. We recommended that the foundation trust implements the requirements of the undertakings and continues with its action plan.

Our work in respect of the trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

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

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

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

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

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

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

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

Jonathan Gooding (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom

Date: 8 July 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 8 July 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 8 July 2021, we had not completed our work on the foundation trust's arrangements.

In our audit report for the year ended 31 March 2021 issued on 8 July 2021, we reported significant weaknesses in the foundation trust's governance arrangements in respect of: weaknesses identified by the Care Quality Commission in a report issued in December 2020; weaknesses identified by the Trust's internal auditor in respect of capital purchasing and procurement, capital governance and data quality and assurance; and weaknesses reflected in the Trust's enforcement undertakings from NHS Improvement which remained in force during the year.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 8 July 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing further to report in respect of the trust's arrangements for securing economy, efficiency and effectiveness in its use of resources above the significant weaknesses already reported at 8 July 2021 as referenced above.

We certify that we have completed the audit of The Hillingdon Hospitals NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Jonathan Gooding, FCA (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
15 September 2021

Statement of Comprehensive Income

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	258,853	230,096
Other operating income	4	47,825	35,110
Operating expenses	6, 8	(301,444)	(289,426)
Operating surplus/(deficit) from continuing operations		**5,234**	**(24,220)**
Finance income	11	5	81
Finance expenses	12	(2,042)	(3,643)
PDC dividends payable		(5,913)	(2,696)
Net finance costs		**(7,950)**	**(6,258)**
Other gains / (losses)	13	(2,456)	4,306
Surplus / (deficit) for the year from continuing operations		**(5,172)**	**(26,172)**
Surplus / (deficit) for the year		**(5,172)**	**(26,172)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,743)	(3,714)
Revaluations	17	3,519	9,597
Total comprehensive income / (expense) for the period		**(5,396)**	**(20,289)**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	14	7,759	4,060
Property, plant and equipment	15	207,981	160,057
Investment property	18	49,855	50,162
Receivables	20	1,459	2,002
Total non-current assets		**267,054**	**216,281**
Current assets			
Inventories	19	4,670	3,167
Receivables	20	25,786	23,373
Cash and cash equivalents	21	47,363	9,791
Total current assets		**77,819**	**36,331**
Current liabilities			
Trade and other payables	22	(73,662)	(38,701)
Borrowings	24	(1,236)	(103,709)
Provisions	26	(158)	(151)
Other liabilities	23	(2,997)	(1,357)
Total current liabilities		**(78,053)**	**(143,918)**
Total assets less current liabilities		**266,820**	**108,694**
Non-current liabilities			
Borrowings	24	(15,855)	(21,077)
Provisions	26	(1,666)	(1,700)
Total non-current liabilities		**(17,521)**	**(22,777)**
Total assets employed		**249,299**	**85,917**
Financed by			
Public dividend capital		247,715	78,937
Revaluation reserve		53,133	53,357
Income and expenditure reserve		(51,549)	(46,377)
Total taxpayers' equity		**249,299**	**85,917**

The financial statements were approved by the Audit and Risk Committee on behalf of the Board, and authorised for use on 8 July 2021. They were signed below on the same date.

Name Patricia Wright
Position Chief Executive
Date 8 July 2021

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

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**78,937**	**53,357**	**(46,377)**	**85,917**
Surplus/(deficit) for the year	-	-	(5,172)	**(5,172)**
Impairments	-	(3,743)	-	**(3,743)**
Revaluations	-	3,519	-	**3,519**
Public dividend capital received	172,378	-	-	**172,378**
Public dividend capital repaid	(3,600)	-	-	**(3,600)**
Taxpayers' and others' equity at 31 March 2021	**247,715**	**53,133**	**(51,549)**	**249,299**

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

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

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus / (deficit)		5,234	(24,220)
Non-cash income and expense:			
Depreciation and amortisation	6.1	9,723	9,209
Net impairments	7	3,222	1,635
Income recognised in respect of capital donations	4	(1,288)	(86)
(Increase) / decrease in receivables and other assets		(2,151)	2,434
(Increase) / decrease in inventories		(1,503)	(203)
Increase / (decrease) in payables and other liabilities		10,012	(4,258)
Increase / (decrease) in provisions		(82)	(175)
Other movements in operating cash flows		-	(86)
Net cash flows from / (used in) operating activities		**23,166**	**(15,750)**
Cash flows from investing activities			
Interest received		5	81
Purchase of intangible assets		(4,740)	(866)
Purchase of PPE and investment property		(34,350)	(20,633)
Prepayment of PFI capital contributions		(2)	-
Net cash flows from / (used in) investing activities		**(39,087)**	**(21,418)**
Cash flows from financing activities			
Public dividend capital received		172,378	4,077
Public dividend capital repaid		(3,600)	-
Movement on loans from DHSC		(106,341)	49,577
Movement on other loans		-	-
Capital element of finance lease rental payments		(645)	(843)
Capital element of PFI, LIFT and other service concession payments		(251)	(252)
Interest on loans		(739)	(1,868)
Other interest		(7)	(75)
Interest paid on finance lease liabilities		(100)	(136)
Interest paid on PFI, LIFT and other service concession obligations		(1,597)	(1,564)
PDC dividend (paid) / refunded		(5,606)	(2,989)
Net cash flows from / (used in) financing activities		**53,492**	**45,927**
Increase / (decrease) in cash and cash equivalents		**37,571**	**8,759**
Cash and cash equivalents at 1 April - brought forward		**9,791**	**1,032**
Cash and cash equivalents at 1 April - restated		**9,791**	**1,032**
Cash and cash equivalents at 31 March	21	**47,363**	**9,791**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 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.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and investment property.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The 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.

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 the Integrated Care System 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.

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.

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.

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.

Note 1.4 Other forms of income

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

Note 1.5 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

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

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

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Depreciation has been calculated on the straight line basis. Freehold land is considered to have an infinite life and is not depreciated. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

Donated and grant funded assets

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

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

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.

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

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

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

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

Useful lives of property, plant and equipment

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

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

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

Note 1.8 Intangible assets

Recognition

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

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 where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

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

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

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

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is calculated on the straight line basis.

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	5	15

Note 1.9 Inventories

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

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.

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure. The fair value of investment properties is determined by an annual valuation by an independent valuer engaged by the Trust. The valuer is Gerald Eve, whose staff hold recognised and relevant professional qualifications to complete the work; the valuer also has experience of valuing these properties.

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

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

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

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

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

Derecognition

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

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

Note 1.13 Leases

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

The trust as a lessee

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

The trust as a lessor

Operating leases

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

Note 1.14 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:

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

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

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

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.2, but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.
Contingent liabilities are not recognised unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS 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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.17 Value added tax

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

Note 1.18 Climate change levy

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

Note 1.19 Third party assets

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

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.21 Early adoption of standards, amendments and interpretations

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

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 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 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. No adjustments will be made on 1 April 2022 for existing finance leases.

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.

Other standards, amendments and interpretations

No other standards have been issued or adopted for the public sector that are expected to have a significant impact on the financial statements.

Note 1.23 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements about the carrying amount of assets and liabilities, and to disclose material judgements here. The Trust considers that no material judgements have been made during the production of the financial statements.

Note 1.24 Sources of estimation uncertainty

In the application of the Trust's accounting policies management is required to make estimates, and assumptions about the carrying amount of assets and liabilities. The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The estimates and associated assumptions are based on historical experience and other factors considered of relevance. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

In this disclosure, in line with accounting standards, we focus only on uncertainties that have a potential material impact on the financial statements.

Asset valuations and lives

In line with the Trust's Property, Plant and Equipment (PPE) policy (and to comply with accounting standards) a full valuation of all land and property owned by the Trust was undertaken in March 2021 by Gerald Eve LLP, an independent firm of professional valuers. This valuation was carried out in accordance with the Valuation – Global Standards 2020 of the Royal Institution of Chartered Surveyors (RICS) and was consistent with the requirements of HM Treasury, the Department of Health and Social Care and NHS Improvement and International Financial Reporting Standards (IFRS).

As a result of the continuing impact of the novel coronavirus (COVID-19), which was declared a global pandemic on 11 March 2020, on market activity, the external valuers have included a "market conditions explanatory note" in their report. The note makes clear that the valuation is not subject to a material valuation uncertainty, and states the following:

"The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has and continues to impact many aspects of daily life and the global economy – with some real estate markets having experienced lower levels of transactional activity and liquidity. Travel restrictions have been implemented by many countries and "lockdowns" applied to varying degrees. A third national lockdown has now been deployed to attempt to stem the emergence of significant further outbreaks has impacted global financial markets.

The pandemic and the measures taken to tackle COVID-19 continue to affect economies and real estate markets globally. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, our valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation – Global Standards.

To reflect their judgement on the impact of COVID-19 on prevailing land values, the valuer has land sales, which it should be noted were all before the Covid-19 pandemic, and a land price of £2,300,000 per acre at the Hillingdon site was determined; this was applied to the alternative hospital site.

Within the valuation, other factors also considered were build cost inflation, differing choice of cost rates for individual assets, differing non-physical obsolescence judgements, positive adjustments or impairments on capital improvements held at cost until revaluation, differing assumptions on professional fees levels, finance costs etc. the majority of which are inter-linked and are not analysed here.

Note 2 Operating Segments

The Trust has only one segment of business which is the provision of healthcare. The segment has been identified with reference to how the Trust is organised and the way in which the chief operating decision maker (determined to be the Board of Directors) runs the Trust.

The geographical and regulatory environment and the nature of services provided are consistent across the organisation and are therefore presented in one segment. The necessary information to develop detailed income and expenditure for each product and service provided by the Trust is currently not discretely available and the cost to develop this information would be significant.

Significant amounts of income are received from transactions with the Department of Health and other NHS bodies. There are no other parties that account for more than 10% of total income.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.

Note 3.1 Income from patient care activities (by nature)	2020/21	2019/20
	£000	£000
Acute services		
Block contract / system envelope income*	233,919	203,830
High cost drugs income from commissioners (excluding pass-through costs)	12,799	13,070
Other NHS clinical income	3,415	-
Ambulance services		
Patient transport services income	1,198	1,182
Community services		
Block contract / system envelope income*	-	2,079
All services		
Private patient income	-	141
Additional pension contribution central funding**	7,522	7,188
Other clinical income	-	2,606
Total income from activities	**258,853**	**230,096**

*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.

Note 3.2 Income from patient care activities (by source)

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	28,231	21,139
Clinical commissioning groups	227,204	205,710
Other NHS providers	1,077	500
Non-NHS: private patients	7	141
Non-NHS: overseas patients (chargeable to patient)	1,617	1,389
Injury cost recovery scheme	430	1,142
Non NHS: other	287	75
Total income from activities	**258,853**	**230,096**
Of which:		
Related to continuing operations	258,853	230,096

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

	2020/21	2019/20
	£000	£000
Income recognised this year	1,617	1,389
Cash payments received in-year	468	874
Amounts added to provision for impairment of receivables	(1,183)	(39)
Amounts written off in-year	76	425

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	331	-	**331**	421	-	**421**
Education and training	9,131	107	**9,238**	9,196	134	**9,330**
Non-patient care services to other bodies	6,747		**6,747**	7,254		**7,254**
Provider sustainability fund (2019/20 only)			**-**	1,847		**1,847**
Financial recovery fund (2019/20 only)			**-**	5,182		**5,182**
Marginal rate emergency tariff funding (2019/20 only)			**-**	1,581		**1,581**
Reimbursement and top up funding	21,836		**21,836**			**-**
Income in respect of employee benefits accounted on a gross basis	466		**466**	590		**590**
Receipt of capital grants and donations		1,288	**1,288**		86	**86**
Charitable and other contributions to expenditure		3,224	**3,224**		-	**-**
Rental revenue from operating leases		2,694	**2,694**		3,118	**3,118**
Other income	2,001	-	**2,001**	5,701	-	**5,701**
Total other operating income	**40,512**	**7,313**	**47,825**	**31,772**	**3,338**	**35,110**
Of which:						
Related to continuing operations			47,825			35,110

Note 5.1 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	2019/20
	£000	£000
Income from services designated as commissioner requested services	226,462	189,592
Income from services not designated as commissioner requested services	32,391	40,504
Total	**258,853**	**230,096**

The 2019/20 comparative figures were prepared on the basis of detailed activity schedules agreed with commissioning organisation. However, following the COVID-19 pandemic, the planning, contracting and activity process for 2020-21 was aborted. The Trust was not formally requested by commissioners to carry out any activity in the financial year; instead a block contract arrangement has been in place. In this note we have reflected the value of that arrangement to the Trust.

Note 6.1 Operating expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	396	-
Staff and executive directors costs	202,348	191,073
Remuneration of non-executive directors	144	147
Supplies and services - clinical (excluding drugs costs)	27,654	25,518
Supplies and services - general	4,716	4,050
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	15,317	18,156
Inventories written down	-	38
Consultancy costs	16	4,200
Establishment	6,154	6,418
Premises	9,657	8,607
Transport (including patient travel)	2,446	1,961
Depreciation on property, plant and equipment	8,682	8,501
Amortisation on intangible assets	1,041	708
Net impairments	3,222	1,635
Movement in credit loss allowance: contract receivables / contract assets	1,436	163
Movement in credit loss allowance: all other receivables and investments	171	276
Increase/(decrease) in other provisions	61	(44)
Audit fees payable to the external auditor		
audit services- statutory audit	142	128
other auditor remuneration (external auditor only)	-	-
Internal audit costs	89	89
Clinical negligence	11,102	10,789
Legal fees	231	157
Insurance	371	213
Research and development	379	401
Education and training	1,520	1,778
Rentals under operating leases	782	711
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	525	497
Car parking & security	526	467
Hospitality	1	35
Losses, ex gratia & special payments	25	4
Other services, e.g. external payroll	2,236	2,750
Other	54	-
Total	**301,444**	**289,426**
Of which:		
Related to continuing operations	301,444	289,426

The audit fee payable to the external auditors, excluding VAT, is £121k.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

Note 7 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	3,222	1,635
Changes in market price	-	-
Total net impairments charged to operating surplus / deficit	**3,222**	**1,635**
Impairments charged to the revaluation reserve	3,743	3,714
Total net impairments	**6,965**	**5,349**

The Trust had a full revaluation undertaken as at 31 March 2021, primarily for the financial statements, but also to inform the new hospital build business case process. There are some buildings on the Trust's sites which have advanced levels of obsolescence, and the valuation reflected that. In particular, some assets have a low or zero revaluation reserve balance; and when the valuation was updated and showed further downward movement due to the age and condition of the assets, these amounts were taken to I&E in line with accounting standards.

Note 8 Employee benefits

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	152,756	146,442
Social security costs	16,049	15,302
Apprenticeship levy	745	719
Employer's contributions to NHS pensions	24,402	23,344
Pension cost - other	52	51
Temporary staff (including agency)	13,439	9,697
Total gross staff costs	**207,443**	**195,555**
Recoveries in respect of seconded staff	(1,811)	(1,751)
Total staff costs	**205,632**	**193,804**
Of which		
Costs capitalised as part of assets	1,705	1,228

Note 8.1 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 (£93k in 2019/20).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 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.

Note 10 Operating leases

Note 10.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where The Hillingdon Hospitals NHS Foundation Trust is the lessor.

The most significant operating leases generating income for the Trust are located at the Mount Vernon site, most notably the BMI Bishops Wood hospital. In addition the Trust generates some income through the rental of mobile phone masts on the Trust's tower block.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	2,626	2,710
Contingent rent	68	408
Other	-	-
Total	**2,694**	**3,118**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,706	1,919
- later than one year and not later than five years;	6,598	7,010
- later than five years.	93,456	95,312
Total	**101,760**	**104,241**

Note 10.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Hillingdon Hospitals NHS Foundation Trust is the lessee.

The Trust is involved in non-material operating leases for temporary buildings and medical equipment. The most significant is for the Bevan ward, for which the Trust pays approximately £350k per year and has two years to run.

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	731	666
Contingent rents	51	45
Less sublease payments received	-	-
Total	**782**	**711**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	782	780
- later than one year and not later than five years;	1,395	2,167
- later than five years.	-	-
Total	**2,177**	**2,947**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	5	81
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**5**	**81**

Note 12.1 Finance expenditure

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	282	1,868
Other loans	-	-
Overdrafts	-	-
Finance leases	100	136
Interest on late payment of commercial debt	8	16
Main finance costs on PFI and LIFT schemes obligations	806	824
Contingent finance costs on PFI and LIFT scheme obligations	791	740
Total interest expense	**1,987**	**3,584**
Unwinding of discount on provisions	55	59
Other finance costs	-	-
Total finance costs	**2,042**	**3,643**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	8	16

Note 13 Other gains / (losses)

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	26	-
Losses on disposal of assets	-	-
Total gains / (losses) on disposal of assets	**26**	**-**
Fair value gains / (losses) on investment properties	(2,482)	4,306
Total other gains / (losses)	**(2,456)**	**4,306**

Note 14.1 Intangible assets - 2020/21

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**8,397**	**1,774**	**10,171**
Additions	71	4,669	**4,740**
Reclassifications	1,955	(1,955)	**-**
Valuation / gross cost at 31 March 2021	**10,423**	**4,488**	**14,911**
Amortisation at 1 April 2020 - brought forward	**6,111**	**-**	**6,111**
Provided during the year	1,041	-	**1,041**
Amortisation at 31 March 2021	**7,152**	**-**	**7,152**
Net book value at 31 March 2021	**3,271**	**4,488**	**7,759**
Net book value at 1 April 2020	**2,286**	**1,774**	**4,060**

Note 14.2 Intangible assets - 2019/20

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**8,337**	**968**	**9,305**
Additions	60	806	**866**
Valuation / gross cost at 31 March 2020	**8,397**	**1,774**	**10,171**
Amortisation at 1 April 2019 - as previously stated	**5,403**	**-**	**5,403**
Amortisation at 1 April 2019 - restated	**5,403**	**-**	**5,403**
Provided during the year	708	-	**708**
Amortisation at 31 March 2020	**6,111**	**-**	**6,111**
Net book value at 31 March 2020	**2,286**	**1,774**	**4,060**
Net book value at 1 April 2019	**2,934**	**968**	**3,902**

Note 15.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**52,080**	**93,053**	**1,696**	**20,431**	**32,779**	**18**	**17,677**	**93**	**217,827**
Additions	-	350	-	53,486	4,542	-	2,686	-	**61,064**
Impairments	-	(6,527)	-	(574)	-	-	-	-	**(7,101)**
Reversals of impairments	-	136	-	-	-	-	-	-	**136**
Revaluations	1,426	(18,334)	(1,485)	-	-	-	-	-	**(18,393)**
Reclassifications	-	7,996	-	(11,210)	550	-	1,652	-	**(1,012)**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**37,871**	**18**	**22,015**	**93**	**252,521**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**14,870**	**1,152**	**-**	**25,874**	**18**	**15,779**	**77**	**57,770**
Provided during the year	-	5,557	333	-	1,968	-	821	3	**8,682**
Revaluations	-	(20,427)	(1,485)	-	-	-	-	-	**(21,912)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**27,842**	**18**	**16,600**	**80**	**44,540**
Net book value at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**10,029**	**-**	**5,415**	**13**	**207,981**
Net book value at 1 April 2020	**52,080**	**78,183**	**544**	**20,431**	**6,905**	**-**	**1,898**	**16**	**160,057**

Note 15.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**50,792**	**82,823**	**1,731**	**3,587**	**32,332**	**18**	**17,603**	**93**	**188,979**
Additions	-	5,272	-	18,841	447	-	40	-	**24,600**
Impairments	(172)	(5,142)	(35)	-	-	-	-	-	**(5,349)**
Revaluations	1,460	8,137	-	-	-	-	-	-	**9,597**
Reclassifications	-	1,963	-	(1,997)	-	-	34	-	**-**
Valuation/gross cost at 31 March 2020	**52,080**	**93,053**	**1,696**	**20,431**	**32,779**	**18**	**17,677**	**93**	**217,827**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**9,466**	**780**	**-**	**23,949**	**18**	**14,982**	**74**	**49,269**
Provided during the year	-	5,404	372	-	1,925	-	797	3	**8,501**
Accumulated depreciation at 31 March 2020	**-**	**14,870**	**1,152**	**-**	**25,874**	**18**	**15,779**	**77**	**57,770**
Net book value at 31 March 2020	**52,080**	**78,183**	**544**	**20,431**	**6,905**	**-**	**1,898**	**16**	**160,057**
Net book value at 1 April 2019	**50,792**	**73,357**	**951**	**3,587**	**8,383**	**-**	**2,621**	**19**	**139,710**

Note 15.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	52,906	65,483	211	62,133	7,310	-	5,390	13	**193,446**
Finance leased	-	-	-	-	1,431	-	25	-	**1,456**
On-SoFP PFI contracts and other service concession arrangements	600	9,384	-	-	-	-	-	-	**9,984**
Owned - donated/granted	-	1,807	-	-	1,288	-	-	-	**3,095**
NBV total at 31 March 2021	**53,506**	**76,674**	**211**	**62,133**	**10,029**	**-**	**5,415**	**13**	**207,981**

Note 15.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	51,480	67,516	544	20,431	4,199	-	1,824	16	**146,010**
Finance leased	-	-	-	-	2,174	-	74	-	**2,248**
On-SoFP PFI contracts and other service concession arrangements	600	8,955	-	-	-	-	-	-	**9,555**
Owned - donated/granted	-	1,712	-	-	532	-	-	-	**2,244**
NBV total at 31 March 2020	**52,080**	**78,183**	**544**	**20,431**	**6,905**	**-**	**1,898**	**16**	**160,057**

Note 16 Donations of property, plant and equipment

The Trust received £1.288m in donated assets during the year. The majority of this was equipment donated by DHSE (£1.225m), partly for advancement of diagnostics at the Trust (£642k) and partly in the form of ventilators and associated equipment to help the Trust in its pandemic response (£583k).

The Trust also received an ultrasound machine donated by the Trust's linked charity, with value of £63k.

Note 17 Revaluations of property, plant and equipment

Land, buildings and dwellings were valued as at 31 March 2021 following an inspection by qualified independent valuers Gerald Eve. The assets were revalued on the basis of their current value in existing use.

As has been the case with previous valuations of operational land and buildings, most of the hospital buildings on both the Hillingdon and Mount Vernon sites are designated as specialised assets (on the grounds that there is no active market for them and hospital buildings are seldom sold in the market). On this basis, valuation guidance available in the RICS Red Book determines that a Depreciated Replacement Cost basis be used to value such assets.

The valuation of land assets has been completed using available and comparable market information, which represents an estimate of the likely sale price in the unlikely event that it were to be sold. As is common in NHS organisations, the size of the site is calculated using a Modern Equivalent Asset methodology, which aims to estimate what size site the Trust's buildings would occupy if it were newly built at the valuation date.

Dwelling assets are not specialised, and are valued at market value.

The values for buildings reported in the accounts reflect the significant amount of investment made in the site over the last 2-3 years, but also the advanced obsolescence of some parts of the site.

Assets are depreciated on the straight line basis, with the useful economic lives of the buildings reflecting their level of obsolescence.

Note 18.1 Investment Property

	2020/21	2019/20
	£000	£000
Carrying value at 1 April - brought forward	**50,162**	**45,856**
Additions in year	1,163	-
Movement in fair value	(2,482)	4,306
Reclassifications to/from PPE	1,012	-
Carrying value at 31 March	**49,855**	**50,162**

The Trust has reclassified £1.012m from PPE (assets under construction) to investment property in year to reflect spend incurred on the Trust's incinerator asset. Additions listed in year also relate to the incinerator.

Note 18.2 Investment property income and expenses

	2020/21	2019/20
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(2,361)	(2,222)
Direct operating expense arising from investment property which did not generate rental income in the period	(137)	(208)
Total investment property expenses	**(2,498)**	**(2,430)**
Investment property income	2,497	3,081

Note 18.3 Fair value of investment property

As stated above in note 1.10 (Accounting Policies: Investment Properties) the Trust's investment properties are held at fair value. As such, there is a requirement for the Trust to comply with IFRS 13 *Fair Value Measurement* . Note 18.1 above demonstrates the fair value of those investment properties.

All of the Trust's properties are categorised at level 3 of the fair value hierarchy. This means that there are "unobservable inputs" in the valuation of the properties (that there is not an active market for the properties with quoted market prices that determine the valuation of the assets). As the properties are categorised at level 3, some additional disclosures are required by the accounting standard. These are below.

As stated in note 1.10, to ensure that the value of the Trust's investment properties are not materially misstated, the properties are valued on an annual basis. This work is carried out by an independent valuer engaged by the Trust. The valuer is Gerald Eve, whose staff hold recognised and relevant professional qualifications to complete the work; the valuer also has experience of valuing the properties. To complete the work, the Trust provides the valuer with two key inputs:
- the annual rental income for each property; and
- floor plans showing the Gross Internal Area (GIA) of each property.

There has been no change to the GIA of any of the assets held as investment properties at 31 March 2021. As such, the only significant unobservable input to the valuation is the rental income. Below we demonstrate the relationship between rental income and valuation. The valuer uses the rental income to generate a valuation using the income capitalisation approach. There has been no change in the valuation technique or approach between the last and the current financial years.

The Trust owns a range of investment properties ranging in value from £80,000 to £31.5m. The rents generating these valuations range from £7,000 per year to £1.6m per year. Based on the valuation and the rents driving it, we can see that there is a broadly linear relationship between the two factors. For example, as a result of a national commercial rent court case (Cornerstone vs Ashloch), the Trust's income from telecommunications masts has reduced by approximately 90%; this has resulted in a change in the valuation of the masts from £1.9m to £211,000, a reduction of 89%.

As such, the sensitivity of the rent is not particularly high. The example provided above demonstrates that it takes a significant change in rental income to result in a significant change in value. Most of the other investment properties owned by the Trust have seen relatively small changes to rent, and as such the resulting change in valuation between years is also small.

Note 19 Inventories

	31 March 2021 £000	31 March 2020 £000
Drugs	1,320	1,630
Consumables	3,039	1,375
Energy	108	80
Other	203	82
Total inventories	**4,670**	**3,167**

Inventories recognised in expenses for the year were £3,016k (2019/20: £173k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £38k).

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 £3,224k 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.

Note 20.1 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	24,284	20,236
Capital receivables	26	-
Allowance for impaired contract receivables / assets	(2,716)	(1,210)
Allowance for other impaired receivables	(1,135)	(964)
Prepayments (non-PFI)	2,190	2,126
PDC dividend receivable	134	441
VAT receivable	1,251	893
Other receivables	1,752	1,851
Total current receivables	**25,786**	**23,373**
Non-current		
Contract receivables	807	1,499
Allowance for impaired contract receivables / assets	(181)	(327)
Prepayments (non-PFI)	810	810
Other receivables	23	20
Total non-current receivables	**1,459**	**2,002**
Of which receivable from NHS and DHSC group bodies:		
Current	19,415	18,006
Non-current	23	20

The balance of contract receivables at 1 April 2020 was £22.812m.

Note 20.2 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**1,537**	**964**	**1,801**	**688**
New allowances arising	1,436	171	166	276
Reversals of allowances	-	-	(3)	-
Utilisation of allowances (write offs)	(76)	-	(427)	-
Allowances as at 31 Mar 2021	**2,897**	**1,135**	**1,537**	**964**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**9,791**	**1,032**
Net change in year	37,572	8,759
At 31 March	**47,363**	**9,791**
Broken down into:		
Cash at commercial banks and in hand	1,184	221
Cash with the Government Banking Service	46,179	9,570
Total cash and cash equivalents as in SoFP	**47,363**	**9,791**
Total cash and cash equivalents as in SoCF	**47,363**	**9,791**

Note 22 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	13,111	12,229
Capital payables	34,443	7,854
Accruals	18,947	11,936
Other taxes payable	4,475	4,041
Other payables	2,686	2,641
Total current trade and other payables	**73,662**	**38,701**
Of which payables from NHS and DHSC group bodies:		
Current	10,125	13,717

Note 23 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	2,997	1,357
Total other current liabilities	**2,997**	**1,357**

Note 24.1 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Loans from DHSC	397	102,805
Obligations under finance leases	546	651
Obligations under PFI, LIFT or other service concession contracts	293	253
Total current borrowings	**1,236**	**103,709**
Non-current		
Loans from DHSC	3,955	8,345
Obligations under finance leases	979	1,519
Obligations under PFI, LIFT or other service concession contracts	10,921	11,213
Total non-current borrowings	**15,855**	**21,077**

The opening balance for loans and borrowing in 2020-21 was £124.8m. At 31 March 2021, the balance is £17.1m, a reduction of £107.7m. The main movements were as follows:

As documented in the 2019-20 financial statements, the Department for Health and Social Care stated in April 2020 that interim (emergency) loans would be converted into Public Dividend Capital with effect from 1 April 2020. The value of loans converted was £99.451m.

The Trust also repaid over £7m in relation to other DH loans that remained on the balance sheet after the consolidation exercise.

Note 24.2 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**111,150**	**-**	**2,170**	**11,466**	**124,786**
Cash movements:					
Financing cash flows - payments and receipts of principal	(106,341)	-	(645)	(251)	**(107,237)**
Financing cash flows - payments of interest	(739)	-	(100)	(807)	**(1,646)**
Non-cash movements:					
Application of effective interest rate	282	-	100	806	**1,188**
Carrying value at 31 March 2021	**4,352**	**-**	**1,525**	**11,214**	**17,091**

Note 24.3 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**61,434**	**-**	**3,013**	**11,718**	**76,165**
Cash movements:					
Financing cash flows - payments and receipts of principal	49,577	-	(843)	(252)	**48,482**
Financing cash flows - payments of interest	(1,868)	-	(136)	(824)	**(2,828)**
Non-cash movements:					
Application of effective interest rate	2,007	-	136	824	**2,967**
Carrying value at 31 March 2020	**111,150**	**-**	**2,170**	**11,466**	**124,786**

Note 25 Finance leases

Note 25.1 The Hillingdon Hospitals NHS Foundation Trust as a lessor

The Trust has no finance lease arrangements in which it is the lessor.

Note 25.2 The Hillingdon Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2021 £000	31 March 2020 £000
Gross lease liabilities	**1,655**	**2,394**
of which liabilities are due:		
- not later than one year;	603	747
- later than one year and not later than five years;	948	1,543
- later than five years.	104	104
Finance charges allocated to future periods	(130)	(224)
Net lease liabilities	**1,525**	**2,170**
of which payable:		
- not later than one year;	546	651
- later than one year and not later than five years;	877	1,417
- later than five years.	102	102

The vast majority of the Trust's finance leases as lessee relate to the lease of medical equipment. None of the individual items included are significant in value.

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020	**1,485**	**346**	**-**	**-**	**-**	**-**	**20**	**1,851**
Arising during the year	101	54	-	-	-	-	3	**159**
Utilised during the year	(124)	(23)	-	-	-	-	-	**(147)**
Reversed unused	(94)	-	-	-	-	-	-	**(94)**
Unwinding of discount	45	10	-	-	-	-	-	**55**
At 31 March 2021	**1,413**	**387**	**-**	**-**	**-**	**-**	**23**	**1,824**
Expected timing of cash flows:								
- not later than one year;	62	96	-	-	-	-	**-**	**158**
- later than one year and not later than five years;	-	291	-	-	-	-	**23**	**314**
- later than five years.	1,351	-	-	-	-	-	**0**	**1,352**
Total	**1,413**	**387**	**-**	**-**	**-**	**-**	**23**	**1,824**

All of the provisions held by the Trust relate to pensions. The most significant group relates to early retirement benefits for the Trust's former staff. The scheme is controlled by NHS Pensions; they inform the Trust of movements in the provision and advise when payments are due to individuals. As such, they control the timing of those cash outflows; other than that the length of the provision is determined by the longevity of the individuals concerned.

'Other' provisions relate to clinicians' pension tax, which was introduced in 2019/20. The Government Actuaries Department and the NHS Business Services Authority provided an updated estimate of £3,927 as the likely value for each scheme member eligible to claim. Based on current information, the Trust has estimated that 6 staff members are eligible to claim.

Note 26.2 Clinical negligence liabilities

At 31 March 2021, £227,125k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Hillingdon Hospitals NHS Foundation Trust (31 March 2020: £206,150k).

Note 27 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	6,740	3,905
Total	**6,740**	**3,905**

Note 28 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has one Local Improvement Finance Trust (LIFT) scheme on balance sheet. It relates to the Treatment Centre on the Trust's Mount Vernon site, and was added to the balance sheet in 2008/09.

Note 28.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**19,095**	**20,153**
Of which liabilities are due		
- not later than one year;	1,080	1,058
- later than one year and not later than five years;	4,312	4,308
- later than five years.	13,703	14,787
Finance charges allocated to future periods	(7,881)	(8,687)
Net PFI, LIFT or other service concession arrangement obligation	**11,214**	**11,466**
- not later than one year;	293	253
- later than one year and not later than five years;	1,385	1,288
- later than five years.	9,536	9,925

Note 28.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**24,661**	**35,837**
Of which payments are due:		
- not later than one year;	1,557	2,297
- later than one year and not later than five years;	6,228	9,188
- later than five years.	16,876	24,352

Note 28.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**2,347**	**2,297**
Consisting of:		
- Interest charge	806	824
- Repayment of balance sheet obligation	251	252
- Service element and other charges to operating expenditure	499	481
- Contingent rent	791	740
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	26	16
Total amount paid to service concession operator	**2,373**	**2,313**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing commissioner provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations; this assessment has not changed since the last financial statements.

Interest rate risk
As documented in note 21 on borrowings, the Trust has a significantly reduced level of borrowings on the balance sheet at 31 March 2021, compared with the previous year - this has reduced significantly an already low level of interest rate risk. In addition, remaining loans are all from the Department of Health to ensure the Trust has sufficient liquidity and working capital, and can also invest in its infrastructure. Nominally, the borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is generally charged at a fixed 1.5%. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2021 are in receivables from customers, as disclosed in the trade and other receivables note; and the Trust has taken action during 2020-21 to reduce its exposure to default, through increasing bad and doubtful debt provisions in critical areas such as overseas patients.

Liquidity risk
The Trust has set out in the going concern section of the accounting policies accompanying these financial statements that the accounts are being prepared on the going concern basis. However, the Trust is in receipt of working capital support and does not expect this position to change in the foreseeable future. The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament.

As in 2019-20, the Trust assesses that liquidity risk, while underwritten by DHSE, is low.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	22,809	-	-	**22,809**
Cash and cash equivalents	47,363	-	-	**47,363**
Total at 31 March 2021	**70,172**	**-**	**-**	**70,172**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	21,085	-	-	**21,085**
Cash and cash equivalents	9,791	-	-	**9,791**
Total at 31 March 2020	**30,876**	**-**	**-**	**30,876**

Note 29.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	4,352	-	**4,352**
Obligations under finance leases	1,525	-	**1,525**
Obligations under PFI, LIFT and other service concession contracts	11,214	-	**11,214**
Trade and other payables excluding non financial liabilities	66,527	-	**66,527**
Total at 31 March 2021	**83,618**	**-**	**83,618**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	111,150	-	**111,150**
Obligations under finance leases	2,170	-	**2,170**
Obligations under PFI, LIFT and other service concession contracts	11,466	-	**11,466**
Trade and other payables excluding non financial liabilities	32,627	-	**32,627**
Total at 31 March 2020	**157,413**	**-**	**157,413**

Note 29.4 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	68,756	137,535
In more than one year but not more than five years	7,304	10,008
In more than five years	16,539	20,213
Total	**92,599**	**167,756**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30 Losses and special payments

	2020/21		2019/20	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	1	18	4	1
Bad debts and claims abandoned	33	76	76	431
Total losses	**34**	**94**	**80**	**432**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	19
Ex-gratia payments	18	36	5	2
Total special payments	**18**	**36**	**8**	**21**
Total losses and special payments	**52**	**130**	**88**	**453**
Compensation payments received		-		-

Note 31 Related parties

During the year no Trust Board members or members of key management staff, or parties related to them, has undertaken any material transactions with the Trust. Transactions that did take place are set out below, and related party transactions and balances are included in the table below.

Sir Amyas Morse, Chair of the Trust, is also the Chair of London North West University Hospitals NHS Trust.

Linda Burke was a non-executive director at the Trust and also a councillor for Ealing Council.

Catherine Jervis was a non-executive director at the Trust and also at Barnet, Enfield and Haringey (BEH) NHS Trust. There were no transactions with BEH in year.

Sue Smith, Chief People Officer, has also been the CPO at Chelsea and Westminster Hospitals NHS FT since October 2020.

The husband of the former Medical Director, Dr Catherine Cale, is an executive for Thermo Fisher, a company that provides equipment, services and consumables to NHS Trusts.

	Income (£000s)	Exp (£000s)	Debtors (£000s)	Creditors (£000s)
London North West University Hospitals	23	3,069	438	472
Ealing Council	150	7	0	1
Chelsea and Westminster Hospitals	293	214	143	166
Thermo Fisher	0	1	0	0

The Trust has a linked charity, Hillingdon Hospitals NHS Foundation Trust Charity (1056493). No material transactions flowed between the Trust and the Charity during 2020-21.

The Department of Health is considered a related party as the parent department of the Trust. During the year the Trust has had a significant number of material transactions with the Department and with other entities for which the Department is the parent Department (please note, for the purposes of this section, management has set materiality at £5m). Material transactions occurred with the following such entities within the NHS (all numbers reported are in £000s):

	Income (£000s)	Exp (£000s)	Debtors (£000s)	Creditors (£000s)
Imperial College Healthcare NHS Trust	407	7,568	7,727	7,116
NHS England	43,221	211	6,792	52
Central London Clinical Commissioning Group	18,388	0	1,407	0
Ealing CCG	28,596	0	190	0
East Berkshire CCG	1,869	0	3	0
Harrow CCG	6,670	0	0	0
Hillingdon CCG	160,394	0	0	0
Health Education England	9,149	0	191	0
NHS Pensions	0	24,402	0	2,449
NHS Resolution	0	11,200	0	3

In addition, the Trust has had a number of material transactions with other governmental bodies. Most of the material transactions have been with HMRC, as follows:

	Income (£000s)	Exp (£000s)	Debtors (£000s)	Creditors (£000s)
HM Revenue and Customs	0	16,794	0	4,475

Note 32 Events after the reporting date

The Trust has considered whether there are any material post balance sheet events to disclose. At the end of May 2021, the Trust settled £6.1m of mutual debtor and creditor balances with Imperial College Healthcare; this reduced the Trust's debtors and creditors by this amount.