NHS
University College London Hospitals
NHS Foundation Trust

uclh

Annual report and accounts 2020/2021

UCLH is an NHS Foundation Trust comprising: University College Hospital (incorporating the Elizabeth Garrett Anderson Wing, Grafton Way Building, Macmillan Cancer Centre and University College Hospital at Westmoreland Street) Royal London Hospital for Integrated Medicine, Royal National ENT and Eastman Dental Hospitals, National Hospital for Neurology and Neurosurgery at Queen Square and Cleveland Street, Institute of Sport, Exercise and Health, Hospital for Tropical Diseases.

University College London Hospitals NHS Foundation Trust

Annual Report and Accounts 2020/21

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

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1. Performance report

1.1 Overview of performance

The purpose of the performance report is to provide an overview of our organisation, its purpose, the key risks and opportunities ahead, and our performance in the year.

The annual report has been prepared on the same group basis as the accounts.

1.1.1 Chair and chief executive's overview

The annual report is an opportunity to reflect on the achievements and challenges of the past year and to thank our fantastic staff for all they do for our patients every day.

This year has been dominated by the COVID-19 pandemic. Our staff have responded to this unprecedented challenge, going above and beyond to continue to provide safe and effective services to patients throughout the year. The pandemic has also provided an opportunity for us to work more collaboratively with other partners within the North Central London integrated care system – a network of NHS and other health and care organisations in the boroughs of Barnet, Camden, Enfield, Haringey and Islington. This year has also seen the opening of the Grafton Way Building, a new hospital that when fully open will be one of Europe's largest centres for treating blood disorders, as well as one of two proton beam therapy services in the country and also providing much-needed additional surgical capacity for the NHS.

We would like to acknowledge the inspirational leadership contribution made throughout the year by Professor Marcel Levi who left UCLH at the end of March 2021 to take up an exciting new role as the chairman and chief executive of the Netherlands Research Council and Chief Scientific Officer of the Netherlands. His leadership during the pandemic united teams across the Trust, allowed reorganisation of services to take place to free up space and people to treat patients with COVID-19, at an extraordinary pace that would have previously been thought impossible. As a front line clinician himself, Marcel was highly visible throughout the year not just to clinicians but also to porters, cleaners, catering and other staff working in crucial support roles.

We would also like to thank our chief nurse, Flo Panel-Coates, for co-leading the response to the pandemic and co-chairing our COVID-19 Strategic Incident Management Group which has been meeting since March 2020. This group has ensured that UCLH is ready and able to adapt to the many changes required as a result of COVID-19, and to keep our patients and staff as safe as possible. UCLH has been well prepared because of our fantastic staff who worked so hard throughout the year to allow us to continue to deliver excellent care for our patients despite the challenges of the pandemic.

UCLH was appointed as the lead provider for COVID-19 testing and vaccination services for North Central London. We would like to thank Laura Churchward, director of strategy, and the wider team, for their leadership of these services. Working closely with Health Services Laboratories and the Francis Crick Institute, testing services for hospitals and community services were set up and they ensured that both staff and patients received prompt testing, fundamental to providing safe care. The COVID-19 vaccination service has been a huge success across North Central London and UCLH has set up two mass vaccination centres at the Francis Crick Institute and the Islington Business Design Centre as well as a hospital

vaccination centre at UCLH, in addition to supporting many other centres across the sector. Together we have administered over a million doses of Pfizer, AstraZeneca and Moderna vaccines to health and social care staff and local residents.

Keeping our staff and patients safe has been a priority throughout the year. Thanks to our excellent procurement team, we ensured that our staff had access to personal protective equipment and key supplies throughout the pandemic. Across the organisation, clinical and non-clinical staff have worked tirelessly as #oneteam to reconfigure hospital services and repurpose areas for new uses so that safe pathways are in place for all our patients. Many staff have been redeployed or have volunteered to work in new areas to support the team effort, which has been fantastic to see and much appreciated by all.

The performance of our critical care, high dependency, acute medicine and emergency departments has been truly exceptional. They have worked collaboratively with our partner providers in North Central London to support other units where necessary and ensure that all patients receive the best possible care. The critical care transfer service has been invaluable in supporting the movement of critically ill patients. Over the year critical care capacity has been increased and UCLH is now one of two critical care hubs within North Central London.

The pandemic has also resulted in many new ways of working being introduced rapidly. Remote telephone and video outpatient clinics were established and have been positively welcomed by our patients. Face to face clinics are now being re-introduced where appropriate in order to ensure that we provide the best possible care for our patients. The digital healthcare team has helped to support remote working so that staff who can work from home are able to do so, in line with government guidance. Face to face meetings have in many cases been replaced by video conferencing and Epic – our electronic health records system - has proved invaluable in supporting remote working and providing staff with the flexibility to work anywhere, where appropriate.

We are very proud of the many research studies which were undertaken to improve our understanding of the virus. The UCLH team has made a significant contribution to national COVID-19 research programmes. UCLH was one of the highest recruiting sites to the trial of the Oxford AstraZeneca vaccine and we also opened a dedicated centre for vaccine trials in November. The pandemic provided an opportunity for many staff to get involved with research, some for the first time, and their enthusiasm will support the development of UCLH as a research hospital, with research embedded across the Trust.

During the COVID-19 surges, particularly in spring 2020, there were times when some elective care was postponed in order to ensure that we had the capacity to care for patients with COVID-19. However, we are proud that we managed to continue to provide urgent procedures for our cancer and other elective patients throughout the year. This was made possible by working with the independent sector to provide additional capacity and by identifying COVID-19-free sites, such as UCH at Westmoreland Street, where elective procedures could continue safely. For some months we have been focusing on recovery, working closely with other local NHS providers, in order to ensure that we are able to re-introduce services safely, reducing the waiting lists that have built up during the pandemic whilst continuing to support our staff. We are using the learning from the pandemic to accelerate transformation of services and introduce new pathways and ways of working in 2021/22.

It was exciting to be able to open the Grafton Way Building to surgical and imaging patients in April 2021 - the building provides eight operating theatres and a new critical care unit, and will open to haematology patients and for the proton beam therapy service later this year. The facility will allow UCLH to provide additional surgical capacity to London and beyond, and we are committed to working closely with partner organisations to maximise the impact we can

make on those who have been waiting a long time for treatment across the integrated care system, whilst minimising inequity of access to treatment.

Special financial arrangements have been in place throughout 2020/21 and will continue for at least the first half of the 2021/22 financial year. UCLH reported a surplus of £11.8m in 2020/21 before technical exceptional items. The underlying financial position, considered a better measure of underlying financial performance, was a £15.2m surplus. Total income over the period grew by just over ten per cent as the national funding arrangements provided sufficient income to cover the additional costs associated with COVID-19 and to address, in a non-recurrent way, the underlying deficit that UCLH was carrying prior to the pandemic and which will remain after the special financial arrangements in place for the pandemic come to an end.

UCLH scored well in the national staff survey with very strong improvement in overall staff engagement and the Trust was ranked seventh of all NHS organisations nationally on the key measure of staff recommending their organisation as a place to work. However, we recognise the need to improve in other areas and have plans for further improvement in equality, diversity and inclusion, and reducing bullying and harassment experienced by staff. We, with our colleagues on the Board, are committed to improving patient and staff experience supported by the Trust values of safety, kindness, teamwork and improving to underpin all our improvement programmes.

The support from the community for the NHS and for carers has continued to be overwhelming and we would also like to thank the UCLH Charity, the Friends of UCLH, the National Brain Appeal and the UCLH fundraising and staff experience teams for their support during this challenging time. Supporting the wellbeing of our staff, and those that work for partner organisations providing services to UCLH, remains a top priority to ensure that our people are looked after and that our teams have resilience to continue to provide excellent services for our patients over the coming year. We are investing in several initiatives to further improve staff experience and support the recovery of our staff.

We would like to take this opportunity to thank every single member of our staff for continuing to deliver fantastic and compassionate care during this most difficult time and we look forward to the challenge of continuing to improve our services and deliver even better healthcare for patients over the next year and for generations to come.

Baroness Julia Neuberger DBE
Chair

Tim Jaggard
Acting chief executive

14 June 2021

1.1.2 About UCLH

UCLH (University College London Hospitals NHS Foundation Trust) is situated in the heart of London. Our vision is to deliver top quality patient care, excellent education and world-class research. Our values of safety, kindness, teamwork and improving are at the heart of everything we do for our patients and staff.

UCLH comprises:

- University College Hospital (incorporating the Elizabeth Garrett Anderson Wing, the Macmillan Cancer Centre, the Grafton Way Building and University College Hospital at Westmoreland Street)
- Royal London Hospital for Integrated Medicine
- Royal National ENT and Eastman Dental Hospitals
- National Hospital for Neurology and Neurosurgery at Queen Square, Cleveland Street and Chalfont
- Institute of Sport, Exercise and Health
- Hospital for Tropical Diseases

UCLH has a devolved management structure with strong clinical leadership. The board, led by the chair, sets the vision and values of UCLH and works to promote the success of the organisation. The board comprises non-executive directors, who bring independent advice and judgement to the board, and executive directors who manage day-to-day operational services.

The senior director team is chaired by the chief executive, Professor Marcel Levi (who left the Trust on 31 March 2021) and includes our medical, nursing and corporate directors. We have three clinical boards (medicine board, specialist hospitals board, and surgery and cancer board) led by medical directors Dr Charles House, Dr Tim Hodgson and Professor Geoff Bellingan, respectively. Dr Gill Gaskin is medical director, digital healthcare. Our chief nurse, Flo Panel-Coates, oversees nursing and midwifery and delivery of care at UCLH in general. Our chief financial officer and deputy chief executive is Tim Jaggard. We have a number of corporate directorates. David Probert has been appointed to be the next Chief Executive and will take up this position in late August 2021. Interim arrangements are in place from 1 April 2021, with Tim Jaggard as Acting Chief Executive, Flo Panel-Coates as Acting Deputy Chief Executive and Vicky Clarke as Acting Chief Financial Officer.

Our council of governors comprises patient, public and staff members, and appointed representatives from stakeholder organisations. The council provides support and advice to UCLH and ensures we deliver services that meet the needs of the patients and communities we serve.

We provide acute and specialist services to a diverse local population and to patients from across England and Wales. We balance the provision of nationally recognised specialist services with delivering high quality acute services to our local population.

UCLH is part of North London Partners in Health and Care, the integrated care system (ICS) for North Central London (NCL). The aims of the ICS are to improve health and care and reduce health inequalities for the 1.3 million people who live in these areas. UCLH is also part of the newly formed NCL Provider Alliance.

We are proud of our close partnership with UCL (University College London) which is consistently reported as one of the best performing universities in the world, especially for biomedical science. UCL's facilities are embedded across much of our hospital campus and the partnership is linked through a large number of joint clinical and academic appointments.

We are one of England's 20 biomedical research centres (BRCs) and we are a founding partner of UCLPartners, one of the UK's first academic health science centres (AHSCs).

We incurred expenditure of £1,411m. We have approximately 10,600 staff who come from over a hundred nations and we care for more than one million patients a year. We are committed to the principles of equality and fairness for all of our staff and patients. We work with different communities to deliver better patient care that is inclusive, accessible and fair.

1.1.3 Strategic developments

North Central London Sustainability and Transformation Partnership

The North Central London Sustainability and Transformation Partnership (STP) brings together councils, the NCL clinical commissioning group (CCG) and healthcare providers across the five boroughs of Haringey, Islington, Camden, Barnet and Enfield. Together we are the North London Partners in Health and Care. The aims of the STP are to improve health and care for the 1.3 million people who live in the area and to reduce health inequalities.

The collaboration of North London Partners in Health and Care came to the fore during the COVID-19 pandemic, with mutual aid and support provided across North Central London.

UCLH led in a number of areas, including COVID-19 testing and as the lead provider for the COVID-19 vaccination programme.

UCLH helped to develop the critical infrastructure required to enable PCR testing at the start of the pandemic in March 2020. This included setting up a partnership with the Francis Crick Institute and Health Services Laboratories (HSL) to implement a broad portfolio of COVID-19 tests using a variety of technologies. This ensured that we could rapidly test patients and healthcare workers for COVID-19. As the pandemic progressed, the service has adapted to our needs and includes testing of patients prior to admission for non-COVID-19 related treatment and of household members of staff.

The portfolio of tests includes multiple PCR tests, including in-house developed tests and commercial assays. We have introduced two rapid (60-90 minutes) COVID-19 PCR tests, deployed in our Emergency Department (ED), the NHNN Neuro-immunology laboratory and the Rapid Response laboratory. Over winter we also introduced a rapid test in the ED hot laboratory, able to detect SARS-CoV-2, influenza A/B and RSV virus. We also have access to two different COVID-19 antibody tests that can detect between natural infection and vaccination. Our virology laboratory has operated on a 24/7 basis for many months to provide timely COVID-19 PCR testing at scale. At the peak of the recent COVID-19 surge, our virology laboratory at the Halo Building was testing 11,000 samples per day. UCLH Virology worked closely with the Francis Crick Institute to develop COVID-19 PCR testing capability very rapidly in the spring of 2020, further increasing our testing capacity and allowing for asymptomatic staff screening to happen at scale. Finally, the UCLH Advanced Pathogens Detection Unit (APDU) developed a COVID-19 whole genome sequencing capability and contributed UCLH COVID-19 case genomic data to national COVID-19 surveillance studies.

In relation to the vaccination programme, UCLH is responsible for mass vaccination centres at the Francis Crick Institute and the Islington Business Design Centre, as well as the hospital centre at University College Hospital. UCLH had vaccinated over 35,000 people by the end of March 2021. 81.9 per cent of our frontline staff had been vaccinated by the end of March 2021.

UCLH has also actively led and participated in the NCL Intensive Care Unit (ICU) network that was established in response to the first COVID-19 surge. This network has overseen the sector wide delivery of critical care services including the creation of several ICU transfer teams which have ensured that critically ill patients could be safely moved from the most pressurised of hospitals to those with capacity and the provision of mutual aid.

As well as these COVID-19 related programmes of work, existing programmes continued. This included the completion of the public consultation on proposals to consolidate orthopaedic services into two hubs in NCL – one in the north and one in the south, with the Royal National Orthopaedic Hospital delivering more complex surgery. As a result of the consultation, the decision was made to implement the proposals and create the North Central London Orthopaedic Network. As part of this, two partnerships have been developed: UCLH and Whittington Health NHS Trust, and Royal Free London NHS Foundation Trust and the North Middlesex NHS Trust, with the network due to open to patients in late April 2021, delayed due to the pandemic.

Working together in this way means patients can receive timely, high-quality care. Clinicians from across hospitals will work together as a single team, share joint training and education, and hospitals can also share their facilities, opening up access to more dedicated beds and operating theatres. In addition, clinical networks have proved important in managing waiting lists across NCL.

All NHS providers in NCL have agreed to form a Provider Alliance. The NCL Provider Alliance Board has been appointed to and priorities will be agreed over the coming months. The NCL Provider Alliance will foster closer working across all parts of the system and build on the excellent collaboration which has developed during the pandemic.

Digital healthcare

Our venture to make UCLH a truly digitally integrated hospital has paid dividends during our response to COVID-19. We are one of a handful of trusts to have this capability. The pandemic has tested us all, but, from a healthcare perspective, the single electronic health record (EHR) implemented just under a year before the pandemic has seen us through an exceptionally turbulent time.

It means that our doctors, nurses and other healthcare professionals have immediate access to all relevant patient information in one place. We have been able to make rapid advancements in care through secure information sharing across hospital settings and healthcare organisations. Colleagues across UCLH say they could not have imagined working in any other way during the pandemic.

We supported the rapid rollout of telephone and video clinics at UCLH and, with the power of an integrated EHR and patient portal (MyCare UCLH); we could continue care for a large number of patients through remote outpatient clinics and remote monitoring.

At the start of the pandemic, we rapidly introduced new technology, applications and guidance to support large numbers of staff working remotely. We had to scale up the means to access UCLH systems remotely very quickly and support staff in doing so.

In May 2020, we switched on a link to the NCL Health Information Exchange (HIE) within our EHR. Since then, UCLH clinicians have been able to use our EHR to access a summary view of data from different GPs, hospitals and other healthcare organisations across London. In February 2021, UCLH started sharing data from our EHR securely with the HIE so colleagues across NCL can view important and current information about their patients at the point of care. This will further help improve health and care across our sector and eventually across London

as part of the OneLondon programme. It is about making health and care information more consistent, more joined-up and more available to those who need to access it.

Throughout the year, UCLH digital healthcare teams worked with our technology partner, Atos, to ensure the necessary technology and digital infrastructures were in place to start to open our new landmark hospital for proton beam therapy, cancer inpatients and surgery, University College Hospital Grafton Way Building, from April 2021.

New clinical facilities

Our ambitious programme to improve and expand our estate continued through 2020/21.

The University College Hospital Grafton Way Building will open in a phased way. This is later than planned due to the complexity of the project and the additional challenges caused by the COVID-19 pandemic. Handover from the builders, Bouygues UK, took place on 19 March 2021. The eight theatres, the surgical ward, the critical care unit and the imaging centre opened in April 2021, as we came out of the second wave of the COVID-19 pandemic.

The new hospital will also provide three floors dedicated to the care and treatment of blood disorders, and one of only two proton beam therapy centres in England, which will open later in 2021.

Mount Vernon Cancer Centre

Following an “expressions of interest” process, UCLH was announced in 2020 as the preferred provider for services delivered at Mount Vernon Cancer Centre (MVCC), which is currently part of East and North Herts NHS Trust. This decision is subject to a due diligence process which was paused as a result of the COVID-19 pandemic. The process resumed in late 2020 and the timeframe now means the earliest that UCLH would take over responsibility for the site is during 2022 with a decision being made about whether to proceed in mid-2021.

NHS England and Improvement (NHSEI) has been working with patients and stakeholders, East and North Herts NHS Trust and UCLH to develop a range of options for the future of services at MVCC.

UCLH private healthcare

UCLH private healthcare has maintained low levels of private activity this year to accommodate the most complex or urgent cases more generally. The majority of private healthcare capacity in UCLH hospitals was appropriately reprioritised to support the COVID-19 response and NHS elective work.

This year the private healthcare team has been focusing on significantly upgrading the overall business infrastructure for private care. This has included improving the billing and business function with the implementation of a new IT platform, the renegotiation of contracts with private medical insurers, debt reduction, and the development of a new UCLH private healthcare brand to support better communications and marketing. All profits from private work are reinvested to support NHS patients under our care.

1.1.4 Education and training

Delivering excellent education is integral to our mission and one of our strategic objectives. The education directorate works to improve patient care and staff experience by helping individuals, teams, the wider organisation and its partners to develop to their full potential. In this

extraordinary year, we are proud to have played our role in the organisation's response to COVID-19.

Responding to COVID-19

In the initial COVID-19 surge, and mindful of the need to maintain staff and patient safety, we took immediate steps to ensure that our education centre was appropriately staffed and equipped. Since then, throughout the pandemic, our staff and facilities have been fully available to the Trust to support essential face-to-face COVID-19-related training and activity.

We played a critical role in the redeployment of junior doctors and other medical staff so that the organisation was able to provide sufficient ICU cover and maintain effective and safe patient care. Furthermore, we supported the deployment of volunteer medical students, and reconfigured clinical training programmes to maintain effectiveness and continuity of professional and undergraduate training. Despite the obvious challenges, we achieved outstanding General Medical Council survey results for the year.

Our Epic EHR training team rapidly transitioned to delivering on-line training so that new and redeployed staff could be given the knowledge and skills to work safely and effectively with the Epic system. The Epic training team also provided training on the best use of MS Teams and other collaborative tools, so that our staff could move rapidly to remote working and yet maintain continuity of service and support.

Similarly, our induction and core skills team worked to move the new starter process on line and streamline it to ensure the rapid on-boarding of COVID-19 response staff. Mandatory training requirements were reviewed and again moved to virtual delivery where possible.

Individually, a number of directorate staff volunteered to be temporarily redeployed, sometimes externally - for instance to the London Nightingale Hospital project – and sometimes within the organisation. Through the first and second COVID-19 waves, directorate staff have, for instance, variously supported an expanded HR Helpdesk, updated PPE fit testing records, helped with training checks on volunteer COVID-19 vaccinators and supported the work of the family liaison teams. Much work was done to improve locker availability so that staff could safely store PPE and other personal equipment and belongings. Some directorate staff with a clinical background volunteered to spend more time in their clinical roles or to provide support to other clinical areas.

The expertise of our clinical education team was hugely relevant throughout the COVID-19 response. In addition to helping to operationalise the London Nightingale Hospital, they used their *in-situ* simulation skills to test and improve COVID-19-related systems and pathways in UCLH and its partner organisations. It helped prepare wards and departments for their role in the COVID-19 response and trained individuals and teams in key critical care skills.

Our audio visual team was also much in demand, supporting essential virtual meetings and events, and producing dozens of video resources on issues such as correct PPE usage and infection prevention and control. Similarly, our e-learning designers were vital to the effort, helping to produce a range of essential on-line learning resources. Many of these resources were hosted on our on-line learning portal, which was also progressively modified to accommodate essential staff training records around PPE training and fit testing, continuous positive airway pressure (CPAP) machines, ICU and critical care skills.

As effective vaccines became available, we worked in partnership with Bank Partners, the Francis Crick Institute, Middlesex University and others in the NCL sector, to create an accessible COVID-19 vaccination training programme, supporting vaccinators working right across the NCL health community.

Finally, as the organisation sought to learn from its experience of COVID-19, members of our improvement team facilitated a range of high level After Action Reviews, helping to create the new ways of working that will emerge as a result.

Business as usual: creating the "new usual"

Despite these challenges, we have sustained a significant proportion of our usual activity. Most of our programme of face to face teaching in staff development, quality improvement and organisational learning has moved successfully on line.

The five staff networks we oversee have continued to expand, now covering some 1,500 members, and our apprenticeship programme provides for some 300 staff members at any one time. Our coaching network continues to grow, with more than 50 trained coaches now in place.

We continue to work on important programmes to reduce violence and aggression to staff, and to support the development of the UCLH exemplar accreditation programme. Our health coaching programme – enhancing self-management for patients – launched this year as planned, is also making the transition from a face to face to a virtual approach.

We look to a future no longer dominated by COVID-19. We are working hard on the design and implementation of our leadership and management skills framework, due to launch in 2021, and are looking forward to doing more to support the UCLH outpatient transformation programme.

Nursing and midwifery education

A significant contribution has been made by the nursing and midwifery education team and clinical practice facilitators to support the preparation for staff redeployment and the education of a vast number of staff within nursing, midwifery and other staff groups during the COVID-19 pandemic. This had a significant impact on undergraduate placements during 2020/21. The Nursing and Midwifery Council (NMC) introduced emergency standards for nursing and midwifery education in March 2020, enacting paid extended placements. These standards were withdrawn in September 2020 and re-introduced in February 2021 during the second surge of the pandemic. Nearly two hundred 2nd and 3rd year students opted in to support the COVID-19 pandemic at UCLH. Students from existing as well as external university partners joined the team. UCLH opted not to adopt the standards in February and maintained students on programme as usual via unpaid, supernumerary placements. A total of 467 nursing students were supported on placement at UCLH between April 2020 and March 2021.

Placement expansion continues to be high on the government's agenda to secure an increase in future nurses. UCLH was successful in a funding bid to support placement expansion for the academic year 2021/22.

Despite the challenges of COVID-19, the undergraduate education team supported the Graduate Guarantee in July 2020 and March 2021 to enable students to apply for newly qualified nursing posts at UCLH. 106 adult student nurses were offered posts, equating to a 75 per cent conversion rate. This figure is adjusted to 91 per cent for those who were hosted on their final paid placement during COVID-19.

The nursing and midwifery education teams also continue to support and promote a variety of apprenticeships at ULCH. During the second surge, all apprentices were supported to continue on programme. 47 trainee nursing associates (TNAs) continue on programme with Middlesex University. We were delighted to see our first cohorts of 15 TNAs qualify as Nursing Associates in December 2020 and February 2021. UCLH successfully submitted a joint bid to lead the NCL Nursing Associate Collaborative for 2020/21.

Thirty-two registered nurse apprentices continue on programme with Bucks New University and BPP University. Our attrition rate is 9 per cent compared to 25 per cent nationally for traditional UCAS student nurses (Jones-Berry, 2020).

The CapitalNurse preceptorship programme continues to be delivered to a high standard with UCLH retaining the CapitalNurse Quality Kite Mark. UCLH was the first trust in London to deliver an accelerated preceptorship programme which resulted in UCLH being shortlisted for a Nursing Times award.

Seventy-four international nurses arrived at UCLH during 2020/21. During the same period, eighty-eight passed their OSCE (Objective Structured Clinical Examination) and progressed to NMC registration. This includes fourteen from a cohort prior to March 2020. A further seven internal HCAs who had international nursing qualifications were supported by the nursing education team to sit their OSCE and also progressed to NMC registration. During the pandemic the NMC opened an interim temporary register to allow international nurses to work as Band 5 nurses. Ninety international nurses joined the temporary register in either April 2020 or January 2021. All of these are now on the permanent register as registered nurses at UCLH.

Continuing professional development (CPD) for nurses continues as planned. Learning needs analyses for each clinical area were completed in March 2021 and will inform 2021/22 CPD spend. A CPD programme for allied health professions is also in place and the two programmes work together to ensure parity and appropriate allocation of funding.

UCLH continues to be involved in the development and delivery of the CapitalNurse Qualification in Specialism (QIS) and has representation on all faculties in the following specialties: emergency nursing, care of older people and theatres. Work has resumed to scope and design our local QIS programmes within a number of areas including haematology, neurology, critical care and enhanced care.

1.1.5 Research and development

UCLH is one of the largest NHS trusts and our academic partner UCL is one of the world's leading biomedical research universities. By working together as a biomedical research centre (BRC) we have become leaders in translating fundamental biomedical research into clinical research that benefits patients.

The National Institute for Health Research (NIHR) is funding our BRC for a five-year period until 2022. NIHR BRC status has enabled us to invest in staff, equipment, facilities and training to drive innovation in basic science and to turn this into new treatments and therapies for patients.

In particular, our BRC supports experimental medicine research which focuses on 'first in human' studies. It also supports investment in the development of our data science and artificial intelligence capabilities, as outlined below.

We are committed to embedding a culture of research across our entire organisation in order to push the boundaries of medicine and technology to deliver positive change for patients and our staff.

In 2020/21, 179 new research studies were approved to begin recruitment at UCLH (232 in 2019/20).

We recruited 7,673 participants to research studies at UCLH in 2020/21 (18,705 in 2019/20).

COVID-19 research

When the COVID-19 pandemic started, UCLH paused all clinical trials except those looking at COVID-19, or treatments essential for serious or life-threatening conditions, or held remotely. A total of 1,337 studies were paused in line with NIHR guidance.

UCLH's expertise as a centre of world-class research enabled it to carry out research rapidly to tackle an unknown disease of which clinicians had no direct experience. A total portfolio of 65 COVID-19 studies were active at UCLH during 2020/21, including 22 urgent public health (government-prioritised) studies. Some 4,293 people were recruited into COVID-19 studies at UCLH.

UCLH was praised for its rapid set up of studies – a process which normally takes weeks – including one immune modulatory study that was set up in a matter of hours.

As well as making significant contributions to vaccine trials and to national priority trials, UCLH developed novel therapies for COVID-19 and led on initiatives to analyse data on COVID-19.

Highlights of UCLH-initiated research

Life-saving breathing aid
UCLH clinicians worked at the height of the first wave of the pandemic with UCL and Mercedes Formula 1 engineers to develop a breathing aid that reduced the need for ventilation. The CPAP device went from concept to manufacture within one month. It is now used in more than 130 NHS hospitals.

Determining who should shield
UCLH and UCL researchers worked with Microsoft to see if chest imaging data can better identify who should shield in any future outbreaks.

Tracking infection in healthcare workers
A major UCLH study of healthcare workers highlighted the importance of routine screening after it found that a high proportion of frontline staff had the virus during the peak of the first wave.

Loss of smell
UCLH and UCL research, reported by the international media, found that almost 80 per cent of people with sudden loss of smell or taste tested positive for COVID-19 antibodies. This demonstrated that acute loss of smell or taste is a highly specific virus indicator and should be considered as a criterion for self-isolation, testing, and contact tracing.

'Long COVID-19'
NHS England Chief Executive Sir Simon Stevens and Matt Hancock, Secretary of State for Health and Social Care, visited UCLH's novel long COVID-19 clinic (featured on BBC and ITV and in many newspapers) where researchers are investigating the long-term impacts of COVID-19 and developing care strategies. There are now two clinics available – one at University College Hospital and one at the National Hospital for Neurology and Neurosurgery.

Interactions with other diseases
UCLH studies are looking at how COVID-19 interacts with conditions such as cancer, cardiovascular disease and hearing loss. One study found that cancer and its treatment are independent risk factors for mortality following COVID-19. Separate research laid to rest fears that people with high blood pressure are more at risk from severe COVID-19.

Contributions to national COVID-19 research

Vaccine and drug trials

- UCLH was one of the highest recruiting sites to the trial of the Oxford AstraZeneca vaccine which has been shown to offer a high level of protection and, since being approved, is now being rolled out across England. UCLH is also trialling the vaccine developed by Imperial College London. With more vaccine and prevention trials planned, UCLH opened a dedicated centre for vaccine trials in November 2020.
- UCLH was also a major contributor to:
    - the RECOVERY trial which found that the steroid drug dexamethasone reduced mortality substantially in severely ill COVID-19 patients.
    - a trial of antiviral drug remdesivir**,** originally developed to treat hepatitis C and then investigated for use with Ebola and Marburg disease, which was found to shorten recovery time in hospitalised COVID-19 patients.
    - a trial of a repurposed drug for cystic fibrosis to treat COVID-19.

Research firsts at UCLH

- UCLH was the first site to recruit a patient to an urgent national public health study analysing viral genomic data in real time to reduce the spread of COVID-19 in hospitals.
- UCLH was the first hospital in the world to treat a COVID-19 patient with nebulised (inhaled) surfactant – a substance which makes it easier to breathe – as part of a clinical trial.
- UCLH also recruited the first global participant in a trial of a novel antibody to prevent COVID-19.

Data science

The COVID-19 pandemic highlighted the need for UCLH's expertise in harnessing the power of data science and artificial intelligence (AI) to understand an unknown disease and improve patient care. UCLH opened 19 data studies, of which some highlights included:

- UCLH formed a partnership with University Hospitals Birmingham, UCL and the Alan Turing Institute to pool data to enable real-time research into COVID-19. Analysts have started work looking at risk predictors, coagulopathy and ventilation.
- UCLH is the lead UK site in the international CAPACITY registry of patient data to look at cardiac complications in COVID-19 patients.
- UCLH is now contributing information on COVID-19 as part of the international project ISARIC, initially set up to understand the MERS outbreak in 2012.

Underpinning this work is UCLH's clinical and research informatics unit (CRIU) made up of a team of clinicians, AI researchers, software developers, data scientists and business intelligence analysts.

Restarting clinical trials

In May 2020, UCLH began to restart the 1137 trials that were paused during the first wave of the pandemic. By December 2020, the interventional trials portfolio had reached 75 per cent of its pre-COVID-19 activity level. Trials were restarted after an assessment of their supporting departments' capacity, along with the need for extra hospital visits. Research participants are only asked to visit the hospital if it is necessary for the study requirements. Otherwise studies are continued by remote contact.

1.1.6 Our objectives 2021/22

UCLH has five strategic objectives. We aim to deliver these through annual objectives, which we refresh each year. These have been reviewed in the light of the COVID-19 pandemic and reflect the current priorities for the Trust.

Strategic objective: Provide highest quality care within our resources and increase our focus on safety

Objective
Continue to reduce avoidable harm through agreed safety priorities and annual infection targets
Maintain patient experience, focus on new ways to connect with our patients and their families / carers / visitors
Work towards all contact and booking with patients and GPs being timely, accurate and professional
Ensure our safety and infection prevention and control processes minimise the impact of COVID-19 for patients and staff
Deliver the hospital and community COVID-19 vaccination programme, working with partners across the integrated care system

Strategic objective: Become a world class academic research hospital embedding research throughout the organisation and all disciplines

Objective
Continue to deliver the objectives of the existing Biomedical Research Centre funding and achieve success in the next competition
Develop our digital health research capability and partnerships to develop advanced analytics as a key part of the “Research Hospital”
Develop and encourage research opportunities for junior doctors, nurses and other clinical staff across UCLH, so that everyone is ultimately involved in research
Drive and lead research to understand and mitigate the impact of COVID-19 in global healthcare

Strategic objective: Operational excellence through our Electronic Health Record and optimised processes

Objective
Use the capabilities of our Electronic Health Record to transform how we deliver patient care, both within UCLH and with partners in North Central London
Provide rapid treatment to patients with the greatest clinical need and take significant steps towards treating patients within agreed waiting times standards working collaboratively within clinical networks
Improve the flow of acute patients in our emergency department to admission and shorten the time patients wait for discharge from the Trust
As host of the cancer alliance, define and deliver the best approach for cancer recovery across North Central London, spanning early diagnosis, treatment and support for cancer patients
Work with the wider London network to maintain flexible critical care capacity to deal with any future COVID-19 surges
Reduce the time that patients are currently waiting for services from North Central London providers by prioritising patients and aligning resources with all our integrated care system partners
Deliver our strategic programme for 2021/22: complete the reorganisation of all sites to meet post-COVID-19 requirements and work with stakeholders to agree the best solution for the Mount Vernon Cancer Centre transition

Strategic objective: Develop all our diverse staff to deliver their potential and foster talent

Objective
Show care for all our staff by being a diverse and inclusive employer, including improving the experience of our black, Asian and minority ethnic staff
Create a vision for organisational development (OD) at UCLH, with a cohesive OD offering to respond to the needs of an ever-evolving health care environment
Provide excellent education and focused development opportunities, ensuring we are able to respond adequately to any future COVID-19 demands
Make UCLH an even greater place to work by encouraging better working relationships, reducing bullying, offering more flexible and remote working, and focus on staff safety and supporting staff to recover from the pandemic through focus on mental health and wellbeing

Strategic objective: Improve financial sustainability of UCLH and the wider health economy

Objective
Play a lead role in developing an integrated care system in North Central London, enabling transformation of services and financial sustainability post COVID-19 for UCLH and the wider system
Achieve the financial plan with a focus on controlling expenditure, increasing non-NHS income and ensuring underlying financial position is sustainable upon exiting national COVID-19 financial arrangements
Deliver productivity improvements utilising our strategic investments to drive further improvement working closely within our Sustainability and Transformation Partnership to identify further opportunities
Deliver our services sustainably by delivering on our Green Plan, including reduction of our carbon footprint

1.1.7 Key risks and opportunities 2021/22

The table below identifies the most significant risks identified by the board which could prevent us from achieving our five strategic objectives. The table also outlines how we are seeking to reduce these risks in order to ensure the future success and sustainability of UCLH. In light of the COVID-19 pandemic, we undertook a detailed review of the Board Assurance Framework to ensure that this reflects the top strategic risks in the current organisational context.

Strategic objective: Provide the highest quality of care within our resources and increase our focus on safety	
Risk	**Mitigation**
The COVID-19 pandemic could lead to a deterioration in the quality of care and the capacity we are able to provide for other services. It will constrain our ability to provide routine services at normal levels. Reduced capacity to see and treat patient activity may severely prolong the time that patients have to wait for care. There is also risk to clinical outcomes as we may not quickly identify referrals marked as routine which should in fact be treated as urgent cases. Some patients may defer their attendances and then have to be rebooked, leading to a worsening of their condition.	The Senior Directors Team (SDT) is overseeing our response to the COVID-19 pandemic and recovery through a special weekly meeting with an enlarged membership and clear sub-group structure. This group is now also overseeing the COVID-19 vaccination programme. We are prioritising emergency and urgent care on our main site and working within nationally-approved clinical guidelines to ensure patients requiring priority cancer treatments or time-sensitive urgent treatments receive these through designated hubs created on sites that are not directly treating patients with COVID-19 or have defined separate pathways for this care. We are working within the North Central London sustainability and transformation partnership (STP) and wider healthcare colleagues through a strategic recovery framework.
This major disruption to service provision is expected to alter financial arrangements through 2021/22, which could reduce our income.	NHS England and Improvement have put in place special financial arrangements until the end of March 2021. There are further special funding agreements in place until at least until 30 September 2021.

The quality of care we provide could get worse because of the amount of money we need to save.	Our cost improvement plans (CIP) focus on improving patient experience by reducing waste and increasing efficiency so that quality and savings targets can be achieved together. We carry out an assessment of each saving scheme to make sure we have understood and are able to manage any risks to quality before deciding whether to carry on with the scheme. Medical directors (and, where appropriate, other senior clinical staff) scrutinise cost improvement plans before they are implemented. We provide scrutiny and challenge to additional COVID-19 and non-COVID-19 related costs, particularly costs that may become recurrent, in light of the revised financial framework post-COVID-19. We use the national safer nursing care tool to determine ward staffing levels.
Some of the older buildings at UCLH need repairs, and if we fail to carry them out it could impact on the quality of care we give to our patients.	We undertake regular maintenance, focusing on preventative checks and repairing areas in need. We conduct an annual survey to fully evaluate the condition of our buildings.
We could fail to provide high quality care because of weaknesses in keeping track of the appointments, tests or treatments that patients need.	Epic provides much better functionality for tracking all the events that patients need on their pathways at UCLH and we will continue to harness its potential to track patients waiting at all stages of their pathways. We will soon be introducing metrics to monitor each team's success in providing appointments as part of our routine performance tracking systems. The implementation of the EHR system has impacted upon patient administrative processes and data quality. There are mitigating and control factors in place which are overseen by the digital healthcare board. Detailed plans are in place to support the post-live development of the system. This includes a set of key performance indicators (KPIs) to track data quality and enable management action to address any emerging problems.
Strategic objective: Become a world-class academic research hospital embedding research throughout the organisation and all disciplines	
Risk	**Mitigation**
Some annual research funding streams may reduce over time.	Our biomedical research centre (BRC) and clinical research facility are working with the wider research community to achieve the standards needed to generate future income.

Strategic objective: Operational excellence through an electronic health record (EHR) system and optimised processes	
Risk	**Mitigation**
A cyber attack could lead to some of our critical IT systems not being available.	We carry out extensive risk assessments of our ability to defend against cyber attacks.We have good technical controls provided by our IT provider which includes anti-virus, anti-malware, firewalls and data encryption. We test these controls on a regular basis, and have a good system for keeping up to date with the latest protections for computers and servers. We are addressing vulnerabilities identified through our annual NHS Data Security and Protection toolkit review, including better tracking of all our software and hardware so that vulnerabilities can be proactively managed.
UCLH fails to deliver the improvements in quality, safety, patient experience, efficiency and research intended in the investment case for Epic and other digital technology.	We implemented Epic in March 2019 to help improve patient care and help us make financial savings. Our EHR team, our EHR suppliers and teams from across UCLH have focused on addressing any unintended consequences from introducing the new system. We have a number of very senior clinical leaders with roles dedicated to making the system work for the benefit of our patients. We have a set of metrics to track how we are doing against key issues that could be affected by the process of implementing Epic. We also have a comprehensive governance structure around all aspects of Epic. We work with our digital transformation partner, Atos, to deliver benefits from our investment in technology. We are actively involved in NCL plans to improve the use of digital patient records across GP surgeries, hospitals and mental health trusts. We participate in NHS Digital and NHS England and Improvement's regional and national digital programmes. We are aware of the latest standards and are involved in national strategy.

Strategic objective: Develop all our diverse staff to deliver their potential and foster talent	
Risk	**Mitigation**
Not having enough nurses and midwives to cover some roles will make it difficult to deliver the highest quality of care.	We monitor all our wards very closely for risks associated with staffing levels. We also monitor how well we are getting temporary staff to fill vacancies, as well as recruitment rates and national/ international markets. We learn from colleagues across the NHS as to how we can attract more nursing staff and redesign our staffing models to manage with fewer nurses.
Not having enough junior doctors to fill our rotas could make it difficult to provide the quality of care we want to provide.	We continue to create education and research fellowships, as well as registrar posts which allow for enhanced research time. We are seeking funding to explore how an international recruitment campaign for junior doctors could be run. We have streamlined some aspects of joint appointments with UCL, including sharing the recruitment process for joint appointments and student placements. We have agreed to share some pre-employment checks and we aim to do the same for student placements.

Strategic objective: Improve the financial sustainability of UCLH and the wider health economy	
Risk	**Mitigation**
UCLH is allocated insufficient funding or is set unachievable efficiency targets resulting in failure to remain financially sustainable. UCLH is unable to adapt to changes in models of care and tariff structures resulting from a shift of financial and volume risk from commissioners to providers. The risk is exacerbated by regional and national reconfiguration work which could shift responsibility for managing finance envelopes from commissioners to providers, along with the financial risk from lack of national funding.	We are focused on embedding a strong financial control environment to ensure all expenditure is reasonable, justifiable and essential through vacancy control procedures and review of monthly financial positions. We will continue to focus on rigorous cost improvement planning, delivery and oversight processes. We will continuously review opportunities that could be added in to the savings programme as the UCLH progresses through the recovery phase. We are engaged in national work to design the funding regime for 2021/22 and beyond. We are working with the Shelford Group and NHS Providers and engaging with NHS England and Improvement to ensure the financial regime secures sustainability for UCLH and other providers. We closely monitor the commissioning landscape to anticipate any changes to funding streams. Interim funding arrangements for 2020/21 have reduced the immediate risk but the strategic risk for 2021/22 remains. We are actively engaged with the NCL Sustainability and Transformation Partnership and with national colleagues, including the design of new payment mechanisms and financial architecture to ensure no adverse consequences. We are leading new care models that use different tariffs to fund different ways of funding and running clinical services.

Opportunities

There are also a number of opportunities on which we will seek to capitalise in the coming year to help us deliver our strategic objectives. For example, we will continue to build on the successful implementation of Epic to drive forward digital innovation in healthcare, education and research. We will also continue to work closely with our partners in NCL and beyond to deliver on the opportunities and ambitions of the NHS Long Term Plan.

Given increased public awareness of the urgent need to address environmental and sustainability issues, we will also be supporting staff to adopt more green practices which are not only better for the environment but also result in improved patient care and more efficient services.

For further details about all of these opportunities see sections 1.1.3 Strategic developments, 1.1.5 Research and development and 1.2.4 Environmental matters and sustainability.

1.1.8 Going concern disclosure

The directors have given serious consideration to the financial sustainability of UCLH as an entity, and in relation to UCLH's available resources.

In relation to UCLH as an entity, the directors have a reasonable expectation that UCLH has adequate resources to continue to service its debts and run operational activities for at least the next business period (considered to be 12 months) following publication of this report. UCLH has sufficient cash to ensure its obligations are met over this time period given the potential mitigations identified for a downside scenario.

Beyond the 12 month period, financial sustainability will be dependent on how a number of factors develop, not least the funding regime.

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

1.2 Performance analysis

1.2.1 Chief financial officer's report

Introduction

The influence of the COVID-19 pandemic has been felt throughout UCLH in 2020/21. Our response involved significant changes to our estate, with the expansion of critical care beds, the relocation of the hyper acute stroke unit (HASU) from UCH to the National Hospital for Neurology and Neurosurgery and the temporary relocation of acute paediatric services, first to Great Ormond Street Hospital and then to the Whittington Hospital. The increased hospitalisation of COVID-19 patients, combined with stronger infection prevention and control measures, limited our capacity to treat outpatient and elective patients and the prevalence of infection throughout the community has had a lasting and tragic impact on our workforce.

The impact of COVID-19 can also be seen throughout the financial statements. In 2020/21, NHS England and Improvement (NHSEI) changed the way that funding flowed to integrated care systems (ICS) and hospital trusts, with fixed financial envelopes being extended to organisations ("block" funding). In the first six months of the year, NHSEI provided a retrospective top-up to that "block" for all reasonable costs incurred in relation to COVID-19. UCLH received £29.5m for this and as a result, we recovered our costs in full to report a breakeven position at the end of September. For the second half of the year, retrospective top-ups were replaced by increased "block" allocations for each ICS. In collaboration with partner organisations across the North London Partners in Health and Care ICS, UCLH set a plan to deliver a deficit of £4.8m for the second half of the year.

Our financial performance

Whilst UCLH reported a £11.8m surplus on a control total basis, after adjusting for the combined loss on disposal of assets of £3.4m, the underlying position was a £15.2m surplus.

In addition to the exceptional losses on disposal, the position includes impairments (reductions in the carrying value of assets) of £127.4m, the most significant of which is the impairment of the Grafton Way Building. NHS accounting requirements specify that specialised assets (such as hospitals) should be valued according to a technical valuation methodology. A combination of practical considerations, such as the physical size and central London location of Grafton Way, together with the technical valuation methodology, have led to an impairment charge, which does not involve any cash expenditure, of £109m. Whilst this new facility opened within the 2021/22 financial year, we received a valuation report from our specialist estates advisors in 2020/21 requiring us to recognise the costs in accordance with accounting standards. Further detail is set out within note 15 to the accounts.

The removal of the net impact of DHSC (Department of Health and Social Care) centrally procured inventories refers to personal protective equipment (PPE) that the DHSC purchased on UCLH's behalf. We are required to show income in our accounts for these items and offset that with expenditure as we use the goods or against inventories for items not yet used. At the end of the financial year, we were holding a stock of these items and therefore recorded more income than expenditure on them within 2020/21. Further detail is set out in notes 4 and 17.

	2020/21	
	Plan	**Actual**
	£m	**£m**
Reported deficit for the year	**-6.7**	**-111.5**
Items excluded from performance against regulatory control total:		
Less capital donations / donated asset depreciation	-13.1	-2.4
Add back net impairment costs from asset revaluation	15.0	127.4
Remove net impact of DHSC centrally procured inventories	0.0	-0.9
Add back impairment charged to control total	*0.0*	*-0.8*
Reported (deficit)/surplus against original control total	**-4.8**	**11.8**
Add back exceptional net loss on disposal of assets	*0.0*	*3.4*
Underlying (deficit)/surplus before exceptional items	***-4.8***	***15.2***

Total income for UCLH grew by just over ten per cent from £1,217m to £1,342m as the commissioner funding regime provided sufficient income to cover the additional costs associated with COVID-19, and to address our underlying deficit non-recurrently. Non-NHS revenue streams were adversely affected by COVID-19. Private patient income was reduced as capacity was re-prioritised and international travel limited. Non-NHS income was therefore well within the cap laid out by the Health and Social Care Act.

Operating expenditure, excluding impairments, grew by just over nine per cent, from £1,178m to £1,283m. Approximately fifty per cent of our operating expenditure is spent on our workforce. Overall pay costs went up by eight per cent. Within this, temporary staffing costs increased by just over twenty per cent, although the usage of agency decreased from £8.5m last year to £3.4m in 2020/21 – one of the lowest rates of usage in the NHS.

The next largest areas of spend for UCLH were on drugs, where expenditure grew by two per cent, and clinical supplies and services, where expenditure, excluding DHSC purchased PPE, increased by three per cent. Both of these increases are below what we would normally expect, with the COVID-19 pandemic limiting throughput through our hospitals and reducing consumables usage.

The Trust's cash balance has increased during the year from an opening position of £219m to a closing balance of £325m at 31 March 2021. The increase is mostly as a result of the changed way in which we were paid by commissioners during this period, from being paid in arrears to receiving "block" funding in advance.

Outlook for 2021/22 and beyond

The financial regime currently in place continues the "block" funding received in the second half of 2020/21, which will continue until the end of September 2021. This also includes a mechanism to provide a financial incentive to recover elective and outpatient care. We are well placed for this having recently opened the University College Hospital Grafton Way Building, however, our workforce is also in need of recovery and it will be important to balance these competing needs throughout the financial year.

The funding for the second half of 2021/22 and beyond remains uncertain. We expect to continue to incur some higher costs and reduced productivity due to measures introduced in response to the pandemic and will incur costs as we gradually open our new capacity.

In addition to this, our PFI (private finance initiative) costs continue to rise in line with the retail price index each year, which is well in excess of the inflation that UCLH is funded for through the NHS tariff. This is becoming increasingly unaffordable without additional funding or support for UCLH to terminate its PFI contract and bring it back into the public sector.

During 2021/22 we shall re-focus our efforts on ensuring UCLH provides the best possible value. We remain committed to improving productivity and efficiency and support the national work led by NHSEI to help trusts benchmark against each other and identify opportunities to increase productivity and efficiency in ways that improve, or at the very least sustain, patient experience and the quality of care we offer. We shall continue working in collaboration with partner organisations across North Central London with the ambition of helping UCLH to deliver world class care to our patients, as well as continuously improving how efficiently we provide that care, working together with our partners.

Despite ongoing financial uncertainty, the UCLH Board remains committed to taking a medium-term view of financial sustainability. We will do this while maintaining an absolute focus on maintaining quality and safety, providing the necessary support to all areas of the Trust to meet the challenges ahead.

Vicky Clarke
Acting chief financial officer

14 June 2021

1.2.2 Overview of our performance 2020/21

The following table outlines our performance against our objectives for 2020/21.

Strategic objectives	Annual objectives	Good	Acceptable	Limited
Provide the highest quality of care within our resources and increase our focus on safety	Continue to reduce avoidable harm through agreed safety priorities and annual infection targets		X	
	Maintain patient experience, focus on new ways to connect with our patients and their families/ carers/ visitors		X	
	Work towards all contact and booking with patients and GPs being timely, accurate and professional		X	
	Ensure our safety and infection prevention and control processes minimise the impact of COVID-19 for patients and staff		X	
Become a world-class academic research hospital embedding research throughout the organisation and all disciplines	Deliver the promises of the biomedical research centre bid and begin preparations for the next BRC funding round	X		
	Develop our digital health research capability and partnerships to develop advanced analytics as a key part of the “Research Hospital”	X		
	Develop and encourage research opportunities for junior doctors, nurses and other clinical staff across UCLH	X		
	Drive and lead research to understand and mitigate the impact of COVID-19 in global healthcare	X		
Operational excellence through our electronic	Use the capabilities of our electronic health record system to transform how we deliver patient care, e.g. virtual clinics	X		

Strategic objectives	Annual objectives	Good	Acceptable	Limited
health record system (EHRS) and optimised processes	Following the impact of COVID-19 on routine services, ensure patients on routine pathways are clinically prioritised and have clear expectations of timescales for treatment		X	
	Shorten waits for patients in our emergency department and shorten the time patients wait for discharge from the trust	X		
	Deliver clinically appropriate prioritised pathways for patients on cancer pathways, ensuring they are protected as far as possible from risks of COVID-19 and looking for opportunities to shorten waits where possible	X		
	As host of the cancer alliance, define and deliver the best approach for cancer recovery across NCL, spanning early diagnosis, treatment and support for cancer patients	X		
	Work with the wider London network to deliver expansion in critical care capacity	X		
	Work with local and specialist STP partners, including social care, to develop and implement a recovery plan post COVID-19, providing capacity to see the longest waiters through collaborative sharing of resources and prioritisation of patients across the STP as a whole		X	
	Deliver our strategic programme for 2020/21: open the new clinical facility on Grafton Way; complete the redevelopment of our ED; complete the reorganisation of all sites to meet post COVID-19 requirements, and work with stakeholders to agree the best solution for the Mount Vernon Cancer Centre transition		X	

Strategic objectives	Annual objectives	Good	Acceptable	Limited
Develop all our diverse staff to deliver their potential and foster talent	Show care for all our staff by being a diverse and inclusive employer recognising the need to improve the experience of our black, Asian and minority ethnic (BAME) staff		X	
	Provide excellent education and focused development opportunities, ensuring we are able to respond adequately to any future COVID-19 demands		X	
	Improve staff experience by encouraging better working relationships, offering more flexible and remote working and focusing on staff safety and wellbeing	X		
Improve the financial sustainability of UCLH and the wider health economy	Play a lead role in developing an integrated care system in North Central London enabling transformation of services and financial sustainability for UCLH and the wider system		X	
	Achieve financial plan with a focus on controlling expenditure and ensuring underlying financial position is sustainable upon exiting national COVID-19 financial arrangements		X	
	Deliver productivity improvements utilising our strategic investments to drive further improvement working closely within our Sustainability and Transformation Partnership (STP) to identify further opportunities			X
	Deliver our services sustainably by delivering our Green Plan, including reduction of our carbon footprint		X	

Notes to table

Good: good progress made towards achieving the objective, with key milestones and targets met
Acceptable: acceptable progress made towards achieving the objective, with some key milestones and targets met, but some not achieved
Limited: limited progress made towards achieving the objective, with only a small number of milestones or targets met

1.2.3 Detailed review of our performance 2020/21

Operational performance against the constitutional access standards was significantly impacted during 2020/21 due to the onset and duration of the COVID-19 pandemic. A quarterly summary of performance metrics can be found at https://www.uclh.nhs.uk/about-us/what-we-do/our-performance/quick-guide-our-performance-scores.

The sections below provide an overview of our performance against the key targets.

Emergency department (ED) four-hour standard

We did not achieve the standard that 95 per cent of patients should spend less than four hours in our ED in 2020/21. However, we achieved over 90 per cent performance between May and July, with some days above the 95 per cent threshold. Our average waiting times for patients who were critically ill or injured were mostly better than the national and London averages.

The average number of patients attending our ED decreased by 50.7 per cent compared to the previous year. There was a marked reduction in attendances during the first national lockdown due to the decline in students, commuters and visitors that make up our usual ED population. Attendance began to rise slightly from the summer but remained 44.3 per cent below the previous year.

Eighteen patients waited longer than 12 hours in ED in 2020/21. These were mostly patients with complex mental health needs who required admission to a psychiatric inpatient bed elsewhere. Throughout the pandemic we have continued to work with Camden and Islington NHS Foundation Trust to improve care for local patients for whom we have fewer 12 hour breaches.

We continue to work with colleagues in social care, mental health and community healthcare to address the system-wide factors which cause delays in discharging patients who are medically fit to go home but who need support from these services.

The redevelopment and expansion of our ED as originally planned has been delayed due to COVID-19. However, we have reconfigured the space to support delivery of COVID-19 separate to other urgent work streams.

We have also created surge plans which will enable us to flex our capacity at quite short notice to accommodate sudden increases in patients requiring hospitalisation with COVID-19 in dedicated wards.

Cancer waiting times

We met the standard that 93 per cent of patients who are urgently referred with suspected cancer should have their first appointment within 14 days for most months of the year. When we missed the target between November and January, it was mostly due to increased demand during Breast Cancer Awareness month (October). However, the imaging and breast teams were able to agree flexible capacity to bring overall trust waiting times back within target for February and March. However, this capacity remains a live risk which we are actively managing.

During the first wave of the COVID-19 pandemic, there was a marked drop off in patients being referred to UCLH on cancer pathways. Prior to the second wave, this had recovered to approximately 80 per cent of the previous year's volume. The drop in referrals is attributed to many patients being more reticent to see their GP during the pandemic and we are mindful that

this potential demand may subsequently present with higher acuity symptoms once the pandemic is over. We have been working with the sector to reassure and actively encourage those on cancer pathways to keep their appointments where possible.

We achieved the standard that all cancer patients should receive treatment within 31 days of the date of the decision to treat in most months of the year. We missed the target in June and July but failure of the standard in this instance was positive as it reflected that we had been able to offer treatments to patients who had been clinically assessed as safe to be delayed during the first wave of COVID-19.

We did not meet the standard that 85 per cent of patients with cancer should begin their first treatment within 62 days of an urgent GP referral. Once we had emerged from the first wave, our performance began to improve; in October and November we were close to re-achieving the standard. In both August and November, we met this standard for patients whose pathways both started and finished at UCLH.

This relatively strong performance has been enabled by:

- UCLH taking a lead in setting up the North Central and North East London surgical cancer hub, which enabled priority cancer treatments to proceed through independent sector hospitals and dedicated NHS sites, such as University College Hospital at Westmoreland Street.

- Operational teams maintaining a strong grip on our waiting lists, ensuring all patients were clinically prioritised and reviewed at clinically appropriate intervals. This enabled us to put on appropriate treatment sessions to rapidly reduce our volume of patients waiting over 62-days for treatments to within pre-COVID-19 levels.

- Continuing to work with referring organisations in the North Central and East London sector to reduce waiting times for patients who receive care at several hospitals. Our aim is to speed up the diagnosis phase so that patients are referred to UCLH at an earlier stage for specialist treatment.

Throughout the pandemic, we have continued to review breaches, including patients who could not have been treated before their target date, to identify whether their treatment pathways could be shortened for others in future.

Referral to treatment (RTT)

We did not meet the standard that 92 per cent of patients should be treated within 18 weeks of GP referral in 2020/21. The COVID-19 pandemic led to us suspending most routine elective activity during the first wave as staff were redeployed to support COVID-19 and other urgent clinical pathways, for example staff providing support on the intensive care unit.

As with cancer patients, patients on routine pathways were clinically reviewed and assigned priorities. The most urgent patients were also approved for treatment through the surgical hub. We also converted a significant proportion of outpatient work to virtual clinics to enable us to continue to assess patients' clinical needs. Limited capacity compared to the high volume of patients clinically assessed as safe to wait for treatment has unfortunately led to too many patients waiting too long for treatment.

Performance therefore declined through to July and the number of patients waiting more than 52 weeks increased very significantly, which was sadly mirrored across London and nationally.

After the first COVID-19 wave, we implemented recovery plans which saw performance rise to 62.6 per cent in December. Our volumes of patients waiting more than 52 weeks also began to reduce in line with our plan, reflecting our ability to treat a wider range of routine conditions in areas such as ENT, dental and gynaecology. Unfortunately, the second surge has again required us to reduce elective services, though we are maintaining outpatient services (virtually and some face-to-face) where releasing staff would not otherwise support the urgent work stream or vaccination programme.

We are actively planning for recovery following the second wave, including:

- Reviewing patients to identify any whose clinical priority may have increased with the passage of time.

- Working with other providers in the sector to identify opportunities for 'mutual aid', whereby we can pool resources for specialties to offer treatment more quickly.

- Developing our metrics around referrals and bookings to ensure we are also managing the beginning part of patients' pathways efficiently.

Diagnostic waiting times

We did not meet the standard that 99 per cent of patients should wait less than six weeks for a diagnostic test during any month of 2020/21. COVID-19 impacted waiting times for routine diagnostics in a similar way to RTT such that performance declined to 40 per cent in April 2020. Diagnostic teams prioritised test requests for urgent and suspected cancer patients to minimise clinical risk whilst on site capacity remained limited.

The medical director for the specialist hospitals board convened a cross-organisation diagnostics working group early during the first surge to help streamline processes, datasets and resources to ensure that capacity was used most efficiently to increase provision of routine tests. This included implementing a standard clinical prioritisation system which was subsequently more widely adopted across the NCL healthcare sector.

While a significant volume of long-waiting patients on routine endoscopy pathways still remain to be treated, it should be noted that we managed to recover activity to above pre-COVID-19 volumes before the second surge.

Monthly performance gradually recovered from May through to October, which was driven by substantial month-on-month improvement in the UCH imaging modalities (achieving over 90 per cent between July and October). Performance dipped again during the onset of the second wave. However, figures were artificially low due to a reporting error within our electronic health record system which was resolved by January.

As we emerge from the second wave, we expect to continue the gradual improvement seen towards the end of the year as routine activity recommences.

We maintained provision of diagnostics to support the COVID-19 and urgent work streams throughout the pandemic.

Monitoring quality and performance

We undertake a detailed review of performance against all key metrics and monitor the effect of recovery action plans. Results are presented at the Senior Directors Team (SDT) meeting, to

the Quality and Safety Committee (QSC) for assurance monitoring, and to the Trust Board as part of detailed performance and quality packs.

Patient feedback

Due to the pandemic, several national surveys, including the inpatient survey, urgent and emergency care survey and children and young people survey were postponed. This delay means we are unable to share our results for 2020 at the time of writing.

At the beginning of April 2020, NHSEI released guidance advising that mandatory Friends and Family Test (FFT) reporting would be paused until further notice. UCLH took the decision to continue monitoring patients' experience of our services by continuing to collect all automated methods of feedback.

We ask patients in a number of departments the following question from the national FFT: "Would you recommend our services to your friends and family if they needed similar care or treatment?" We have improved our recommendation scores in inpatients (96 per cent) and the emergency department (90 per cent). We have seen a drop in our score for outpatients from 90 per cent in 2019/20 to 87 per cent in 2020/21.

We have continued to use agents to call patients who have used non-emergency transport to collect feedback and we have improved our recommended score for patient transport from 87 per cent in 2019/20 to 95 per cent in 2020/21.

Healthcare associated infections

There were 78 *Clostridium difficile* infection (CDI) toxin positive cases reported in 2020/21 (70 cases in 2019/20) against a threshold of 84 cases. Each case is reviewed with the lead CCG to determine whether or not it was due to the care the patient received at UCLH. Currently all have yet to be reviewed. Our plan to reduce CDI cases aims for the highest standards of environmental cleanliness by ensuring staff follow good infection prevention and control practices including outstanding environmental cleanliness. The multidisciplinary team CDI ward rounds continue to ensure the best treatment of cases.

There were 4 cases of *methicillin-resistant Staphylococcus aureus* (MRSA) bacteraemia in 2020/21 (four cases in 2019/20). The threshold for UCLH is zero. Of the 4 cases, 3 were potentially associated with invasive device care. The COVID-19 surges have impacted on invasive device care. During the surges, there were a number of factors that affected care including an increase of staff to patient ratio, movement of staff to areas they were not used to working in and an increased acuity in the patients admitted to the hospital. Education, training and support will be provided to improve practices in invasive device insertion and management and documentation of ongoing care.

There were 88 cases of *Escherichia coli* bacteraemia this year (95 cases in 2019/20). We continue to reinforce our multidisciplinary programme for reducing the number of infections, improving oral hydration and the use of appropriate antibiotic treatment for urinary infections.

There have been 50 cases of *Pseudomonas aeruginosa* bacteraemia this year (41 cases in 2019/20). The number of cases is related to the number of immune-suppressed patients across UCLH. Collaborative work amongst clinical teams continues to improve practices as well as working with the estates department to ensure the water management in augmented care areas is monitored and mitigations are implemented.

In order to minimise transmission of *SARS-CoV-2* within the hospital setting, strict infection prevention and control procedures were in place throughout the year. These were in line with

Public Health England and NHS London guidance and were regularly reviewed by virology and the infection prevention and control team. Asymptomatic testing for clinical staff and those in contact with patients was put in place and staff were provided with personal protective equipment in line with national guidance. Elective patients were tested before admission in line with the standard operating procedure in place and emergency admissions were rapid tested within the Emergency Department. All inpatients were also tested regularly. Visiting restrictions were put in place to protect patients.

Mortality

UCLH's Summary Hospital-level Mortality Indicator (SHMI) is usually good. However, UCLH has raised concerns about this year's data for the following reason: NHS Digital reports 'Day cases and regular day attenders are excluded from the SHMI. However, some day cases for University College London Hospitals NHS Foundation Trust (trust code RRV) have been incorrectly classified as ordinary admissions, which meant that they were included in the SHMI. Results for this trust should be interpreted with caution'.

This error in classification has had the impact of including lower risk cases in the SHMI calculation, therefore making our SHMI level look stronger than it is. We are in the process of resubmitting historical data to correct these issues.

Non-emergency patient transport service (NEPTS)

Our NEPTS provider, G4S, continued to provide services to UCLH during 2020/21. There have been significant changes to patient transport services as a result of COVID-19 across UCLH, NCL and nationally. In March 2020, NHSEI suspended transport eligibility criteria to minimise the need for patients to travel on public transport during the pandemic. In addition, a new demand for transport journeys was established for pre-elective swabs which has had a significant impact on activity. Social distancing is being maintained on all vehicles which has reduced capacity. Patients known to be COVID-19-positive are transported separately to other patients. As a result of the above changes, and despite overall reductions in on-site clinical activity (particularly for outpatients), the NEPTS experienced an increase in demand.

NHSEI re-introduced amended transport eligibility criteria in September 2020 with the addition of *extremely vulnerable patients* being eligible for transport regardless of their mobility. As a result, NEPTS continues to see higher demand than before the pandemic. In February 2020 there were 6,700 journeys; in February 2021 this had increased by 31 per cent to 8,600 journeys.

Patient feedback on the service has improved (see Patient Feedback section). We continue to work closely with G4S in this changing environment to improve the quality and efficiency of the service.

1.2.4 Environmental matters and sustainability

We are firmly committed to making efficient use of resources and to improving the health and resilience of the communities we serve. Our Green Plan is holistic, setting tangible objectives in ten key areas of sustainability (including governance and policy, core responsibilities, procurement and supply chain and working with staff, patients and communities).

We have aligned our Green Plan with the NHS commitments towards sustainability and have identified four main areas we wish to pursue. These are:

- Reduce our greenhouse gas emissions through efficiency improvements in our energy use. Our current target is to reduce emissions from energy consumption by 80 per cent by 2025 (on a 2007/08 baseline). Our annual consumption of gas and electricity has decreased by 2.6 per cent this year. All our electricity has been generated from renewable sources, which has contributed significantly towards our carbon reduction targets.

- Increase recycling rates to 80 per cent by 2024/25. We have seen a small drop in our recycling rates as a result of stricter controls due to the COVID-19 pandemic. Nevertheless, we have diverted all of our waste from landfill to heat from waste processes and our recycling rates for 2020/21 reached 32 per cent (the rate in 2019/20 was 39 per cent).

- Optimise our non-emergency patient transport services through coordination of clinical appointments and a comprehensive expansion of our video clinic facilities.

- Reduce use of harmful anaesthetic gases.

This will place us favourably on the path towards net zero carbon emissions by 2040.

We have retained our triple Carbon Trust Standard certification for Energy, Waste and Water Management.

Throughout the year, we encouraged our staff to participate in a wide range of events to raise awareness of sustainability issues, including:

- Staff behaviour change programmes
- NHS Sustainability Day
- Recycle Week
- Clean Air Day
- Sustainable Health and Care Week

We provide educational resources on our intranet to support staff to make changes in the workplace, as well as at home.

1.2.5 Social, community and human rights issues

We are committed to ensuring our services and employment practices meet the needs of all people, including those with protected characteristics under the Equality Act 2010. This is in accordance with our public sector equality duties under the NHS Constitution.

Under the Equality Act 2010 there are nine protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

We recognise the importance of respecting and protecting the human rights of our patients, staff and members, in line with the Equality and Human Rights Commission’s guidance.

Our equalities objectives are to improve patient care and staff experience and reduce inequalities among staff and patients. We carry out assessments to confirm that our policies, functions and services are not discriminatory and develop action plans to address any shortcomings. We publish an annual equality report that sets out how UCLH meets specific employment duties and includes monitoring data, achievements and priorities for action.

We are committed to safeguarding all our patients, in particular those living in vulnerable circumstances. We participate in local multi-agency safeguarding boards with our partners. Our trained safeguarding champions apply our policies and procedures around the clock and they are supported by a team of safeguarding child and adult leads who have expert knowledge. There are named executive leaders for child and adult safeguarding and six-monthly reports are presented to the board. There is safeguarding training for all staff.

We provide comprehensive patient information and language support services to meet the needs of our diverse population. Interpreting services are available in most common languages, as well as British Sign Language. We provide core information leaflets in an easy read format.

A multi-faith spiritual care team is available to support patients and staff. The team reflects the diverse faiths and beliefs of our local population and staff.

We have five staff networks: BAME, disability, LGBT+, mental health, and women in leadership. These groups meet regularly to discuss ideas, build professional relationships and hold events. The aim of these networks is to give staff who have traditionally been under-represented at senior levels a collective voice. These networks are part of our strategy to deliver our equalities objectives and reduce inequalities among staff.

For further information see section 2.1.9 Equality reporting (patients) and section 2.3.14 Equality reporting (staff).

For information about anti-bribery matters see section 2.3.6 Staff policies and actions.

1.2.6 Modern slavery and human trafficking statement

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Individuals may be trafficked into, out of, or within, the UK. They may be trafficked for a number of reasons, including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 introduced changes in UK law which focus on increasing transparency in supply chains.

UCLH is committed to improving our practices to combat slavery and human trafficking. We are committed to ensuring there is no modern slavery or human trafficking in any part of our business and, as far as possible, require our suppliers to have a similar ethos.

We consider modern slavery factors when making procurement decisions and we use NHS Terms and Conditions for Goods and Services for specification and tender documents. This requires suppliers to comply with all relevant legislation and guidance, including modern slavery conditions.

We also ensure that procurement staff receive regular legal briefings and appropriate training so that they are aware of legislative requirements in this area.

Modern slavery awareness is included in mandatory safeguarding training for all staff. If a member of staff has concerns relating to modern slavery, these are managed by our safeguarding team which refers into the National Referral Mechanism, as required by the Act.

1.2.7 Important events after year end

The University College Hospital Grafton Way Building opened partially on 1 April 2021 for surgical and imaging patients, together with a new critical care facility. The date for the move of haematology patients has not yet been agreed. The Proton Beam Therapy unit is due to open in late summer/early autumn of 2021.

1.2.8 Overseas operations

There were no overseas operations during 2020/21.

1.3 Progress against 2020/21 quality priorities and priorities for improvement 2021/22

Each year UCLH identifies its quality priorities, following consultation with subject matter expert groups, the clinical boards, the Quality and Safety Committee, governors and commissioners.

1.3.1 Progress against 2020/21 priorities

This section provides a look back over the 2020/21 quality priorities at UCLH. We put in place action plans and developed measures for each of the priorities and our performance has been monitored throughout the year by our clinical teams and trust committees. Progress was limited on some of these due to the COVID-19 pandemic.

Patient safety

Five steps to safer surgery (5SSS): reduce avoidable harm from surgery and invasive procedures

What we said we would do	What success will look like	How did we do?
We will continue to support teams to implement improvements in relation to the 5SSS, as set out in action plans from investigations where surgical or invasive procedure serious incidents have occurred.	Action plans will be completed, and improvements shared across UCLH through the regular publication of news bulletins for staff such as “At The Sharp End” bulletin, quality and safety news bulletin and also through discussion at the reducing surgical harm steering group (RSHSG).	Action plans for investigations where surgical or invasive procedure serious incidents have occurred were completed and improvements shared via "At The Sharp End" bulletin. They were also shared at the RSHSG.
Develop an ESV (enhancing safety visits) policy (which will also include interventional procedures) to include duties and responsibilities when undertaking an ESV, training requirements, the role of the core team, how reports and action plans should be written and monitored, the identification of themes and the programme of ESVs. This will include the learning from the approach taken with improving care rounds (ICRs).	Policy completed and implemented including how we will monitor the success of the policy.	The policy was not completed due to the pandemic affecting resources.
Support the engagement of surgeons being present at sign in, starting with pilot areas. Sign in is normally undertaken by anaesthetists and surgeons lead the next stage – time out.	We will establish a baseline of numbers of surgeons who are recorded as taking part in sign in on EHRS in the pilot areas.	We were not able to measure a baseline on numbers of surgeons present during sign in across the UCLH but we were able to identify a pilot area.

What we said we would do	What success will look like	How did we do?
Measure the completion of the surgeon field at sign in via the EHRS. Use local and trust wide enhancing safety visits (ESVs) to observe surgical engagement with sign in.	We will use this to identify improvement targets within each of the pilot areas. We will reflect on the learning from the pilot areas and agree a roll out plan where appropriate. We will include our findings in the ESV reports.	The Eastman Dental Hospital (EDH) audit showed that 75 per cent of all cases completed had surgeon present at sign in. The benefits were also highlighted in the audit including the views of patients. The observation tool has been modified to include surgeon presence during sign in and some areas were able to undertake local safety visits using this modified tool.
Continue to provide teams with training on how to carry out ESVs in their local areas. This aims to increase the volume of visits in these areas and improve local ownership.	At least a further four teams will be trained to carry out ESVs in their areas and will conduct local visits. Each local team will carry out two ESVs per year in their own area. We will prioritise training where a Never Event or serious incident has occurred.	The COVID-19 pandemic has slowed progress however our theatre and anaesthetic practice educators and the ESV core team have carried out train the trainer sessions for local safety visits. The training consisted of shadowing an ESV and a teaching session. We managed to provide training to four more teams and trained 16 staff as surgical safety champions.
Continue to observe, record and promote the use of the surgical pause.	Observations of surgical pause will be recorded as part of our ESV reports. We will continue to promote the surgical pause through safety bulletins and our other communications.	Seven local ESVs have been conducted where surgical pause has been observed. Of the cases observed, 85 per cent have had surgical pause conducted. An article on surgical pause and lessons learnt from incidents was published in the “At The Sharp End” bulletin.
We will set an expectation supported by the medical directors that safety leads will attend the RSHSG.	Attendance of at least two thirds of the meetings by all safety leads.	A prospective review of membership attendance is on-going as the RSHSG meetings were cancelled during the first wave of the COVID-19 pandemic.

What we said we would do	What success will look like	How did we do?
Increase the percentage of staff completing the 5SSS e-learning module for staff working in theatres and anaesthetics and invasive procedural areas.	We will agree a target for the percentage of staff to complete the 5SSS e-learning module (once we have the baseline).	This priority was delayed due to the COVID-19 pandemic but has been restarted for 2021/22. It has been agreed that the 5SSS e-learning module will be mandatory so the target will be 85 per cent.

Reduce harm from failure to recognise and respond appropriately to deterioration

What we said we would do	What success will look like	How did we do?
Prediction of deterioration: continue to measure whether all the seven parameters have been recorded in order to generate the NEWS2 score.	Last year 78.4 per cent of all sets of vital signs recorded included all seven parameters required to calculate the NEWS2 score. The seven parameters are respiratory rate, SpO^2 (blood oxygen saturation), oxygen/air, BP, pulse, consciousness level and temperature. We will aim for 85 per cent which recognises that not all patients need all the parameters measured every time. However, for patients on four hourly observations, all seven parameters should be recorded and so this year we will look at this particular group and establish a baseline.	We achieved an average of 84 per cent of patients across the year who had all seven parameters recorded across the year. We were unable to collect the data of patients on four hourly observations who had all seven parameters recorded due to resources being redirected during the COVID-19 pandemic.
Recognition of deterioration: review a selection of patients with a NEWS2 ≥7 (our patients at highest risk) including monitoring frequency, escalation and outcome. We will do this by reviewing the frequency of monitoring using reports from the EHRS and comparing with the policy requirements; as well as reviewing the escalation, response and outcomes (e.g. high NEWS score to critical care door) using a case note review of 100 cases per quarter which will also fulfil the requirements of the NEWS2 CQUIN.	We will use the review of these patients to understand the completeness and frequency of monitoring of high risk patients in relation to the trust vital signs policy in conjunction with data regarding escalation and response to (management of) deterioration. We will use this information to improve the vital signs policy and monitoring practices as required.	We were unable to collect data on patients with a NEWS2 ≥7 whose observations were monitored according to the NEWS score, so we have used the data we already collect for patients with a NEWS ≥5 and we have achieved an average of 43.2 per cent across the year of patients who had all seven parameters measured. We have been unable to do a case note review due to clinical capacity during the COVID-19 pandemic.

What we said we would do	What success will look like	How did we do?
Measure adherence to the monitoring of fluid balance. Review the policy in light of the implementation of EHRS. Define what are the most useful measures and identify patients for which these measures may be of the most value.	Fluid balance policy to be reviewed, and monitoring agreed.	We have reviewed the fluid balance policy and this will be monitored via audits. We will explore how regular monitoring of fluid balance checks can be done via our EHRS.
Escalation of deterioration: ensure timely escalation of patients to a relevant clinician according to NEWS2 score of ≥7. We will focus on those patients who are subsequently admitted to critical care.	We will measure escalation time for unplanned critical care admissions as part of the NEWS2 CQUIN.	We have not been able to progress this priority. The NEWS2 CQUIN was put on hold*. * We anticipated being able to undertake CQUIN-related priorities with extra resources as part of the CQUIN. As the CQUIN was put on hold the resources were not available.
Management of deterioration: ensure patients are responded to according to NEWS2 scores by a suitably trained professional, focussing on patients with NEWS2 score ≥7. We will focus on those patients who are subsequently admitted to critical care.	We will measure response time for unplanned critical care admissions as part of the NEWS2 CQUIN.	We have not been able to progress this priority. The NEWS2 CQUIN was put on hold.
Improve the percentage of patients with AKI (acute kidney injury) receiving door to therapy treatment within six hours. We established that our baseline was 79.5 per cent of patients with AKI receiving door to therapy treatment within six hours. This was based on an audit of 74 patients in designated high risk wards. In the same audit we also established a baseline of 70.9 per cent for documentation of diagnosis of AKI by a medical professional based on biochemical testing which	We will achieve 85 per cent of patients with AKI receiving door to therapy treatment within six hours from baseline in the designated high risk wards. We will achieve 80 per cent of documentation of diagnosis of AKI by a medical professional based on biochemical testing.	We have met the target of 85 per cent and we achieved 88.89 per cent of patients with AKI who received door to therapy treatment within six hours in designated high risk wards. We have met the target of 80 per cent as we have achieved 85.19 per cent of documentation of diagnosis of AKI by a medical professional based on biochemical testing.

What we said we would do	What success will look like	How did we do?
means in those cases the reason for the diagnosis was noted.		
We will identify a sample of patients with sepsis based on positive cultures and a qSOFA >= 2 and review the cases to assess quality of care.	We will have reviewed a sample of patients with positive cultures and a qSOFA score* >= 2 and reported on the quality of their care.	We have not been able to progress this priority due to the COVID-19 pandemic.
National CQUIN: record NEWS2 score, escalation time and response time for unplanned critical care admissions.	Achievement of the CQUIN.	We have not been able to progress this priority as the NEWS2 CQUIN was put on hold.

Reduce the harm from failure to follow up on radiology results

What we said we would do	What success will look like	How did we do?
Complete a review of the follow up of imaging results within imaging and within specialties. Implement the results routing algorithm for inpatients and outpatients. Revise our policy to reflect the changes for communicating and following up on radiology results including a description of how each speciality addresses this.	We will have defined how results are followed up within imaging and within specialties and what safety nets are in place. Divisions will be able to use the reports on unread messages in a practical way as part of the fail-safe monitoring.	Progress has been delayed due to the COVID-19 pandemic. However, a results routing scheme for outpatients was agreed which will reduce the number of unread messages by reducing the copying of non-urgent results to consultants. We set up a UCLH wide group to review how results are followed up within imaging and within specialties and what safety nets are in place. The group met in December but further meetings were paused and re-started in March 2021. The policy is being reviewed.

Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels

What we said we would do	What success will look like	How did we do?
Improve the management of low (hypoglycaemia) and high (hyperglycaemia) blood glucose levels in diabetic patients.	Baseline data has been established. A dashboard will be developed so that we can easily identify the changes over time. The dashboard will also help us to identify the wards with poor diabetes management where we can target the new education programme.	We have created a dashboard which is in its final stages of development. This will be used to identify the wards with poor diabetes management so education programmes can be targeted.
Improve diabetes education and continue to promote	Having identified three key wards that see the most	We have developed several strands of the training strategy.

What we said we would do	What success will look like	How did we do?
learning.	patients we will aim to train 50 per cent of staff on our new 10 point training package through face to face training delivered by our clinical practice facilitators. We will also aim for 50 per cent of staff to undertake e-learning on these wards. We will work towards 90 per cent compliance for both types of training. We will then roll out across UCLH.	These include creation of a workbook, development of clinical scenarios, development of an e-learning module, re-vamping of the 10 point training and a review of the competency document. 157 nurses were trained in Q2 however we were unable to sustain this due to the COVID-19 pandemic.
We will also expand on the training needs analysis completed by nurses. The next step is focus groups to better understand diabetes management difficulties. A training needs analysis will be completed for junior doctors and this will help to inform education sessions for them.	We will assess the success of our training by monitoring indicators on the dashboard.	A training needs analysis for doctors was completed and work commenced to create a training plan.
We will continue to share diabetes safety messages through the safety message of the week and the medication and quality and safety bulletins.	At least two diabetes safety messages shared.	We have shared regular safety messages trust wide including the safety message of the week and the quality and safety bulletin.
Improve timing of insulin administration by promoting self-administration. In order to do this we have to ensure that we can support patients having their medication in a bedside locker (a 'patients own drugs' (POD) locker). We will also revise the self-administration policy to take into account the changes that will arise through the EHRS.	We will have established a baseline for timing of self-administration and set an improvement target. We will have adequate storage facilities for patients own medicines/drugs (POD lockers) across the trust. We will have revised the self-administration policy to take into account the changes that will arise through the EHRS.	We are not able to measure self-administration but timing of insulin administration by nursing staff has been incorporated into the dashboard. We have undertaken a quality improvement project on POD lockers and identified a plan for 2021/22. Work continues on the self-administration policy which has been delayed due to COVID-19.

Continue trust wide learning

What we said we would do	What success will look like	How did we do?
Fully establish trust mechanisms for managing risk associated with EHRS in order to ensure any risks to patient safety are prioritised and managed.	Systems for the review and management of risks associated with the EHRS will be fully established.	Systems for the review and management of risks associated with the EHRS have now been fully established
Continue to raise awareness of Never Events. Never Events are a sub-set of serious incidents defined as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers". There are 15 types of Never Events agreed by NHSEI.	All Never Events are thoroughly investigated; investigation reports are monitored by the QSC. The completion of actions arising from investigation reports are monitored by the QSC to provide assurance of learning and mitigation of risks. Publication of two quality and safety bulletins and three patient safety messages which highlight and remind staff about learning from actions relating to Never Events.	In 2020/21 UCLH declared eight Never Events; these are listed in section 2.7 Annual Governance Statement. As of June 2021, four Never Events are still under investigation. We have published three quality and safety bulletins and five patient safety messages which highlight and remind staff about learning from actions relating to Never Events. We have also included Never Events in "At The Sharp End" (surgical safety bulletin)
Develop and implement information for patients, relatives and staff who may be involved in serious incidents.	We will have developed information leaflets or other forms of information which we will issue to support staff, relatives and staff who may be involved in serious incidents.	We developed an information leaflet relating to the serious incident process for sharing with families and their relatives. We will keep this under review and will seek feedback on the use of this in 2021/22.
We will continue to review the controls and assurances around the patient safety alerts relating to Never Events seeking to establish green status.	We will have achieved green status on the patient safety alerts relating to Never Events or identify actions required to meet green status. We will continue to check implementation of patient safety alerts in practice through our programme of matron quality rounds, ICRs and environmental monitoring observations.	We were not able to achieve green status on the patient safety alerts relating to Never Events but we continued to monitor actions as far as possible During the COVID-19 pandemic our ICRs, matron quality rounds and environmental monitoring visits were put on hold.
Continue to promote consideration of human factors when undertaking serious incident investigations.	At least two human factors-based serious incident investigations and action plans will have been identified and implemented. Bespoke human factors work will have been undertaken in a	Three human factors-based serious incident investigations were undertaken and action plans identified and implemented. Our work with the specialties was delayed due to the

What we said we would do	What success will look like	How did we do?
	further three specialties as a result of Never Events.	COVID-19 pandemic.
Continue to provide human factors awareness training and further extend awareness of human factors across UCLH - in particular to senior managers and medical staff.	A further 250 members of staff, including 30 senior managers and 15 members of medical staff will have attended training on human factors awareness in healthcare. Seek feedback on changes and improvements made by staff as a result of attending the human factors awareness raising course. Hold a trust leadership forum in order to further educate and raise awareness.	The human factors training was not undertaken and we were unable to follow up on improvements made due to the COVID-19 pandemic. We were unable to undertake the human factors awareness session at a leadership forum as these were used to share learning about the COVID-19 pandemic.

Clinical effectiveness
Learning from deaths

What we said we would do	What success will look like	How did we do?
Implement the new medical examiner role.	The medical examiner will review all deaths. We will have recruited a team of medical examiners and a medical examiner officer(s). We will have set up a database to capture deaths reviewed. We will have agreed performance indicators.	The medical examiners aimed to review all deaths but due to the COVID-19 pandemic there was a small delay in January 2021 and these are now being completed retrospectively. We recruited a team of medical examiners and the medical examiner officer has been appointed and is due to start early next financial year. We have developed a database for the medical examiner service so that we can capture information about the deaths that are reviewed and also identify learning and good practice. We have not yet agreed performance indicators but plan to do this in 2021/22.
Continue to receive presentations at the MSG from local morbidity and mortality meetings.	MSG will have received at least eight presentations from local mortality and morbidity meetings.	Due to the COVID-19 pandemic and clinical capacity all presentations were put on hold. We will be carrying this into our quality priorities for

What we said we would do	What success will look like	How did we do?
		next year 2021/22.
Continue to review deaths relating to sepsis and AKI (acute kidney injury) to identify and share further learning trust wide.	We will have reported quarterly on the learning from deaths related to sepsis and AKI to the DPSG, AKI steering group and the MSG. We will review at least 75% deaths related to sepsis/AKI.	We have continued to produce our quarterly report on learning from deaths which includes information on sepsis and AKI deaths. We provided structure judgement reviews (SJRs) to the relevant groups and committees and will continue to do this in 2021/22 to identify themes and trends. We have reviewed 100% of all deaths coded for AKI and sepsis
Continue to focus on learning and assessing the impact of actions taken as a result of reviews and investigations and report these in our quarterly board reports.	Our quarterly reports will continue to demonstrate learning from our review of deaths including changes in practice	We continued to submit our learning from deaths board reports quarterly and we have developed these over time to include good practice. We also undertook an annual review for 2019/20 on all deaths that had been reviewed that year via SJRs.
Continue to increase the number of trained SJR reviewers and increase the number of SJRs completed by 50%	We will have trained an additional 20 staff which will be representative across all of the divisions. We will have increased the number of SJRs completed by 50% (by 60) and ensure that all deaths relating to sepsis or AKI are reviewed within three months.	We have met our target of training an additional 20 SJR reviewers which included some subject matter experts such as for sepsis. We have met our target of increasing the number of SJRs undertaken by 50%. We have completed 100% of SJR reviews for Q1 and Q2 and Q3 we have 113 in progress (January and February 221).

Patient experience
Improving overall patient experience as measured by the Friends and Family Test (FFT) question

What we said we would do	What success will look like	How did we do?
We will continue to focus on the same four FFT areas as last year: inpatients/day case, outpatients, transport and emergency department because we made less progress in some areas than we had hoped for in 2019/20. As in previous years, we have chosen the four areas giving us the widest reported experiences across our hospitals. These are the best measures of how we are doing and how we compare with others.	We will maintain our performance against the targets set for each of the four FFT areas. Our targets for 2020/21 are: • Inpatients and day case – 96 per cent • Outpatients – 94 per cent • Emergency Department – 89 per cent • Transport – 85 per cent	We resumed mandatory FFT reporting in January 2021 following a pause due to COVID-19 pandemic, using feedback gathered via automated methods only. Our SMS pilot for inpatients, which we planned to launch in Q3, has continued to experience delays and we have not been able to progress this, but we anticipate launching this in 2021/22. Our recommendation score for inpatients and daycase is stable and on target at 96 per cent. Our emergency and transport departments performed well above target at 92 and 93 per cent respectively. The outpatient recommendation score has reduced from 90 per cent to 87 per cent. Whilst our recommendation scores remain below target, we have been unable to compare ourselves against our peers to identify whether this is an isolated or widespread issue. We will keep this under review in 2021/22.

Improving our patients' experience of waiting

What we said we would do	What success will look like	How did we do?
Focus on waiting times as this is one of the biggest issues affecting patient experience.	The target set for 2019/20 was an improvement target and so we will keep this for 2020/21. As there is no national outpatient survey, local real-time feedback surveys will be used to measure our performance.	Our outpatient activity has varied over the year with the majority of appointments being held remotely where possible. Whilst we have continued to gather data on outpatient activity the target set is less robust for virtual waiting times and therefore it has been difficult to measure our performance. However, we are continuing to monitor patient feedback and look at comments to support improvements in this area. We are currently slightly below our 75 per cent target with waiting time scores of 71 per cent.

Improving our patients' experience of care

What we said we would do	What success will look like	How did we do?
Focus on nutrition and hydration 2020/21.	Address our inpatient care improvements on the four questions asked in the national survey. As we did not meet the target we set last year for patients getting help with meals, we have kept it the same. For the other three questions, we have set targets based on our previous best performance or by comparing ourselves to a national average. This is a four per cent improvement in how patients rate the food provided and two per cent for choice of food and getting enough to drink.	The national inpatient experience survey was delayed and so we have no national data available for comparison. Our local inpatient data collection has been on hold, as we have been waiting for the SMS pilot (see above). Once the pilot is launched we will be able to collect real time data that will help us to monitor progress against our nutrition and hydration priorities. With the support of volunteers, our paediatric and adolescent patients have benefitted from the reintroduction of snack trolley rounds with non-perishable items.

Improving our cancer patients' experience of care

What we said we would do	What success will look like	How did we do?
We set a two per cent improvement for those patients who received easy to understand information to align to the higher performing trusts amongst our London peers.	Achieving the target set to bring us into alignment with the higher performing trusts in London on easy to understand written patient information.	The national cancer patient experience survey was delayed and so we have no data to look at progress. The cancer services patient information team collaborated with the secondary breast cancer clinical nurse specialists to design a patient survey to understand the information needs and satisfaction with current information given to UCLH patients with secondary breast cancer. This survey was disseminated to approximately 200 patients and is currently being analysed. The Macmillan Support and Information Service produced 5 animated videos which give advice about managing the top concerns raised by cancer patients in eHNAs (electronic Health Needs Assessments) The team also developed an online wellbeing programme of groups and workshops which will be launched in Q1 2021/22.

1.3.2 Priorities for improvement 2021/22

Five steps to safer surgery (5sss): Reduce avoidable harm from surgery and invasive procedures

Our quality priorities and why we chose them	What success will look like We will
We will continue to support teams in improving surgical safety in areas within the Trust that perform surgery and invasive procedures. This priority builds on the achievements of our 2020/21 quality priority and supports delivery of our goal to reduce avoidable harm from surgery and invasive procedures.	Increase electronic team brief usage from 35 per cent to 50 per cent as part of a plan to have it regularly used.
	Support the engagement of surgeons being present at sign in, starting with pilot areas. Sign in is normally undertaken by anaesthetists and surgeons lead the next stage – time out. We will establish a baseline of numbers of surgeons who are recorded as taking part in sign in on EHRS in the pilot areas and use this to identify improvement targets within each of the pilot areas.
	Reflect on the learning from the pilot areas and agree a roll out plan where appropriate.
	We will continue to reinforce surgical pause as a necessary step within the 5 steps to surgical safety; promote it through safety bulletins and other communications; undertake two surgical pause audits in the main areas that perform surgery and invasive procedures; and report as part of enhancing safety visits.
	Increase compliance on 5 steps to safer surgery e-learning to 85 per cent.

Reduce harm from failure to recognise and respond appropriately to deterioration

Our quality priorities and why we chose them	What success will look like We will
We will ensure timely recognition and management of the deteriorating patient. This priority builds on the achievement of our 2020/21 quality priority and supports the delivery of our goal to reduce harm from failure to recognise and respond appropriately to deterioration.	Audit a selection of patients with NEWS ≥7 (patients at highest risk) including a review of escalation and response time for unplanned critical care admission.
	Establish a baseline on the use of the ISBARD tool on Epic when escalating deteriorating patients and agree a target once baseline is established.
	Create a plan for looking at how to involve patients in their own care and safety.
	Develop a nurse in charge dashboard to improve patient management and utilise data at bedside to inform day to day care of the patient and use data to improve the oversight of the management of care.

Reduce the harm from failure to follow up on radiology results

Our quality priorities and why we chose them	What success will look like We will
Reduce the harm from failure to follow up on radiology results. This builds on our priorities from last year which were put on hold due to the COVID-19 pandemic in 2020/21.	Have defined how abnormal results are identified within radiology and communicated, how results are followed up within specialties (standard operating procedures) and what safety nets are in place
	Ensure divisions will be able to use the reports on unread messages in a practical way as part of a safety net.

Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels

Our quality priorities and why we chose them	What success will look like We will
Reduce harm from failure to recognise and respond appropriately to both high and low glucose levels. This priority reflects learning from serious incidents and the Getting It Right First Time (GIRFT) for diabetes published in 2020.	Undertake a gap analysis on the GIRFT report recommendations and use this to develop our strategy and plans for this year and next. To include:
	• Integrating the 'blue circle' into our EHRS to aid identification of patients with diabetes.
	• Creating a 7 day service.
	• Creating a training strategy for healthcare professionals including the maternity team to include e-learning, face-to-face training, and simulation scenarios. We will them monitor the success of our strategy.
	Promote self-administration of insulin. In order to do this we need to increase the number of patients having their medication in a bedside locker (a 'patients own drugs' (POD) locker.

Continue trust wide learning and improve patient safety

Our quality priorities and why we chose them	What success will look like We will
Continue trust wide learning and improve patient safety. This priority looks at how we will prepare and plan for implementation of the national patient safety strategy.	Begin to plan for the implementation of the national patient safety strategy with a focus on: • Developing our patient safety incident response plan in line with the patient safety incident response framework (PSIRF).
	• Improving involvement and communication with patients and their relatives following a patient safety incident. We will do this by reviewing the duty of candour and being open policies and implementing any agreed changes.
	• Implementing a revised policy for supporting staff.
	• Using our EHRS to inform and support quality priorities.
Consider the staff survey results and how we might learn from it. This is a valuable assessment of many aspects of patient safety as measured by staff.	Consider the results of the staff survey, in relation to the results on safety culture, ~~t~~o see if this is useful to identify areas of good and less good practice that we can learn from.
Learn from our experience of redeploying staff during the pandemic.	Undertake a learning review looking at the organisational, team and individual experience of redeployment and whether we were able to apply learning from the first wave to the second.

Clinical effectiveness
Learning from deaths

Our quality priorities and why we chose them	What success will look like We will
We will improve the learning from deaths processes and continue to implement the medical examiner service. This priority builds on the work we started last year on learning from deaths in identifying themes and trends.	Have developed a medical examiner policy including guidance on how we might measure performance. Expand our learning by continuing to receive presentations at the mortality surveillance group (at least 6) from the local mortality and morbidity meetings. We will also agree and implement a way of sharing learning across UCLH from the review of deaths, for example SJRs, medical examiner review of deaths, local mortality reviews. We will review the reports and processes from three other trusts to identify any additional learning opportunities.

End of life care

Our quality priorities and why we chose them	What success will look like We will
We will increase knowledge and understanding of end of life decision making for patients and staff. This is important learning from the recent UCLH Treatment	Create a training strategy for healthcare professionals on the assessment and documentation of mental capacity in relation to end-of-life care decision making.
	Improve from our baseline of 58 per cent to 95 per cent the percentage of documented mental capacity assessments of patients whose capacity for DNACPR decision making is in question.

Our quality priorities and why we chose them	What success will look like We will
Escalation Plan (TEP)/ DNACPR audits and the CQC Review of 'Do Not Attempt Cardiopulmonary Resuscitation' decisions during the COVID-19 pandemic.	Improve from our baseline of 52 per cent to 95 per cent the percentage of DNACPR decisions discussed with patient's families and/or representatives.
	Improve from our baseline of 85 per cent to 95 per cent the percentage of patients with completed DNACPR documentation who have a completed TEP form or a documented TEP in the notes.
	Improve to 95 per cent the percentage of TEPs discussed with patients with capacity. Improve from our baseline of 49 per cent to 95 per cent the percentage of TEP decisions discussed with patients' families and/or representatives.

Patient experience
Improving the experience of our patients, their families and carers

Our quality priorities and why we chose them	What success will look like We will
We will improve the experience of our patients, their families and carers by building on the learning from the COVID-19 pandemic and work with carers and advocates to identify key areas of improvement.	Review the impact of the role of the family liaison service and the restrictions on visiting during the COVID-19 pandemic, working with patients and carers, to identify and act on key areas for improvement.

Improving the accessibility and use of patient information

Our quality priorities and why we chose them	What success will look like We will
We will improve the accessibility and the use of patient information. This priority builds on the work that we have already started and is linked to improving accessibility to patients.	Expand our use of alternative format patient information, such as videos and animations. Review and adapt the UCLH approval process to accommodate all patient information formats.

Improve the experience of our outpatient services

Our quality priorities and why we chose them	What success will look like We will
We will improve the experience of our patients using outpatient services. This priority builds on some of the areas where our patients	Increase the use of MyCare UCLH – both number of users and increased engagement from relevant patient groups. Understand the patient experience of the Patient Initiated Follow Up (PIFU) pathway.

Our quality priorities and why we chose them	What success will look like We will
have told us that we can do better.	Improve telephone answering at UCLH by creating a single up to date telephony directory, to replace multiple existing out of date directories. Develop a policy for remote consultations which will include ensuring that patients are offered the right clinic type for them.

Develop creative ways of involving patients to become active partners in service development

Our quality priorities and why we chose them	What success will look like We will
We will develop creative ways of involving patients to become active partners in service development. This priority builds on work that we started in 2020/21.	Develop a new library of stories told by patients and family members in different formats. These stories will assist staff through education and reflection. They will provide insights and a unique perspective to guide our decisions, learning and growth in relation to service developments. Increase and widen our network of patient partners and help them develop the skills they require

Patient equality and diversity priorities

Our quality priorities and why we chose them	What success will look like We will
We will improve the experience of patients by improving our compliance with the Accessible Information Standard and gain an understanding of the experience of individuals from different backgrounds and marginalised groups. This priority builds on some of the areas where our patients have told us that we can do better.	Improve our compliance with the Accessible Information Standard. Understand the experience of individuals from different backgrounds and marginalised groups – linking with work by other providers across NCL. Increase the use of Plain English in all our written communications by introducing a sign off process for all forms of patient information.

Signature to the performance report:

Tim Jaggard
Acting chief executive

14 June 2021

2. Accountability report

2.1 Directors' report

2.1.1 UCLH board and committees

The board, led by the chair, sets the vision and values of UCLH and works to promote the success of the organisation. It is responsible for the organisation's decision-making and performance to ensure UCLH delivers high quality, safe and efficient services.

The board meets six times a year in public, although part of these meetings are held in private to deal with confidential matters.

The board comprises nine non-executive directors (including the chair), and seven executive directors. On 31 March 2021, there was one vacant non-executive director post.

The chief executive is accountable to the board for running all aspects of the operational business of the trust.

The chair leads the board and ensures its effectiveness. The chair sets the agenda for the board. The agenda includes reports from the standing committees of the board and reports on performance and finance.

During the year, the board also receives various presentations to assure board members that the organisation is focused on delivering its objectives.

The board held five seminars this year to discuss strategic issues facing UCLH. Topics covered included equality, diversity and inclusion, leadership and management development, the integrated care system and NCL provider alliance and the safety of maternity services.

Board papers for the public meeting are published on the UCLH website and shared with governors. Governors also receive a monthly performance report, and the agenda and minutes of confidential meetings.

Board members

The board as a whole has a diverse range of skills, experience and expertise to enable it to deliver balanced stewardship of the trust. Directors' details, together with their committee membership as at 31 March 2021, are given below.

Board members declare their interests at the time of their appointment and annually. The register of directors' interests is published annually as part of our annual register of interests, gifts and hospitality. It can be found on our website https://www.uclh.nhs.uk/about-us/what-we-do/our-policies-and-statements/declarations-interest-gifts-and-hospitality or can be obtained from the trust secretary.

Directors are also required to confirm they meet the "fit and proper person" condition set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. All our directors meet the "fit and proper person" test. To contact the board there is a dedicated email address, uclh.directors@nhs.net, as well as a telephone and postal address, which can be found on the UCLH website https://www.uclh.nhs.uk/contact/board-directors.

Non-executive directors

Baroness Julia Neuberger DBE
Chair
Chair of remuneration committee

Baroness Julia Neuberger became UCLH chair on 25 February 2019.

Throughout her career, Julia has made an extensive contribution to healthcare policy and management. In the 1990s she was chair of the Camden and Islington Community Trust, and chief executive of The King's Fund from 1997 to 2004. Julia was also chair of the Liverpool Care Pathway Review and one of the vice chairs of the 2018 Independent Review of the Mental Health Act.

Julia was appointed by NHS Improvement as the chair of Whittington Health NHS Trust from 1 April 2020. Julia continues as chair of UCLH – the two posts are separate appointments. Julia has now also been appointed as one of the vice chairs of the NCL Provider Alliance.

Dr Jane Collins
Vice chair
Chair of audit committee
Member of finance and investment, quality and safety, workforce and remuneration committees

Dr Jane Collins qualified in medicine at Birmingham University. After training jobs in Southampton and London, she was appointed as a consultant paediatric neurologist at Guy's Hospital and then moved to Great Ormond Street Hospital. She was appointed chief executive of both Great Ormond Street Hospital for Children and the Great Ormond Street Hospital Children's Charity in 2001. From 2012 until early 2019 she was chief executive of Marie Curie. Jane was on the advisory board of the King's Fund from 2013 until 2017 before becoming a board member. She was chair of the London Clinical Senate Council between 2013 and 2018. She is an honorary fellow of UCL and the Institute of Child Health, UCL. Other external roles included co-chairing the Ambitions for Palliative and End of Life Care group.

Jane has been a non-executive director and vice chair of the Royal National Orthopaedic Hospital Trust since February 2020.

Jane joined UCLH as a non-executive director in November 2018. She was appointed as vice chair in November 2019 and became chair of the audit committee in January 2020.

Dr Junaid Bajwa
Chair of research and innovation committee
Member of the workforce and remuneration committees

Dr Junaid Bajwa was born at UCLH and is a practising GP with experience of serving a deprived London community. He has been interested in the use of technology and data to improve patient outcomes for many years, and worked with NHS England on projects involving artificial intelligence (AI) and data analytics. Junaid worked for Merck Sharp and Dohme as the global executive director for partnerships and strategic alliances, within its digital accelerator, until June 2020. Since June 2020, he has been the chief medical scientist at Microsoft Research.

Junaid became a trustee of the UCLH Charity in 2020 and was appointed as an associate non-executive director at Whittington Health Trust in July 2020.

Junaid joined UCLH as a non-executive director in September 2018.

Althea Efunshile CBE
Senior independent director
Chair of workforce committee
Member of quality and safety and remuneration committees

Althea Efunshile has had a 30-year career in local and central government, during which she gained extensive senior management experience. She was deputy chief executive of the Arts Council England where she was responsible for the national investment strategy, corporate governance and operational delivery.

Prior to that she held a number of director level posts within the Department for Education, all of which were concerned with improving outcomes for disadvantaged children and young people. She has been the executive director for education and culture in the London Borough of Lewisham, and assistant director of education in the London Borough of Merton. Althea was awarded a CBE for services to art and culture in the 2016 Queen's birthday honours.

Althea joined UCLH as non-executive director in May 2016 and was reappointed in May 2019. Althea was appointed as the senior independent director in November 2019.

Martin Jacobs
Member of audit, finance and investment and remuneration committees

Martin Jacobs spent 20 years with PricewaterhouseCoopers (PwC) where he was a partner within the corporate finance division. He provided corporate finance advice to both public and private sector clients. In particular, he provided financial advice and brought commercial skills to a number of government departments including the Department of Health. He was leader of industry for central government. Prior to joining PwC, Martin worked in banking for Samuel Montagu Ltd and HSBC. He now runs a plural career as a non-executive director and trustee.

Martin also chairs the arts and heritage committee.

Martin joined UCLH as a non-executive director in January 2020.

Professor David Lomas
Chair of quality and safety committee
Member of research and innovation and remuneration committees

Professor David Lomas is UCL vice-provost (health), head of the UCL School of Life and Medical Sciences, head of UCL Medical School, academic director of the UCLP Academic Health Science Centre and works as a respiratory physician at UCLH. He received his medical degree from the University of Nottingham and undertook his PhD at Trinity College, Cambridge.

He was a Medical Research Council (MRC) clinician scientist, university lecturer and professor of respiratory biology in Cambridge before moving to UCL in 2013 to be chair of medicine and dean of the faculty of medical sciences. He was deputy chief executive at the MRC and previously chaired the respiratory therapy area unit board at GlaxoSmithKline. He is also a senior investigator for the National Institute for Health Research (NIHR).

David joined UCLH as non-executive director in September 2015 and was reappointed in September 2018.

Simon Porter
Member of the audit, finance and investment and remuneration committees

Simon Porter is a chartered accountant whose executive career at the London office of Ernst and Young ranged across audit, corporate finance and risk management. He mostly specialised in transaction support, advising corporate and private equity clients on the financial aspects of mergers, acquisitions, disposals, buy-outs and IPOs. He now has a small portfolio of non-executive director roles and was non-executive director of University Hospital Southampton from 2011 until January 2020.

Simon joined UCLH as a non-executive director in April 2020.

Adam Sharples CB
Chair of finance and investment committee
Member of audit and remuneration committees

Adam Sharples was a civil servant for nearly 25 years, holding a range of posts in HM Treasury, including director for public spending. In the Department for Work and Pensions he was a director general, advising ministers on welfare reform, labour market policies and commissioning employment programmes. Prior to joining UCLH, Adam was a lay member of the governing body of Haringey Clinical Commissioning Group (CCG) for five years, and chaired the audit committee of the five North Central London CCGs. He is chair of the Money Advice Trust, a national debt advice charity. Adam has an MSc in Economics and lives in north London. He was made Companion of the Bath in 2007.

Adam joined UCLH as a non-executive director in September 2019.

Robert Vincent
Member of the workforce, research and innovation and remuneration committees

Robert Vincent was the chief executive of Kirklees Council in West Yorkshire until 2010 and then the Secretary of State's appointee as chief executive to lead an intervention at Doncaster Council, then in special measures. He left Doncaster at the end of 2011 and has since been a non-executive director on the board of the Department of Communities and Local Government, adviser to the Department of Health, and then Public Health England, over the implementation of the Lansley Act, lead chief executive for a number of engagements with local authorities recovering from a critical report, deputy chair of a mental health trust and a regional coordinator for the COVID-19 Contain strategy.

Robert is currently a non-executive director and audit chair for Whittington Health Trust and an electoral commissioner.

Robert joined UCLH as an associate non-executive director in October 2020.

Executive directors

The remuneration committee of the board appoints executive directors on permanent contracts.

Professor Marcel Levi
Chief executive

Professor Marcel Levi joined UCLH as chief executive in January 2017. Marcel has had a distinguished career as a clinician, academic, educator and clinical leader. Prior to joining UCLH he was chairman of the executive board of the Academic Medical Center at the University of Amsterdam for six years and before that, he was chairman of its department of

medicine and division of medical specialisms for 10 years. Marcel is a practising consultant physician at UCLH, specialising in haemostasis, thrombosis and vascular medicine. He was named the best specialist in internal medicine in the Netherlands for three consecutive years. Marcel obtained his PhD in 1991 and was appointed a member by the Royal Netherlands Academy of Science. Marcel left UCLH on 31 March 2021 to return to the Netherlands to take up the position of chairman and chief executive of the Netherlands Research Council and chief scientific officer of the Netherlands. Marcel has retained an honorary contract with UCLH and an honorary chair at UCL.

Professor Geoff Bellingan
Medical director, surgery and cancer board

Professor Geoff Bellingan was appointed as a medical director in September 2009. He previously held posts as clinical director and divisional clinical director between 2006 and 2009. He trained as a chest physician and then in intensive care in which he has been a consultant at UCLH since 1997. He was appointed as a professor in intensive care medicine at UCL in 2015.

As medical director for surgery and cancer, Geoff has a particular interest in cancer care across North and East London and West Essex. He was instrumental in the creation of the UCLH Cancer Collaborative, now known as the North Central London Cancer Alliance. Geoff is also the senior responsible officer for the development and management of our new clinical facility, the Grafton Way Building, which will incorporate one of the UK's two NHS proton beam therapy units, a short stay surgical centre and haematology wards.

Dr Gill Gaskin
Medical director, digital healthcare

Gill Gaskin was appointed as medical director for digital healthcare in October 2019. This was a new position and highlights the strategic importance of digital healthcare at UCLH. Prior to this, Gill had been medical director of our specialist hospitals board since January 2010.

She graduated from the University of Cambridge and trained in renal and general medicine at Hammersmith Hospital and the Royal Postgraduate Medical School, completing a PhD on the biology of systemic vasculitis. Between 1995 and 2010 she held consultant-level posts at Hammersmith Hospitals and Imperial College Healthcare trusts. She had additional responsibilities as director of postgraduate medical education and professional development, clinical director and director of the medicine clinical programme group. Gill is a member of the Faculty of Medical Leadership and Management. She was the senior responsible officer (SRO) for the implementation of Epic, our electronic health record system.

Dr Tim Hodgson
Medical director, specialist hospitals board

Dr Tim Hodgson was appointed medical director of the specialist hospitals board in November 2019 and joined the UCLH board as an executive director in January 2020. He was the divisional clinical director of the Eastman Dental Hospital (EDH) for six years before this. He successfully led the merger of the Royal National Ear Nose and Throat Hospital and the EDH and their move to a bespoke new building in October 2019.

He became a consultant in oral medicine in 2003 and is an honorary associate professor. Tim is dually qualified in medicine and dentistry. He has been a member of the Royal College of Physicians and a fellow in dental surgery of the Royal College of Surgeons since 1998. He has an active research profile with 90 citations in peer reviewed journals.

Dr Charles House
Medical director, medicine board

Charles House was appointed medical director of the medicine board in July 2017, having previously been interim medical director since March 2016. He studied medicine at St Mary's Hospital Medical School. He trained in radiology at UCLH, being appointed as a consultant radiologist in 2005, with subspecialist interests in bone and soft tissue sarcoma, myeloma and orthopaedic imaging. After spells as a college tutor for the UCLH radiology training scheme and clinical lead in radiology, Charles held posts as divisional clinical director of imaging and associate medical director. Charles has a keen interest in clinical leadership and evolving models of healthcare, with focus on collaboration between organisations and across sectors.

Tim Jaggard
Deputy chief executive and chief financial officer

Tim Jaggard was appointed finance director in April 2016 having previously held the posts of interim finance director and deputy finance director at UCLH. In summer 2019 he became chief financial officer of UCLH. This reflects his broader focus on the North London Partners in Health and Care sustainability and transformation partnership (STP) where Tim is part of the leadership team, and also reflects changes to the senior finance team at UCLH. In October 2020 Tim was appointed as the deputy chief executive, in addition to his role as chief financial officer.

Tim joined UCLH from the Whittington Hospital in 2010 where he had been deputy finance director for two years. Prior to this, Tim held senior finance positions in service line reporting, patient level costing, commissioning and financial management. He graduated from the NHS graduate training scheme in 2006. He has a degree in psychology from the University of Cambridge which was followed by further study at the Judge Business School.

Tim is the acting chief executive from 1 April 2021.

Flo Panel-Coates
Chief nurse

Flo Panel-Coates was appointed UCLH chief nurse in April 2015, coming to the organisation from Barking, Havering and Redbridge University NHS Trust where she was chief nurse for two and a half years. In February 2021 she took on additional responsibility as the executive director lead for organisational development. Prior to that, she was director of nursing and quality at Maidstone and Tunbridge Wells NHS Trust from August 2008 until September 2012. She also held positions of director of nursing and midwifery, and director of infection prevention and control at the North Middlesex University Hospital NHS Trust from September 2005 to August 2008. She has a keen interest in organisational culture and in creating different ways of working to release more time to care.

Flo is the acting deputy chief executive from 1 April 2021.

Other directors who attend the board:

Professor Bryan Williams
Director of research

Professor Bryan Williams joined the UCLH board as a non-voting member in December 2017. Bryan is chair of medicine at University College London (UCL) and director of the UCL and UCLH National Institute for Health Research (NIHR) Biomedical Research Centre (BRC). He is a consultant physician at UCLH and a NIHR senior investigator.

Liz O'Hara
Director of workforce

Liz was appointed as the substantive director of workforce in February 2021 and joined the Board as a non-voting member. She had previously served as interim workforce director from 25 March 2020 and prior to this as deputy director of workforce at UCLH. Liz has worked at UCLH since 2012. In 2018 she undertook a secondment to Oxford University Hospitals NHS Foundation Trust as interim director of workforce. Her particular interests are staff experience, engagement and partnership working.

Board members who stood down during the year:

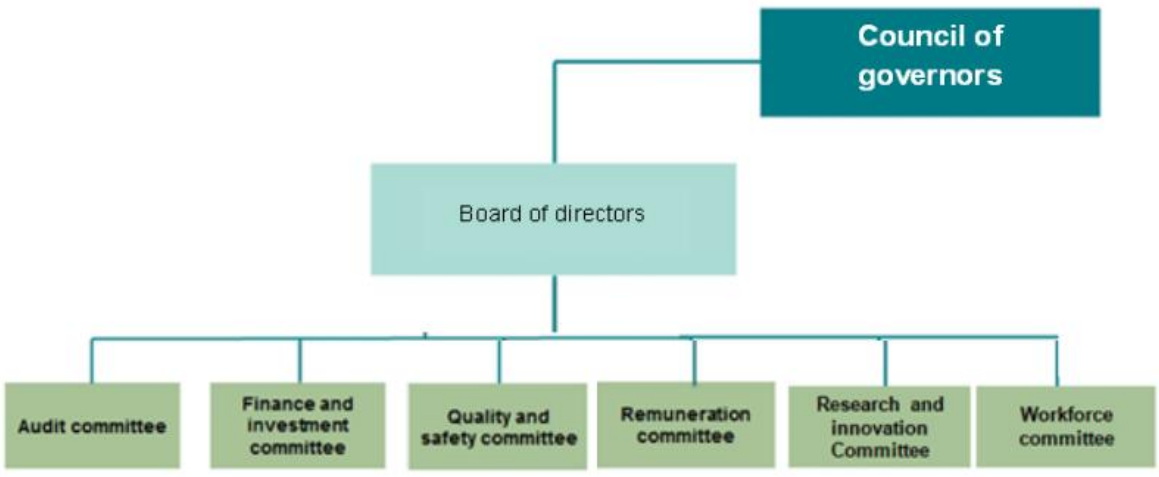
Dame Clare Gerada
Dame Clare Gerada was appointed as a non-executive director in September 2018. She was a member of the quality and safety and workforce committees. Her resignation as a NED took effect from February 2021.

Ben Morrin
Ben Morrin joined UCLH as the workforce director in September 2014 and was a non-voting member of the Board. He was seconded to NHS London from 25th March 2020 until 5th January 2021. He resigned as the UCLH workforce director in January 2021 when he became acting deputy chief executive at Barking, Havering and Redbridge University NHS Trust.

Board committees

The effectiveness of the Board committee structure was reviewed in 2019/2020 in order to engage the board more fully in decision making and ensure it has oversight of all key areas. Performance is a key agenda item at all board meetings and seminars.

Our new committee structure is as follows:



Terms of reference set out the responsibilities of each committee. This structure monitors and provides assurance to the board on the delivery of our objectives and other key priorities. During 2020/21 all Board and Board sub-committee meetings have been held virtually due to the COVID-19 pandemic.

Directors' attendance at the board 2020/21:

Non-executive director	Board attendance	Executive director	Board attendance
Junaid Bajwa	6/6	Geoff Bellingan	6/6
Jane Collins	6/6	Gill Gaskin	6/6
Althea Efunshile	5/6	Tim Hodgson	6/6
Clare Gerada	4/5	Charles House	5/6
Martin Jacobs	6/6	Tim Jaggard	5/6
David Lomas	5/6	Marcel Levi	6/6
Julia Neuberger	6/6	Ben Morrin* **	0/0
Simon Porter	5/6	Liz O'Hara*	2/2
Adam Sharples	5/6	Flo Panel-Coates	6/6
Robert Vincent*	1/3	Bryan Williams*	6/6

* The workforce director and director of research attend board meetings in a non-voting capacity. The director of strategy will attend board meetings in a non-voting capacity from April 2021.
** On secondment during 2020/21.

Audit committee

Membership comprises at least three non-executive directors (including the committee chair), selected for their skills and experience. Jane Collins has been the audit committee's chair since 1 January 2020. Jane has significant audit committee experience and has been a member of the audit committee since January 2019.

Representatives from our external auditors Deloitte LLP, local counter-fraud specialists (RSM Risk Assurance Services LLP until 31 March 2021 and KPMG LLP from 1 April 2021), our internal auditors KPMG LLP, the chief financial officer, the deputy chief financial officer, the chief accountant and trust secretary also attend the committee. Other executive directors and senior managers are invited to attend when deemed appropriate by the chair. The chief executive attends annually when the committee reviews the financial statements.

The committee meets six times a year to discharge its duties. Its primary role is to review the adequacy and effectiveness of the systems of integrated governance (corporate, clinical and financial). It also ensures internal control and risk management are in place to support the achievement of UCLH's objectives. Its responsibilities are set out in its terms of reference which can be found on our website. These are refreshed annually.

Non-executive attendance at audit committee in 2020/21:

Member	2020/21 membership term dates	Attendance
Jane Collins	April 2019 to March 2021	6/6
Martin Jacobs	January 2020 to March 2021	6/6
Simon Porter	April 2020 to March 2021	6/6
Adam Sharples	September 2019 to March 2021	6/6

The committee is well-placed to fulfil its assurance role. Its members attend other committees of the board giving them significant breadth and depth of knowledge of the organisation which strengthens the audit committee's effectiveness.

During the year the committee approved the internal audit plan for 2020/21 and received thirteen assurance reports from KPMG. The reports included reviews of absence management, financial governance and controls during COVID-19, lessons learned from the first surge of COVID-19, core financial controls, risk management, financial/scenario planning for the new financial regime, ICS linked projects and programmes, health and safety, ICS: workforce, procurement, sustainability reporting, data security and protection toolkit and data quality (RTT). The committee reviewed the appropriateness and implementation of management's response to the findings, receiving further updates from responsible officers where required.

The committee monitored counter fraud arrangements through the review of quarterly progress reports, including fraud risk assessments. It also received regular updates from management on the financial metrics in place to meet the better payment practice standards.

The head of internal audit opinion is one of significant assurance with minor improvement opportunities.

The committee reviewed key areas of judgement in both financial and non-financial reports. This included the significant audit risks identified by the external auditors, including the local risks of valuation of land and buildings, and accounting for capital expenditure.

The committee received Deloitte's conclusions from its audit of the 2020/21 annual accounts and considered the annual report and annual governance statement before submission to the board for approval.

The committee monitored the performance and independence of the external auditors and the effectiveness of both internal audit and local counter fraud services. It also reviewed its own effectiveness.

In 2020/21 the committee received regular updates on the key financial and non-financial risks facing the trust, including the impact of the COVID-19 pandemic. Regular accounting updates have been provided reflecting both national and local ongoing financial accounting issues.

The external and internal audit partners and the local counter fraud specialists have direct access to the committee. The committee members held private meetings without management present with both the external audit partner and the head of internal audit during the year.

The council of governors appointed Deloitte LLP as external auditors for three years commencing with the 2016/17 audit. Included within this appointment was the option to extend for a further two years. In 2020/21, governors agreed to the second of two possible one-year

extensions. The auditors' opinion and report on the financial statements is included in the annual accounts. The council of governors participated in a tender exercise to appoint new external auditors from April 2021 and agreed that Deloitte should be awarded a new contract from 1 April 2021.

Deloitte may also provide non-audit services with the agreement of the committee and the council of governors. No non-audit work was provided in 2020/21.

The total cost of the external audit of the annual report and accounts for 2020/21 was £150k (£115k in 2019/20). There was no requirement to audit the quality report in 2020/21.

Finance and investment committee

The finance and investment committee provides oversight and scrutiny of all aspects of financial management and investment decisions. It provides assurance to the board on the management of financial risk. It examines financial performance and reviews costing and benchmarking work. It also oversees UCLH's approach to contracting and considers longer-term financial performance issues.

The committee also reviews the annual capital programme and reports to the board on major capital investment proposals. In conducting an independent review of investment proposals, it considers strategic fit and ensures business cases have been appropriately assessed with regards to risk. It also reviews medium-term investment strategy, including the financial and economic aspects of the estate strategy.

Quality and safety committee

The quality and safety committee (QSC) provides the board with assurance on three key areas of quality: safety, effectiveness and patient experience. It 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. It reviews compliance and receives assurance on meeting regulatory standards set by the Care Quality Commission (CQC). For further information see section 1.3 Progress against 2020/21 quality priorities and priorities for improvement 2021/22.

Research and innovation committee

The research and innovation committee (RIC) provides oversight of all research matters at UCLH. The RIC is chaired by a non-executive director and its membership includes the chief executive, the director of research, two medical directors and UCL's vice provost (health) who is also a non-executive director of UCLH. The focus of the RIC has been on UCLH as a research hospital, research innovation and research relating to data.

Workforce committee

The workforce committee provides oversight and governance of our workforce framework. It is responsible for assuring appropriate arrangements are in place for achieving the trust's strategic and corporate objectives in relation to our workforce and is chaired by one of the non-executive directors. The committee includes executive and non-executive directors, a union representative, a staff network representative, a staff governor, a divisional clinical director and divisional manager.

Remuneration committee

The remuneration committee sets pay and employment policy for very senior managers (VSMs). It also considers the performance of the executive directors. The committee sets remuneration using benchmarking information and survey data of other comparable senior posts within the NHS, taking into account national guidance. All UCLH's non-executive directors are members of this committee. It is chaired by the chair of the board.

The remuneration committee met on four occasions this year. Non-executive director attendance was as follows:

Non-executive director	Remuneration committee attendance
Junaid Bajwa	4/4
Jane Collins	4/4
Althea Efunshile	3/4
Clare Gerada	1/3
Martin Jacobs	4/4
David Lomas	1/4
Julia Neuberger	4/4
Simon Porter	4/4
Adam Sharples	4/4
Robert Vincent	1/3

Marcel Levi, the chief executive, attended parts of all meetings in an advisory capacity. The interim workforce director or a senior workforce manager, attended parts of all the meetings.

Details of salary and pension entitlements for the directors of UCLH are set out in section 2.2 Remuneration report.

There is also a governors' nomination, appointments and remuneration committee (NARC) which deals with non-executive appointments – see section 2.1.2 Governors and members.

Board, committee and directors' evaluation

The description of each director's experience demonstrates the balance and relevance of the skills and expertise of the board. To help the board assure itself in this regard, it undertakes a collective self-assessment of its performance and governance practices.

The council of governors sets objectives for the chair of the board. The chair of the council of governors' nomination, appointments and remuneration committee and the senior independent director of the board appraise the chair of the board.

The chair undertakes the performance review of the non-executive directors and the chief executive.

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

Directors' expenses

In 2020/21 no directors claimed out of pocket expenses.
In 2019/20 two directors claimed out of pocket expenses totalling £1,123.

2.1.2 Governors and members

Being a member of UCLH gives people interested in the trust the opportunity to find out more about the services we provide and help shape the future of the organisation.

We have three membership constituencies, as defined in the trust constitution:

- Public
- Patient
- Staff

Anyone aged 14 or over can become a patient or public member of UCLH.

Public membership includes individuals living in one of the 32 London boroughs or the City of London and individuals living in Berkshire, Buckinghamshire, Essex, Hertfordshire, Kent and Surrey.

Patient membership is divided into three groups:

- Patients living in one of the 32 London boroughs or the City of London (London)
- Patients from elsewhere in England (out of London)
- Individuals who are unpaid carers of patients of UCLH

Anyone who joins as a patient or carer member must have attended a UCLH hospital within the last three years.

Staff membership comprises:

- Individuals who have a permanent contract with UCLH
- Individuals who have a fixed term contract of at least 12 months with UCLH
- Individuals who have had an honorary contract of at least 12 months with UCLH
- Individuals who are not employed by UCLH but who have provided services to the trust continuously for at least 12 months

There are four staff groups:

- Medical and dental practitioners
- Nurses and midwives
- Other clinical staff
- Non-clinical staff

When staff join UCLH they become members automatically unless they opt out. This right is explained to staff. Staff cannot be public or patient members.

Our overall membership numbers are as follows:

Constituency	31 March 2021	31 March 2020
Staff	10,411	10,688
Public	2,645	2,650
Patient	7,548	7,849
Total	20,604	21,187

Membership engagement and strategy

Our current membership strategy covers 2019 to 2022 and focuses on improving our engagement and communication with members.

We provide members with regular updates through the UCLH Magazine, by email and at events, such as the annual members' meeting. Events have been held virtually or by email because of the pandemic. Governors follow up on members' concerns and communicate members' views to the board.

We invite members to join groups such as the patient experience and engagement committee and the allied health professional patient forum. We have also invited members to take part in projects covering the use of patient data in research and to review the options for providing orthopaedic care across North Central London. In 2020/21 patient-led assessments of the care environment (PLACE) inspections were cancelled due to the pandemic.

A member has the option to vote for, or stand to become, a governor. There is an annual session for interested members to ask questions about the role.

We acknowledge that we need to do more to ensure our membership is truly representative of the communities we serve. Our biomedical research centre is organising a series of events for under-represented communities, focusing on health matters which are of particular interest to them.

Council of governors

UCLH is accountable to the communities it serves through the council of governors which represents the views of patients, the public, stakeholders and staff.

The council of governors works closely with UCLH to help shape and support its future strategy and ensure that we focus on issues that benefit patients and staff.

Who sits on the council?

The council has 33 governors of which 24 are elected governors and nine are appointed governors. Of the 24 elected governors:

- 5 are public
- 12 are patients
- 1 is a carer of a patient
- 6 are staff

On 31 March 2021, 32 of the 33 governor seats were occupied.

Governors normally hold office for three years and are eligible for re-election or re-appointment at the end of their first term. Governors may not hold office for more than six consecutive years. They must then have a break of two years before being eligible for a further and final three-year term.

The council also elects one of its members to be the lead governor. Claire Williams held the position from September 2017 until her resignation on 31 March 2021. The governors elected a new lead governor, Pam Peers, who took over as lead governor from 1 April 2021.

The council meets four times a year in public, although part of these meetings can be held in private to deal with confidential matters. This year, due to the pandemic, all meetings have been held virtually.

The following tables give details of the governors, their terms in office during 2020/21 and attendance at council meetings.

Elected governors

Governor	Constituency	Current term	Current term start date	Current term end date	Council attendance
Alexander De Mont	Public	First	1 September 2019	31 August 2022	3/4
Isaac Kohn	Public	Second	1 January 2021	31 August 2023	4/4
Frances Lefford	Public	Second	1 September 2018	31 August 2021	4/4
Pam Peers	Public	First	1 January 2021	31 August 2023	1/1
Brian Steve Potter	Public	Second	1 January 2021	31 August 2023	1/4
Sally Bennett	Patient – London	First	1 September 2018	31 August 2021	4/4
Graham Cooper	Patient – London	Second	1 September 2019	31 August 2022	4/4
Ann Fahey	Patient – London	Second	1 September 2019	31 August 2022	2/4
Michael Goss	Patient – out of London	Second	1 January 2021	31 August 2023	3/3
Jonathan Harper	Patient – London	First	1 September 2018	31 August 2021	3/4
Gilbert Howarth	Patient – London	First	1 January 2021	31 August 2023	0/1
Rosalind Jacobs	Patient Carer	Third	1 January 2021	31 August 2023	0/1
Philip Matthews	Patient – out of London	First	15 February 2021	31 August 2022	1/1
Fiona McLean	Patient – out of London	First	1 January 2021	31 August 2023	1/1
Emma Szelepet	Patient – London	Second	1 January 2021	31 August 2023	1/1
Andrew Todd-Pokropek	Patient – London	Second	1 September 2018	31 August 2021	1/4
Katie Wright	Patient – London	First	1 September 2019	31 August 2022	4/4
Allesa Baptiste	Staff	First	1 September 2018	31 August 2021	4/4

Governor	Constituency	Current term	Current term start date	Current term end date	Council attendance
Richard Cohen	Staff	First	1 September 2018	31 August 2021	4/4
Anna Collinson	Staff	First	1 January 2021	31 August 2023	1/1
Caroline Dux	Staff	Final	1 September 2018	31 August 2021	4/4
Innica Halsey	Staff	First	1 September 2019	31 August 2022	2/4
Josie Turgill-Clarke	Staff	First	1 September 2019	31 August 2022	1/4

Appointed governors

Governor	Constituency	Current term	Current term start date	Current term end date	Council attendance
Katie Coleman	GP for NCL CCG	Second	16 December 2020	15 December 2023	2/4
Sara Hyde	Islington Council	First	11 January 2021	10 January 2023	1/1
Rishi Madlani	Camden Council	Second	10 December 2020	9 December 2023	2/4
John McGrath	GP for NCL CCG	First	18 December 2020	17 December 2023	1/1
Diarmid Ogilvy	UCLH Charities	Second	1 December 2020	30 November 2023	4/4
Rachel Picton	London South Bank University	First	6 November 2020	5 November 2023	1/1
Jenny Shand	UCL Partners	First	10 August 2020	9 August 2023	1/2
Irving Taylor	UCL	First	27 January 2020	26 January 2023	4/4

Governors whose term ended in 2020/21

Governor	Constituency	Term	Term end	Attendance
Amanda Gibbon	Public	Third	31 December 2020	3/3
John Green	Patient – London	Third	31 August 2020	1/2
Christine Mackenzie	Patient – London	Third	31 August 2020	2/2
Warren Turner	Stakeholder - London South Bank University	Second	16 October 2020	2/3
Martha Wiseman	Patient Carer	First	31 August 2020	2/2

Governors who stood down in 2020/21

Governor	Constituency	Term	Date stood down	Attendance
Annabel Kanabus	Patient – out of London	Third	8 February 2021	0/4
Helen Wheatley	Patient – London	First	31 August 2020	2/2
Claire Williams	Stakeholder - Friends of UCLH	Second	31 March 2021	4/4

Role of the council

The council has a number of statutory responsibilities including:

- Holding the non-executive directors to account for the performance of the board
- Appointing or removing the chair and non-executive directors
- Deciding the remuneration of non-executive directors
- Appointing or removing UCLH's auditors

The council also has the final decision on significant transactions; receives the annual report, quality report, accounts and auditor's report; approves changes to the constitution and gives its views on the development of our forward plan.

How the council works

The chair of the board is also chair of the council. This establishes an important link between the two bodies and helps governors to fulfil their statutory responsibilities. Other board members, both executive and non-executive, may also attend council meetings.

Directors' attendance at the council of governors 2020/21:

Non-executive director	Council attendance	Executive director	Council attendance
Junaid Bajwa	4/4	Geoff Bellingan	3/4
Jane Collins	3/4	Gill Gaskin	3/4
Althea Efunshile	4/4	Tim Hodgson	3/4
Clare Gerada	3/4	Charles House	4/4
Martin Jacobs	4/4	Tim Jaggard	4/4
David Lomas	3/4	Marcel Levi	4/4
Simon Porter	4/4	Ben Morrin*	0/0
Julia Neuberger	4/4	Flo Panel-Coates	3/4
Adam Sharples	4/4	Bryan Williams	1/4
Robert Vincent	1/1	Liz O'Hara**	0/0

**On secondment*
***Appointed February 2021*

The council receives regular reports from the board on clinical and financial performance and is presented with a report from the chair of the audit committee annually. It also considers reports from the council's nomination, appointments and remuneration committee and a governors' group with a focus on high quality patient care.

The chair and the lead governor seek the views of governors when preparing the agendas for meetings. During the year, the council has presentations on specific topics. In 2020/21 this included presentations on maternity services, the 2019/20 financial results, our new clinical facilities and the pandemic. Throughout the year, the chair and chief executive held regular virtual briefings so that governors were aware of the current situation. The governors also met with the director of quality and safety to review progress against quality objectives and contribute to the setting of quality targets and priorities for 2021/22.

The lead governor holds regular meetings with governors to keep in touch with opinion and further enhance communication between the council and board members. Governors also meet separately with the non-executives to hear first-hand how they have sought assurance from the executive on areas of performance. This is also an opportunity for the non-executives to hear the views of the governors.

Governors and board members were unable to undertake walk-arounds to keep in touch with patients during 2020/21 because of the pandemic.

Papers for the council meetings are published on the UCLH website.

Training

On joining UCLH, each governor attends an induction session and meets with the membership manager, trust secretary, chair and lead governor.

Externally facilitated training is also provided to help governors gain greater understanding of their role in specific areas. These sessions are run by NHS Providers and cover governor core skills, finance and accountability.

Governors' expenses

Governors can claim reasonable expenses for carrying out their duties. In 2020/21 no expenses were claimed by governors.

Register of interests

Governors sign a code of conduct and declare any interests that are relevant and material at the time of their appointment or once elected. The register of governors' interests is published annually and can be found on our website on the council of governors' page (https://www.uclh.nhs.uk/about-us/who-we-are/council-governors/meet-your-governors).It can also be obtained by emailing uclh.directors@nhs.net or calling 020 3447 9290.

UCLH constitution

No changes were made to the UCLH Constitution in 2020/21.

Committees of the council

The council of governors is responsible for approving the reappointment or appointment of non-executive directors.

Non-executive directors are appointed by the council for an initial period of three years, which may be extended for a further three years. In exceptional circumstances a non-executive director can serve for one or more additional defined periods.

The council may also remove the chair or another non-executive director. This requires the approval of at least three-quarters of the members of the council.

Nomination, appointments and remuneration committee (NARC)

Since November 2019, the committee has had 11 governor members (including the committee chair). There are six public/patient governors, two staff governors and three appointed governors. The committee decided to hold over vacancies from the summer of 2020 until January 2021 when the new cohort of governors started. As of 31 March 2021, all posts are filled.

The committee makes recommendations to the council of governors on the appointment, re-appointment and remuneration of the UCLH chair and non-executive directors, and contributes to the appraisal of the UCLH chair.

The committee had triggered the appointment process for a new associate non-executive director post in July 2020. The panel recommended Robert Vincent for appointment on 1 October and the council of governors approved this recommendation on 12 October 2020. Robert started as an associate non-executive director on 14 October 2020.

The committee also agreed to the appointment of an additional associate non-executive director post as a development post for someone from an under-represented group. The appointment to this post has been deferred until at least the summer of 2021 due to the pandemic.

In November 2020, the committee was advised of the outcome of the chair's appraisal by the senior independent director and the chair of the NARC. They also received a report from the chair on the appraisals of the non-executive directors.

In February 2021, the committee recommended that there should be no discretionary uplift to the remuneration of the chair and non-executive directors from 1 April 2021. This decision was in line with NHSEI guidance. The council of governors approved this recommendation on 27th April 2021.

In February 2021, the committee agreed to delay the appointment of a non-executive director to replace Dame Clare Gerada.

Membership of the NARC is reviewed each year.

The committee met four times this year: 23 July 2020, 1 October 2020, 27 November 2020, and 25 February 2021.

Members and attendance at the committee is as follows:

NARC member	NARC attendance
Allesa Baptiste	4/4
Sally Bennett	4/4
Graham Cooper	4/4
Amanda Gibbon	3/3
Gil Howarth	1/1

NARC member	NARC attendance
Rachel Picton	1/1
Pam Peers	1/1
Innica Halsey	3/4
Frances Lefford	4/4
Emma Szelepet	1/1
Christine Mackenzie	1/1
Diarmid Ogilvy	4/4
Helen Wheatley	0/1
Claire Williams	4/4

The UCLH chair attended the parts of all four meetings to which she was invited and the Senior Independent Director attended part of the meeting on 27 November to which she was invited.

Contacting the governors

The UCLH membership office is the point of contact for members, patients and the public who wish to contact governors.

Email: uclh.governors@nhs.net

Post:
Membership office
University College London Hospitals NHS Foundation Trust
2nd Floor Central
250 Euston Road
London NW1 2PG

Phone: 020 3447 9290

2.1.3 Cost allocation and charging guidance

UCLH has complied with all cost allocation and charging guidance issued by HM Treasury.

2.1.4 Political and charitable donations

UCLH has not made any political or charitable donations this year.

2.1.5 Better payment practice code

Bills paid by volume

		2020/21	2019/20
Total	Invoices paid	129,807	158,613
	Paid within due date	93,327	82,537
	%	72.8	51.9
NHS	Invoices paid	5,339	4,930
	Paid within due date	1,583	627
	%	29.6	12.7
Non-NHS	Invoices paid	124,468	150,654
	Paid within due date	91,654	81,730
	%	73.6	54.3

Bills paid by value

		2020/21	2019/20
Total	Invoices paid	951,619	963,392
	Paid within due date	771,872	709,289
	%	81.1	73.6
NHS	Invoices paid	65,367	43,818
	Paid within due date	28,645	9,870
	%	43.8	22.5
Non-NHS	Invoices paid	886,252	919,575
	Paid within due date	743,227	699,419
	%	83.9	76.1

2.1.6 NHSI's well-led framework

Our senior directors team reviews itself against NHS Improvement's well-led framework and reports its findings to the board. The board reviews the key lines of enquiry of the framework. It is the board's view that there are robust arrangements in place to ensure that services are well-led.

The planned external well-led review was deferred due to the pandemic.

There are six board committees: audit; finance and investment; quality and safety; remuneration; research and innovation; and workforce. All board committees review their effectiveness regularly and take actions to improve. Overall performance continues to be monitored closely at board meetings.

The following measures are in place to drive further improvements:

- The performance data pack which is presented to the board is regularly reviewed to ensure areas of key concern are clearly identified.
- The recruitment process for non-executive directors seeks to ensure that our board is diverse and representative of our local population and staff and the council and board have agreed to the appointment of a development post for an associate non-executive director from an under-represented group to improve diversity of the board.
- The remuneration committee has agreed a succession plan for senior leaders. This is supported by a senior leader development programme and making coaching and mentoring available to all staff.
- We continue to review the ways we communicate with the public to see if this can be improved. We will increase opportunities for patient and public engagement in our activities and decision-making.
- The workforce committee is using the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) to drive improvements in the experience of staff. The staff networks play an important part in engaging with staff on the issues which matter to them. Many senior leaders are taking part in a new reverse mentoring scheme.
- Improving staff experience and reducing bullying and harassment are key priorities for the board and are discussed regularly.
- The guardian service is a well-established route for staff to raise concerns and the board has appointed a non-executive champion who meets regularly with the guardian.
- The board has appointed a non-executive director to be the Trust Board safety champion for maternity services in line with the recommendations of the Ockenden report.

2.1.7 Patient care activities

National Inpatient Survey 2020

See Patient Feedback in section 1.2.3 Detailed review of our performance 2020/21. However, due to the pandemic, the national inpatient survey for 2020 was postponed and the results are not yet available.

Patient experience groups

Patient experience and engagement is monitored at our monthly QSC meetings. A non-executive director chairs the QSC and two patient/public governors attend. There are many other local groups which monitor patient experience and we are always looking for ways to improve and share best practice in this area.

Patient information

Workshops on how to write good quality patient information are available to staff. A volunteer leads these workshops. Prior to the pandemic and in response to patient feedback, we were developing more patient information online and considering how printed information needs to be adapted for print in black and white only wherever possible. Since the pandemic, the development of online resources for patients has become critical.

Complaints

Patients and their relatives are encouraged and able to provide feedback or make a complaint in a number of ways. This can be in writing or email (UCLH.complaints@nhs.net) or via the trust website (www.uclh.nhs.uk). We also accept complaints by phone and in person, although most

complaints are sent in by email. We aim to acknowledge all complaints within 3 days and usually respond in writing.

We aim to deal with complaints as quickly as possible and we report regularly to our trust board on our performance and quarterly to NHS Digital. All complaints are seen as an important part of helping us to improve the quality of patient experience, safety and effectiveness whilst also providing evidence to our patients and the public of the action UCLH has taken to learn as a result of the lessons learned (see annual complaints report on the UCLH website).

Further information

For further information about how we are seeking to improve and monitor patient experience see section 1.3.

2.1.8 Stakeholder relations

North Central London Cancer Alliance

Cancer alliances provide local clinical and operational leadership by bringing together commissioners and providers to improve cancer services. UCLH hosts the North Central London Cancer Alliance. The cancer alliance hosted by UCLH was originally known as the UCLH Cancer Collaborative and subsequently the North Central and East London Cancer Alliance. This year has been dominated by the response to the COVID-19 pandemic. The cancer alliance has played an important role in ensuring that urgent diagnosis and treatment services for cancer were sustained.

Clinical and operational networks – the alliance's pre-existing structure of pathway boards and expert reference groups were supported to meet frequently and agree new pathways to ensure services were kept safe and available. The alliance coordinated with NHS London across London-level tumour pathway groups too, gaining agreement around clinical changes at sector and regional level.

Supporting diagnostics and endoscopy recovery – the alliance played a leading role in the recovery of backlogs for diagnostics in NCL. It took leadership of the overall endoscopy recovery and NCL hospitals delivered a rapid return to pre-pandemic levels of activity. Specialist staff were redeployed from the cancer alliance to the NCL imaging programme.

Surgical hub – the cancer alliance played a key role in delivering the surgical hub led by UCLH and spanning NHS and non NHS sites. The alliance set up the standard operational procedures for ensuring that cases were discussed in a timely way and the alliance tumour working groups fed into the central hub. The alliance also provided analytical support and redeployed programme staff to ensure the smooth running of the surgical hub.

Addressing the 'missing cancers' – the pandemic led to a drop in presentation by people with worrying symptoms. The cancer alliance was able to quantify this gap – the so called 'missing cancers' - and has developed a large scale communications campaign to encourage people with worrying symptoms to speak to their GP and those eligible for screening to take up their screening invitations.

Innovation – The cancer alliance has continued to be at the forefront of innovation. It launched Youscreen, a nationally sponsored pilot for self-sampling as part of the cervical cancer screening programme. The alliance also completed the evaluation of use of the 'FIT' test for colorectal cancer and rolled out the test for a new cohort of patients.

Patient and public involvement (PPI) activities

We are committed to involving patients, their families and the local community in the decisions we make, and to delivering improvements that matter to them. Most of this engagement is undertaken by clinical services and teams at a local level. We also have a number of trust wide projects.

The patient working group we created to support the development of Epic, our new electronic health record system, has continued to meet regularly and has five patient members to ensure a diverse range of views is represented.

For information on how we engage with our members see section 2.1.2 Governors and members.

2.1.9 Equality reporting (patients)

Performance against our equality objectives is monitored by our diversity and equality group, with progress reported to the SDT.

Our main areas of focus this year built on 2019/20 priorities to:

Improve the environment for patients, their families and carers

- Continue to build on the priority recommendations from the charity AccessAble and support the continued improvement of “way-finding” across our hospitals.
- Supporting the planning and commissioning of the University College Hospital Grafton Way Building to provide an environment that recognises and supports patients with sensory and cognitive impairments.

Improve access into our services for patients with specific communication requirements

- Monitor the collection of data on the protected characteristics and multiple disabilities of our patients. Ensure that this is recorded on patients’ records via Epic, our EHR, to better understand the needs of our patient population.
- Ensure that we record the communication preferences of this population and improve the monitoring of how we meet patient preferences in line with the Accessible Information Standard (AIS).
- Complete the installation of hearing loops across our administration and frontline services.

Specialist priorities

- Develop Easy Read information for patients with learning disabilities who require elective treatment.
- Use of innovation and technology to support effective communication with patients and their carers.
- Support the experience of BAME women receiving maternity care at UCLH.
- Engage with national procurement initiatives to support patients with communication, such as transparent face masks, to facilitate use of lip reading and a standardised programme for video, SignLive.
- Continue the development of MyCare UCLH to include patient proxy opportunities.
- Develop a patient access and advocacy service for patients using our outpatient services.

We continue to meet the expectations of the Equality Act 2010 and the NHS Equality Delivery System 2. Further information about our work in this area is available in UCLH's annual equality report.

2.1.10 Income disclosures

In 2020/21, 7 per cent of our total operating income was derived from non-NHS income (seven per cent in 2019/20).

Surpluses from non-NHS income have been used to support the provision of NHS services.

2.2 Remuneration report

2.2.1 Annual statement on remuneration

All decisions regarding the pay of our very senior managers (VSMs) are made by the remuneration committee. VSM contracts cover the following staff:

- the chief executive
- executive directors, except those on the national consultant contract
- senior managers who report directly to the chief executive
- senior managers who fall outside of the agenda for change framework because of the size and complexity of the role and the knowledge, skills and experience needed.

All of UCLH's non-executive directors are members of this committee. It is chaired by the chair of the board. The committee is responsible for determining and agreeing, on behalf of the board, the broad policy for the remuneration of our VSMs. The committee is also responsible for considering the performance of the chief executive and executive directors and received assurance on these matters.

In 2020/21, a consolidated increase of 1.03 per cent was offered to VSMs whose terms and conditions were not covered by nationally-determined contracts, subject to each individual pay award being reviewed to ensure that it did not result in a consolidated award that was in excess of the combination of the NHSI recommended awards for 2019/20 and 2020/21.

The medical directors' basic salaries are defined through national agreements for medical and dental staff.

Three medical directors received the nationally-set uplift of 2.8 per cent to base salary in 2020/21, in line with the agreement for medical and dental consultant staff whose terms and conditions are covered by nationally-determined contracts. A fourth medical director is an employee of UCL (University College London).

Chief financial officer Tim Jaggard was appointed to the post of deputy chief executive in October 2020. Flo Panel-Coates, chief nurse, was appointed to be the lead executive for organisational development in February 2021. Liz O'Hara was appointed as the director of workforce in February 2021 and joined the Board as a non-voting member. Laura Churchward, director of strategy, joined the Board as a non-voting member from 1st April 2021.

Marcel Levi, chief executive, left the trust on 31st March 2021 and David Probert was appointed as chief executive and will take up his post in August 2021. Interim arrangements are in place.

We strive to operate with openness and transparency when reviewing and setting the pay of VSMs.

Baroness Julia Neuberger DBE
Chair

14 June 2021

2.2.2 Senior managers' remuneration policy

The committee sets basic salary remuneration using benchmarking information from NHS Providers and the Shelford Group of NHS trusts. We also take into account NHS Improvement's guidance on pay for very senior managers (October 2020) and NHS Employers' very senior manager pay framework (updated in July 2013).

Decisions on any annual uplift to basic salary are informed by recommendations from the senior salaries review body (SSRB).

We use our leader model to review our leaders' abilities to deliver priorities in a manner which demonstrates our values and develops effective working relationships. This assessment continues to support the objectives of UCLH.

UCLH's policy on diversity, equality, inclusion and human rights applies to all staff and is used when setting the remuneration of very senior managers (VSMs). One of the trust's corporate objectives is to promote diversity, equality and inclusion and this is linked to our strategic objective to develop all of our diverse staff to deliver their potential and foster talent by being a diverse and inclusive employer which recognises the need to improve the experience of all our staff. Information about the diversity of our VSMs is included in our annual equality report.

The remuneration committee confirmed that female VSMs at UCLH are paid at, or above, the median rate of comparable roles in other trusts of a similar size.

We remain disappointed that BAME staff are under-represented at senior level. We are developing plans to increase the opportunities for BAME staff to progress their careers and move into leadership roles.

VSMs are employed on contracts with a standard six-month notice period, with the exception of the medical directors who are on a three-month notice period in line with the NHS consultant contract. VSMs are substantive employees of the trust, with the exception of those directors who are employees of UCL.

UCLH's disciplinary policies apply to VSMs, including the sanction of dismissal for gross misconduct.

UCLH's redundancy policy is consistent with NHS redundancy terms for all staff. No compensation for early termination was paid during this financial year. No early terminations are expected and no accounting provisions are therefore required. No awards have been made to any past VSMs.

The only non-cash element of VSMs' remuneration packages provided by the trust are pension-related benefits accrued under the NHS pension scheme. Contributions are made by the employer and employee in accordance with the rules of the national scheme.

The following table includes a description of each component of VSMs' remuneration:

Component	Application	Description
Basic salary inclusive of London weighting	All VSMs	Agreed at appointment by the remuneration committee.
Clinical excellence award (CEA)	Applicable to medical directors and director of research only	The is intended to recognise and reward those consultants who contribute most towards the delivery of safe and high quality care and to the continuous improvement of NHS services. It includes those who do so through their contribution to academic medicine.
Additional programme activity	Applicable to medical directors only	The remuneration for this is covered by schedules 13 and 14 of the Terms and Conditions – Consultants (England) 2003.
Medical director allowance	Applicable to medical directors only	Recognises the increased responsibilities associated with the role of medical director.
Medical on call	Applicable to medical directors only	The on-call availability supplement recognises the time spent being available while on call. It does not recognise the work actually done while on call.

In 2020/21, seven VSMs were paid in excess of the threshold of £150,000.

UCLH has taken the following steps to satisfy itself that this remuneration is reasonable:

- The remuneration committee sets pay and employment policy for the executive directors and other senior staff designated by the board.
- The committee sets remuneration with due regard to national guidance and benchmarking information of other comparative senior NHS posts.
- All non-executive directors are members of the remuneration committee and provide objective scrutiny of any salaries set in excess of the threshold.
- A substantial part of the medical directors' remuneration is made up of an NHS consultant's basic salary determined in accordance with NHS national terms and conditions.

The remuneration and expenses for the UCLH chair and non-executive directors are determined by the council of governors, taking into account national guidance.

2.2.3 Annual report on remuneration

Senior Manager Remuneration

Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual

Name and Title	2020/21				2019/20			
	Total salary and fees	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*	**Total salary and fees**	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*
	(bands of £5,000)	*(bands of £5,000)*	*(in bands of £2,500)*	*(bands of £5,000)*	**(bands of £5,000)**	*(bands of £5,000)*	*(in bands of £2,500)*	*(bands of £5,000)*
	Banding	*Banding*	*Banding*	*Banding*	**Banding**	*Banding*	*Banding*	*Banding*
J Neuberger Chair	**60-65**	-	-	60-65	**60-65**	-	-	60-65
H Bush Non-executive director (to 31 August 2019)	**N/A**	-	-	N/A	**5-10**	-	-	5-10
R Makarem Non-executive director (to 31 December 2019)	**N/A**	-	-	N/A	**15-20**	-	-	15-20
C Woolley Non-executive director (to 31 January 2020)	**N/A**	-	-	N/A	**10-15**	-	-	10-15
J Collins Non-executive director	**20-25**	-	-	20-25	**15-20**	-	-	15-20
J Bajwa Non-executive director	**10-15**	-	-	10-15	**10-15**	-	-	10-15
C Gerada Non-executive director (to 15 February 2021)	**10-15**	-	-	10-15	**10-15**	-	-	10-15
D Lomas Non-executive director	**10-15**	-	-	10-15	**10-15**	-	-	10-15

Name and Title	2020/21				2019/20			
	Total salary and fees	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*	**Total salary and fees**	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*
	(bands of £5,000)	*(bands of £5,000)*	*(in bands of £2,500)*	*(bands of £5,000)*	**(bands of £5,000)**	*(bands of £5,000)*	*(in bands of £2,500)*	*(bands of £5,000)*
	Banding	*Banding*	*Banding*	*Banding*	**Banding**	*Banding*	*Banding*	*Banding*
A Efunshile Non-executive director	**10-15**	-	-	10-15	**10-15**	-	-	10-15
M Jacobs Non-executive director (from 1 January 2020)	**10-15**			10-15	**0-5**	-	-	0-5
A Sharples Non-executive director (from 1 September 2019)	**10-15**	-	-	10-15	**5-10**	-	-	5-10
S Porter Non-executive director (from 1 April 2020)	**10-15**	-	-	10-15	**N/A**	-	-	N/A
R Vincent Associate non-executive director (from 6 October 2020)	**5-10**	-	-	5-10	**N/A**	-	-	N/A
M Levi Chief executive (note a)	**270-275**	10-15	-	285-290	**270-275**	10-15	-	285-290
T Jaggard Chief financial officer and deputy chief executive	**185-190**	-	37.5 – 40.0	225 - 230	**180-185**	-	-	180-185
F Panel-Coates Chief nurse	**165-170**	-	-	165-170	**165-170**	-	-	165-170
G Bellingan Medical director (note b)	**210-215**	-	37.5 – 40.0	250 - 255	**205-210**	-	2.5 - 5.0	210-215
C House Medical director	**195-200**	-	55.0 - 57.5	250 - 255	**185-190**	-	50.0 - 52.5	235 - 240
G Gaskin Medical director	**215-220**	-	27.5 - 30.0	240 -245	**210-215**	-	25.0 - 27.5	235 - 240

Name and Title	2020/21				2019/20			
	Total salary and fees	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*	**Total salary and fees**	*Annual performance related bonus*	*Notional pension related benefits*	*Total including annual performance related bonus and notional pension related benefits*
	(bands of £5,000) **Banding**	*(bands of £5,000)* *Banding*	*(in bands of £2,500)* *Banding*	*(bands of £5,000)* *Banding*	**(bands of £5,000)** **Banding**	*(bands of £5,000)* *Banding*	*(in bands of £2,500)* *Banding*	*(bands of £5,000)* *Banding*
A Mundy Medical director (to 31 Dec 2019)	**-**	-	-	-	**160-165**	-	-	160-165
B Williams Director of research (note b.)	**85 - 90**	-	-	85 - 90	**85-90**	-		85 - 90
T Hodgson Medical director (from Nov 2019)	**180-185**	-	-	180-185	**175-180**	-	-	175-180
B Morrin Workforce director (note c)	**N/A**			N/A	**125-130**	-	42.5 - 45.0	170 - 175
L O'Hara Workforce director (note d)	**125-130**	-	110.0 - 112.5	235 - 240	**N/A**	-	-	N/A

note: All salary paid in the year is reflected in the first column. The table also shows the notional increase / (decrease) in pension-related benefits (see note below). Therefore the final column should not be interpreted as the total salary paid in the year.

note a: In October 2020, the remuneration committee agreed that Professor Marcel Levi should receive £15,000 in performance related pay as he had met his performance targets in 2019/20. Professor Levi received the £15,000 in 12 monthly instalments in 2020/21.Professor Levi is provided with accommodation by UCLH Charity. This is not included in the disclosures above.

note b: Salary amounts represent totals recharged to the Trust.

note c: Ben Morrin stepped down from the director of workforce role on 26 March 2020.

note d: Liz O'Hara stepped into the interim workforce director role on 27 March 2020. Following a competitive recruitment process, Liz was substantively appointed to the post with effect from 24 Feb 2021. The salary shown is for the period 1 April 2020 to 31 March 2021.

Senior manager pension entitlements

(Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual)

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £000	Cash equivalent transfer value at 1 April 2020 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2021 £000
Medical Director: G Bellingan	0 - 2.5	5.0 - 7.5	70 - 75	210 - 215	1,898	33	1,964
Medical Director: C House	2.5 - 5.0	0 - 2.5	60 - 65	130 - 135	1,071	81	1,170
Medical Director: G Gaskin	2.5 – 5.0	7.5 – 10.0	35 - 40	115 -120	n/a	n/a	n/a
Chief financial officer and deputy chief executive: T Jaggard	2.5 – 5.0	0 – (-2.5)	35 - 40	75 - 80	468	37	512
Workforce director: L O'Hara	5.0 – 7.5	10 – 12.5	35 – 40	65 - 70	430	101	538

The information above is based on that provided by the NHS Pensions Agency. The cash equivalent transfer value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member of staff at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETVs are stated as actual values with the increase/(decrease) adjusted for inflation. NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, NHS Pensions has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.

Fair Pay Multiple

Audited in terms of paragraph 2.21 of the NHS Foundation Trust Annual Reporting Manual

The Trust is required to disclose the relationship between the remuneration of its highest-paid director in the Trust and the median remuneration of the Trust's workforce.

	2020/21	2019/20
Band of the highest paid director's total remuneration:	£285k-£290k	£285k-£290k
Median pay remuneration	£42,588	£41,395
Fair pay multiple	6.8	6.9

The banded remuneration of the highest paid director in the Trust in the financial year 2020/21 was £285k-290k (2019/20 £285k-290k). This was 6.8 times (2019/20 6.9) the median remuneration of the workforce, which was £42,588 (2019/20 £41,395).

In both 2020/21 and 2019/20, no 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.

Tim Jaggard
Acting chief executive

14 June 2021

2.3 Staff report

2.3.1 Staff costs

Staff costs

	Permanent	Other	2020/21 Total	2019/20 Total
	£000	£000	£000	£000
Salaries and wages	442,450	32,446	**474,896**	430,712
Social security costs	51,132	-	**51,132**	46,846
Apprenticeship levy	2,265	-	**2,265**	2,119
Employer's contributions to NHS pension scheme	76,756	-	**76,756**	70,848
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	41,217	**41,217**	49,372
Temporary staff	-	3,422	**3,422**	8,453
Total gross staff costs	**572,603**	**77,085**	**649,688**	**608,350**
Recoveries in respect of seconded staff	(6,164)	-	**(6,164)**	(5,488)
Total staff costs	**566,439**	**77,085**	**643,524**	**602,862**
Of which				
Costs capitalised as part of assets	1,050	209	**1,259**	8,162

2.3.2 Staff numbers

Average number of employees (WTE basis)

	Permanent Number	Other Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	1,658	56	**1,714**	1,554
Ambulance staff	1	-	**1**	1
Administration and estates	2,014	397	**2,411**	2,165
Healthcare assistants and other support staff	851	145	**996**	967
Nursing, midwifery and health visiting staff	3,197	879	**4,076**	3,490
Nursing, midwifery and health visiting learners	8	-	**8**	11
Scientific, therapeutic and technical staff	1,273	-	**1,273**	1,191
Healthcare science staff	454	-	**454**	419
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**9,456**	**1,477**	**10,933**	**9,798**
Of which:				
Number of employees (WTE) engaged on capital projects	16	3	**19**	139

Table notes:
Table does not include employees who have honorary contracts with UCLH
Bank and agency WTE numbers have been allocated to the relevant occupational categories. In 2020/21, the average number of bank and agency WTEs was 1,477 (2019/20, 633)

2.3.3 Staff gender analysis

Headcounts as at 31 March 2021	Male	Female	Total
Directors	12	6	18
Other senior managers*	7	8	15
Other staff	3,152	7,526	10,678

*the definition of other senior managers used for 2020/21 has been changed in line with guidance and now includes only senior managers on Very Senior Manager pay scales.

Headcounts as at 31 March 2020	Male	Female	Total
Directors	12	6	18
Other senior managers**	30	33	63
Other staff	2,770	6,888	9,658

Table notes:

- Tables include clinical staff with honorary contracts which have a cost implication for UCLH.
- Tables do not include bank and agency staff.
- ** in 2019/20 the definition of other senior managers included all senior managers reporting to an executive director

The director headcount figures for 31 March 2021 and 31 March 2020 include the non-voting members of the board.

2.3.4 Sickness absence data

Please see link to NHS Digital for this information:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
Absence data in 2020/21 included COVID-19 related absence, staff shielding and staff required to self-isolate.

2.3.5 Recruitment and retention

We continue to deliver our evidence-based strategy to recruit and retain staff in an increasingly competitive UK and international labour market.

Our vacancy rates remain below the average for London and our workforce continues to grow. Our vacancy rate decreased from 8.7 per cent in April 2020 to 6.2 per cent in March 2021. Recruiting the number of staff we need remains a challenge due to workforce shortages across the UK and abroad.

Across the country, it continues to be difficult to recruit to certain specialisms such as emergency medicine, anaesthesia, theatres, critical care, neonatology and medical imaging. In these specialisms, we rely on recruits from outside the UK to fill key vacant positions, as well as temporary staff to fill some short notice rota gaps.

Our average time to hire increased to 8 weeks in March 2021 from 7 weeks in April 2020 (excluding notice period).

Our staff turnover rate as at 31 March 2021 was 8.5 per cent compared to 13.1 per cent in April 2020. The COVID-19 pandemic has affected the turnover rate at the trust. Through delivery of the NHS People Plan, we will continue to focus on areas that aid retention into roles at UCLH.

International recruitment

In 2020, 75 candidates were recruited from India and the Philippines to work at UCLH. This was enabled, in part, by our successful bid for more than £100k in financial support to enable the recruitment of these individuals and support for them to undertake their OSCE assessments. In addition, our staff experience team successfully obtained funding from the Friends of UCLH for new international recruits to be issued with a voucher in order to allow them to buy food online during the mandatory two-week self-isolation period following their arrival to the UK.

Equality, diversity and inclusion in recruitment

In the past year, we have taken steps to support equality, diversity and inclusion through recruitment at UCLH including:

- Appointing an equality and diversity lead for recruitment in August 2020
- Piloting the advertisement of roles on specialist sites and use of social media to target under-represented groups at different levels in the trust
- Developing guidance for hiring managers on interviewing candidates with disability status, including clear definitions on reasonable adjustments
- Promoting job sharing as an option from November 2020 in advertisements for staff with disabilities.
- Developing an e-learning module for recruitment and selection, including a module on unconscious bias and disability awareness, which was launched in January 2021 with the aim that each recruitment panel has a member with this training.

In 2021/22, we will focus on the following in relation to equality, diversity and inclusion:

- A positive action talent pool for staff with protected characteristics including shadowing/secondment opportunities, protected slots on management development and leadership programmes and exclusive coaching/mentoring opportunities, with a focus on staff with disabilities
- Priority access for staff with protected characteristics to interview training, mock interviews, application completion support and assessment centre participation practice. This includes staff with disabilities
- Analysis of all appointments at band 7 and above from a protected characteristics point of view. This will be provided on a regular basis to the SDT and Board of Directors, and will be completed in line with the objectives set out in the Model Employer to support increasing black, Asian and ethnic minority representation at senior levels.

Model employer targets

NHSEI targets have been set for all employers as part of implementing the NHS Workforce Race Equality Standard (WRES) leadership strategy.

The annual targets (based on our 2018 data) will contribute to the ambitious challenge of ensuring black, Asian and minority ethnic (BAME) representation at all levels of the

workforce. This includes leadership being representative of the overall BAME workforce by 2028.

We will continuously focus on the recruitment and development of BAME staff into senior roles at UCLH to fulfil these targets and improve representation at the top of our organisation.

Progress will be looked at by the NHSEI WRES team and by national regulators.

North Central London collaboration

In 2021/22, we will migrate some of our recruitment service to a new North Central London collaborative transactional recruitment hub. This will bring a range of benefits to us and other trusts within the sector. We will retain an in-house resourcing function which will handle senior and specialist recruitment and large-scale projects such as international recruitment.

We reviewed all our recruitment processes this year and have implemented a number of changes including:

- conducting identity document checks on the day of interview so that candidates do not have to come back at a later date
- using DBS checks issued in the last three years by another NHS organisation, or supplier to the NHS, rather than applying for a new one.

These changes apply to all staff groups, except consultants.

2.3.6 Staff policies and actions

Health and safety

Our health and safety committee meets quarterly to review information on incidents and injuries and ensures learning is shared across the organisation. Incidents and injuries involving exposure to blood-borne viruses are reviewed by the trust infection control committee which meets quarterly.

We have a health and safety policy with a comprehensive handbook to support staff and managers.

We have undertaken our tenth annual risk assessment audit which included:

- staff, outpatient and visitor slips, trips and falls
- manual handling
- first aid
- security including violence and aggression and lone working
- control of substances hazardous to health
- stress

The audit checked whether risk assessments were up-to-date and where appropriate they have been logged on the risk register. Detailed feedback was provided to each division.

The health and safety committee is focusing on the most significant risks to safe working as a central London trust. Reducing assaults and violence is a priority, supported by our in-house training programme along with ensuring that the workplace is COVID-19 safe for staff

and patients. A comprehensive supported fit testing programme for FFP3 and reusable half masks has been established.

Staff Psychological and Welfare Service

UCLH is fortunate to have an in-house staff psychological and welfare service (SPWS), providing support to staff, based within the workforce directorate. Throughout the pandemic, the SPWS clinical lead has worked closely with colleagues in the mental health sector to respond to trauma of our staff, ensuring that the support we offer is clinically led and evidence-based. SPWS has and continues to be able to offer a range of forms of informal support and psychological/therapeutic evidence-based interventions and the provision of mental health first aid on site. Training within the SPWS team is being developed and implemented to facilitate intervention for the trauma response and increase in complexity of presentations to the service due to the pandemic.

The SPWS clinical lead is working with the NCL hub providers which has enabled a reduction in waiting times for triage and treatment. The hub is also developing webinars for NCL which will complement the UCLH offering. However, hub provision is not confirmed post May 2021 and is unlikely to offer treatment support in the long term.

Prior to the first lockdown, SPWS produced a support guide for staff to help them manage anxiety, address concerns about working from home, how to support and talk to their children as well as a range of other helpful information. This was added to the staff intranet, myUCLH, to the UCLH app and has been made available to staff across NCL. To meet the high demand to support staff on site, the clinical lead resource was fully utilised in supporting the COVID-19 wards and respite centres. This allowed the majority of the clinicians to continue to offer remote access to triage, assessment and therapy services so the service was able to continue its business as usual. Crisis support continued to be offered to managers and staff in need and was increased to manage the larger numbers of bereavement requests and suicidal presentations. There was an increase in demand for team interventions, especially following the first surge, and this, along with mediation, continues to grow as a service pressure. SPWS worked with colleagues to support other wellbeing initiatives including the wellbeing champions initiative. To tackle the increase in acute stress, burnout, moral injury and trauma, proactive support was developed in group format. SPWS is also rolling out mental health first aid training with centralised oversight to ensure training is appropriate and well supervised. SPWS will also support the trust to upskill more of its staff and is working towards a training and supervision programme for practitioners across the trust.

Staff Wellbeing and Recovery

During the first surge, SPWS was supported by the clinical trials research group to undertake a survey launched in April 2020 and regularly refreshed which was used to ascertain staff needs so that appropriate support could be offered.

The survey highlighted a number of concerns:

- Self-rated physical and mental health had worsened since the pandemic
- The proportion of respondents who reported their mental health was poor or fair had worsened significantly since the start of the pandemic
- On average, psychological distress was high regardless of role compared with the general population
- 43 per cent of respondents reported that they had experienced morally distressing situations

- Respondents who had been exposed to morally distressing situations had significantly higher levels of psychological distress and emotional exhaustion
- 49 per cent of respondents reported that they had experienced emotional exhaustion
- 38 per cent of respondents reported feeling burnt out
- 27 per cent of respondents reported feeling burdened emotionally (depersonalisation)
- Over half of respondents criticised themselves for not doing enough, 30 per cent reported not getting help or advice from others and 20 per cent did not engage with emotional support
- 84 per cent of respondents reported they had engaged with at least one resource or service
- 83 per cent of those who utilised a service said that it had been useful
- 58 per cent had used other SPWS resources such as YouTube videos and staff support sessions
- Those struggling were accessing SPWS resources and many of these were new to UCLH, young and female
- Psychological distress positively predicted burnout through engagement in avoidance coping, e.g. self-criticism
- Approach coping was associated with lower levels of burnout.

Raising concerns (whistleblowing)

We encourage staff to raise concerns with senior managers about patient safety, criminal offences, breaches of legal obligations, miscarriages of justice, damage to the environment or the deliberate concealment of information. Our raising concerns policy guides this process. We also provide an external guardian service which offers independent and confidential advice to support staff to raise issues with senior management. There is an annual report which is presented to the audit committee and to the board of directors.

Counter fraud, anti-bribery and corruption

UCLH takes a zero-tolerance approach towards fraud and bribery and will prosecute in this area wherever possible.

Our counter fraud team works to investigate and prevent fraud and bribery, and ensures that adequate procedures are in place.

We have an anti-fraud and bribery policy and our counter fraud team gives advice to staff on how to be on the alert for, and report fraud, bribery and corruption as quickly as possible.

Equality and diversity

See section 2.3.14 Equality reporting (staff).

2.3.7 Staff engagement

We have a strategic objective to improve staff engagement and experience and the NHS People Plan provides a framework for achieving this in a holistic way that is in line with national standards. Engaging with our staff and focusing on their experience and wellbeing has been critical during the COVID-19 pandemic and will continue to be as we recover. Alongside this, we have given strategic prioritisation to our equality, diversity and inclusion agenda for our workforce.
In the coming year, we will deploy a range of measures to boost engagement with our staff, including:

- Launch of the ImproveWell app which will allow us to do pulse checks, wellbeing check-ins and get staff feedback and suggestions
- Live events – to include guest speakers and sharing best practice from UCLH.
- Live staff Q&A sessions
- Staff networks
- Regular line manager sessions with human resources business partners
- Local team meetings and forums
- Refresh and review of the myUCLH workforce pages with a strong health and wellbeing focus
- Annual NHS staff survey.

Staff engagement will continue to be an area of focus at the workforce committee which will monitor our progress throughout the year.

Online support for staff

In the coming year, we will undertake a holistic review and renewal of all the workforce pages on the intranet to create a 'one stop shop' for the needs of all our staff with a strong focus on staff experience, welfare and health and wellbeing. These resources will be fine-tuned responsively as the needs of our staff change, for example providing dedicated COVID-19 resources for BAME staff.

We will seek input and feedback from staff and managers as we undertake the work on myUCLH and, in particular, from representatives from our staff networks. This will help to ensure that we are meeting the diverse needs of our workforce and making everything fully accessible from a disability and inclusion perspective.

In an environment where remote working is increasing and those on the frontline have limited opportunity to engage with the workforce function during office hours, it is essential that we provide online resources and service-signposting of the highest quality. This is especially important for our managers who now have to fulfil their responsibilities and manage teams in new ways and who will benefit from improved resources with a stronger self-service approach.

Staff communication

UCLH-wide communications include:

- Team brief: the chief executive's monthly briefing delivered by managers to their team members who are encouraged to discuss the content. It ensures that all staff get the same messages within the same time frame

- UCLH Magazine: our award-winning, quarterly magazine available for staff, patients and foundation trust members

- myUCLH: The intranet is updated daily with articles about our staff and services. There is also a mechanism for staff to comment and engage in online conversation and write blogs. The new intranet can be accessed from mobile devices, meaning easier access for staff. To support staff during the COVID-19 pandemic, we have provided dedicated resources relating to this and frequently asked questions which are updated responsively as guidance has changed and the needs of our staff have evolved

- Daily email: sent to all staff every day and includes the latest trust news

- Regular briefings for staff on COVID-19 and on recovery

- Regular MS Teams live events with the CEO, senior directors and other senior colleagues, such as our virology consultants, to support staff through the COVID-19 pandemic

- Meet the CEO sessions: these are open to all staff and held on each hospital site. The chief executive delivers a presentation followed by a question and answer session

- Team meetings: where staff are kept informed and can discuss matters at a local level

- Dedicated MS Teams live events such as a regular BAME COVID-19 question and answer session supported by the staff networks and subject matter experts from staff experience, occupational health and wellbeing, infection control and virology.

- Social media: Twitter, Facebook, Instagram, LinkedIn and YouTube

- Staff surveys

- Staff suggestion scheme.

NHS People Plan

We have begun work this year to deliver the NHS People Plan. This is a national and all-encompassing framework which requires employers to make positive changes that will improve the health and wellbeing of the workforce and support recruitment, retention and workforce growth.

There are three areas of the plan, in particular, which we have identified as our priority and where we have focused our efforts and will continue to do so in 2021/22. They are:

- Equality, diversity and inclusion
- Bullying and harassment
- Violence and aggression.

Equality, diversity and inclusion will be an under-pinning theme in all we do this year to support our workforce. We held the first of our planned regular live workforce engagement events in November 2020 which focused on our equality data, what we need to improve and gave our staff an opportunity to tell us what else we need to work on from a diversity and inclusion perspective. Feedback gained during this event and those we hold in the future will be used to shape our ongoing work.

We have relaunched our violence and aggression steering group and will be launching a new civility and respect group to tackle bullying and harassment. These groups have wide membership from subject experts and stakeholders across UCLH. Actions plans have been developed to drive improvement in these areas and are being monitored at the workforce committee which has received regular updates about staff experience. New resources will be provided for staff and managers to help drive local improvement, such as the civility and respect toolkit, and these will be piloted in 2021.

We are reviewing the role of the staff pledges launched in 2019 in relation to the delivery of our response to the NHS People Plan.

Staff health and wellbeing

Our occupational health and staff psychological and welfare service teams deliver a number of programmes for staff aimed at promoting healthy lifestyles and good physical and mental health.

Occupational health provides a confidential, multidisciplinary service advising on the impact of health on work, and work on health. The team works closely with individuals, teams and managers to ensure our staff are supported. Occupational health has also been working with the newly-formed disability network to break down barriers in access to work and to promote inclusivity.

In response to the COVID-19 pandemic, risk assessments were offered to all our staff with occupational health providing a series of live events to support staff and managers on how to complete these assessments. UCLH completed 100 per cent risk assessments for those staff who needed a risk assessment by the end of July 2020. A process has been introduced to ensure that all new staff joining the trust are offered a risk assessment as part of the on-boarding process and that staff who were shielding are offered a further risk assessment when returning to the workplace.

Our flu campaign this year resulted in 72 per cent of patient-facing staff being vaccinated against the virus – the largest ever number at UCLH. We will continue to refine our campaign each year to increase vaccine uptake.

Our COVID-19 vaccination programme for staff started in late December 2020. Vaccination was offered to all staff. As at 31st March 2021, 81.9 per cent of frontline staff had received at least one vaccination.

We run a number of initiatives to encourage staff to keep active, including the annual pedometer challenge and posters advocating the use of stairs rather than lifts. Our award-winning 4WeekForward health and fitness programme, which supports staff with musculoskeletal or mental health issues to get active, is still proving popular. We also run health-themed weeks to engage staff in choosing healthier lifestyles and self-care techniques.

Improving psychological wellbeing and removing the stigma surrounding mental health issues in the workplace remains a top priority for the staff psychological and welfare service team. It continues to provide bespoke workshops to equip managers with the skills to manage staff wellbeing, and it has launched a programme of wellbeing seminars and self-care days for all staff. The service has also launched an e-learning module for staff on suicide awareness.

A key priority for the team this year has been to support staff who have been the victims of violence or aggression at work. The team is also undertaking research into innovative ways to support staff who have suffered trauma.

The service works with all our staff networks and supports the delivery of the trust's mental health strategy.

Nutrition, hydration, rest and respite

In responding to the COVID-19 pandemic, we have made significant efforts to ensure our staff have had access to food, drinks and additional external spaces to rest while at work. These efforts were led by our staff experience team with support from the UCLH Charity and an overwhelming response from external donors made much of this possible.

In 2021, the staff experience team, in partnership with key stakeholders and supported by the UCLH Charity, is undertaking a significant programme of work to ensure that rest and respite remains a priority, including:

- Ensuring we have a consistent approach to staff rest and respite areas through common standards of staff rest areas/break spaces. A trust wide engagement exercise has been undertaken to review staff kitchens/rest areas/break spaces with a view to sprucing them up. A wish list, which was developed using information from many teams across the trust, has now been submitted to UCLH Charity who are supporting these requests. Items on the wish list included kettles, microwaves, coffee machines, tables, chairs, and pictures for walls, all of which staff felt would improve the quality of their break and rest areas.

- Ensuring that staff rest areas are a priority and a common agenda item in senior and other meetings, that staff are regularly engaged in these matters and that staff rest and respite space will be continuously reviewed. In preparation for the second lockdown, three respite areas for staff were found off site – The Cavendish in Westmoreland Street; The Kimpton Fitzroy in Russell Square (for NHNN) and the Grafton Hotel for UCH and other surrounding sites. We are learning and evaluating the impact as we go. Staff are utilising these spaces.

- Empowering staff to improve rest areas through charitable support and trust investment in space and quality of space.

Remote working

A significant number of staff began working remotely throughout this year and we anticipate that many will continue to do so in 2021. They will be supported and enabled to so by the new remote working policy launched in 2020. In 2021, we will continue to give focus to support staff to work remotely, as follows:

- Remote working group to continue to oversee a trust wide approach to enabling people to work from home
- Remote working risk assessments to be undertaken for staff continuing to work at home, in line with the recently launched remote working policy
- Staff and managers to be supported to request funding for equipment and technology needed to enable people to work from home safely and effectively on a case by case basis. Any problems will be escalated to the remote working group for support
- Occupational Health to support the provision of remotely-accessible psychological support, DSE (display screen equipment) advice, physiotherapy and manual handling input and physical activities to promote wellbeing.

Staff friends and family test

The staff friends and family test was suspended this year because of the COVID-19 pandemic.

Staff partnership

Our partnerships with unions and representative bodies are important to us. Our joint partnership forum (JPF), comprising management and staff representatives, meets every two months to review policies and discuss staff experience. There are also regular meetings

of the Local Negotiating Committee for medical and dental staff, comprising management and staff representatives.

Staff recognition

Our annual celebrating excellence awards ceremony was held virtually in November 2020. This was a hugely successful event which allowed all staff across UCLH to take part in the celebration of many well-deserving colleagues who were recognised by our chair, chief executive and senior directors for their outstanding contributions to UCLH in 2019/2020. The event also included a special recognition award for the efforts of all staff from across UCLH who delivered the new Royal National ENT and Eastman Dental Hospitals. We were fortunate also to receive two recorded video messages from broadcast journalists Jon Snow and Fergus Walsh who took time to thank our staff for their phenomenal efforts. These videos were played during the online ceremony.

In addition, we took time during the ceremony to remember and recognise the colleagues we have sadly lost in the past year. We did this with a special video after receiving the kind permission from their families to do so. The next of kin of the colleagues we have sadly lost received a personal message and a copy of the video from our chair after the ceremony.

Our celebrating excellence programme in 2021 will be launched in the spring and will include recognition for the efforts of our staff during the COVID-19 pandemic. We expect that there will be a virtual component to our awards ceremony again in the coming year because of likely social distancing limitations.

To thank staff for their efforts in 2020/21, the chair and chief executive gave all staff a £25 voucher in December 2020 which was funded by the UCLH Charity. This was very well received by staff who could choose to use the voucher in one of a number of online or high street shops or donate it to charity.

We have been able, with the support of the UCLH Charity, to distribute thank you boxes and other tokens to our staff across UCLH throughout the year in recognition of their incredible hard work.

Education and training

See section 1.1.4 Education and training.

2.3.8 NHS staff survey: results and actions

Results

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators, however this changed to 11 in 2019/2020 and then back to 10 in 2020/2021. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. There has been wide engagement with staff and managers on the results and the actions to be prioritised.

The response rate to the 2020/21 survey among trust staff was 43 per cent (2019/20: 45 per cent). Scores for each indicator, together with that of the survey benchmarking group (Acute Trusts & Acute Community Trusts) are presented below:

	2020/2021		2019/2020	
Theme	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	8.5	9.1	8.4	9.0
Health and wellbeing	6.2	6.1	5.7	5.9
Immediate managers	6.9	6.8	6.8	6.8
Morale	6.2	6.2	6.0	6.1
Quality of appraisals *	N/A	N/A	6.3	5.6
Quality of care	7.7	7.5	7.6	7.5
Safe environment – bullying and harassment	7.7	8.1	7.5	7.9
Safe environment – violence	9.4	9.5	9.4	9.4
Safety culture	7.0	6.8	6.8	6.7
Staff engagement	7.4	7.0	7.2	7.0
Team working	6.7	6.5	6.6	6.6

***Removed in 2020**

Overall UCLH remains above the national average for staff engagement, a measure closely linked to patient experience. In particular:

- 88 per cent of staff said they would be happy for a friend or relative to be treated here (82 per cent in 2019/20). The national average was 71 per cent
- 79 per cent of staff would recommend UCLH as a place to work (72 per cent in 2019/20). The national average was 63 per cent
- 89 per cent of staff agreed that the care of patients is UCLH's top priority (84 per cent in 2019/20). The national average was 77 per cent.

The survey response rate was as follows:

	2020		**2019**		**UCLH percentage change**
	UCLH	**National average**	**UCLH**	**National average**	
Response rate	43 per cent	47 per cent	46 per cent	49 per cent	-3 per cent

A total of 4,104 staff (43 per cent) completed the 2020 survey, compared with 4,162 staff (46 per cent) in 2019.

Results in nine of the ten themes improved in 2020, compared to 2019, with one result unchanged from 2019. When benchmarked against other acute trusts, UCLH scored above the national average for quality of care, safety culture, staff engagement and quality of appraisals.

This year, given the pandemic, UCLH will particularly focus on four staff-related areas, each of which has work programmes and work plans:

- Equality, diversity and inclusion (EDI): UCLH has its WRES and WDES work streams that include UCLH's plans about promotion, recruitment, employee relations and staff development.

- Staff recovery and wellbeing: Throughout 2020/21 we have held a number of staff wellbeing interventions. In addition, we are investing in our staff psychological and occupational health services and we will have a new staff recovery and wellbeing programme commencing in the summer of 2021.

- Violence and aggression towards staff from patients and the public: The preventing and managing violence and aggression working group continues to meet and has a new work programme which is based on the new national violence reduction standards. Work includes supporting staff to report incidents, an updated annual assessment of risk associated with violence and aggression, a data dashboard to raise awareness of incidents across UCLH and extended training to include support for staff working remotely/from home.

- Bullying and harassment: a new civility and respect working group started meeting in April 2021 with 70 members of UCLH staff from a range of roles and teams. The group has a work programme which includes ensuring that staff are aware of support and where to report incidents. Active bystander training has been piloted and will be rolled out across UCLH in 2021/22, along with a guide and toolkit on civility and respect at work.

We will monitor the impact of these actions throughout the year. This will be done through a variety of methods, including staff "pulse point checks", as well as reporting to various committees to ensure there is clear oversight and governance of these work areas.

2.3.9 Trade unions

The following four tables are published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017.

Table 1: Number of relevant trade union officials

	2020/21	2019/20
Total number of employees who were relevant trade union officials	28	35
Total WTE employees who were relevant trade union officials	27.8	34.0

Table 2: Percentage of time spent on facility time

Percentage of working hours spent on facility time	Number of employees 2020/21	Number of employees 2019/20
0 per cent	0	0
1- 50 per cent	26	33
51 per cent - 99 per cent	1	1
100 per cent	1	1

Table 3: Percentage of total pay bill spent on facility time

	2020/21	2019/20
Total cost of facility time	£131,249	£140,916
Total pay bill*	£543,115,000	£525,408,000
Percentage of total pay bill spent on facility time	0.02 per cent	0.03 per cent

* Excluding bank and agency costs

Table 4: Percentage of time spent on trade union activities

	2020/21	2019/20
Total hours spent on paid trade union activities by relevant trade union officials	3,209	3,726
Total paid facility time hours	3,209	3,726
Percentage of total paid facility time spent on trade union activities	100 per cent	100 per cent

2.3.10 Expenditure on consultancy

In 2020/21 expenditure on consultancy was £4.8 m, compared to £4.0m in 2019/20.

2.3.11 Off-payroll engagements

UCLH has a policy for off-payroll engagement which reflects guidance from HM Revenue and Customs (HMRC) and is compliant with the latest guidance from the Tax Centre for Excellence.

UCLH's policy does not allow off-payroll arrangements with personal service companies (PSCs) or with our bank staff provider.

The policy requires managers to notify the workforce department when an off-payroll engagement is being considered so the team can do the required assessments for employment and IR35 status. When the assessment shows that the engagement would be within IR35, direct off-payroll engagement is rejected. Alternative methods of engagement are arranged, either through fixed-term employment contracts, or through our bank employment provider with associated full deduction of tax and national insurance (NI).

Further measures are taken within our procurement department where all direct engagement purchase orders are referred to the workforce team for assessment.

There were no off-payroll engagements as of 31 March 2020 for more than £245 per day that lasted longer than six months.

There were no off-payroll engagements for more than £245 per day which started in 2019/20 and lasted longer than six months.

There were no off-payroll engagements for more than £245 per day which started in 2018/19 and reached six months in duration in 2019/20.

The following table details 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*	9

* We have applied this definition to voting and non-voting executive directors of the board.

2.3.12 Exit packages

In 2020/21 UCLH agreed the following 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	2	2
£10,000 – £25,000	0	0	0
£25,001 – £50,000	0	1	1
£50,001 – £100,000	0	1	1
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,001	0	0	0
Total by type	**0**	**4**	**4**
Total resource cost	**0**	**£103,000**	**£103,000**

In 2019/20 UCLH agreed the following 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	10	10
£10,000 – £25,000	0	2	2
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	1	1
Total by type	**0**	**13**	**13**
Total resource cost	**£0**	**£134,000**	**£134,000**

Exit packages: Non-compulsory departure payments

This note discloses the number of non-compulsory departures which attracted an exit package in the year, and the values of the associated payment by individual type. The note is prepared on the same basis as the exit packages note, i.e. showing the exit packages agreed in the year, irrespective of the actual date of accrual or payment.

In 2020/21 UCLH agreed the following non-compulsory departure payments:

Exit Package	Agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	1	63
Mutually agreed resignations (MARS) contractual costs	1	37
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	3
Exit payments following Employment Tribunal or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**4**	**103**

In 2019/20 UCLH agreed the following non-compulsory departure payments:

Exit Package	Agreements Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	2	65
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	11	67
Exit payments following Employment Tribunal or court orders	1	2
Non-contractual payments requiring HMT approval	0	0
Total*	**14**	**134**

*a single exit package agreement can be made up of multiple components, each of which are counted separately in this note. The difference between the staff exit packages total and departure payments total is due to one individual receiving two components (MARS and PILON) as part of their package.

2.3.13 Equality reporting (staff)

We are committed to the principles of equality and fairness for our staff and recognise that we need to do more. We have now committed to equality, diversity and inclusion as the underpinning theme in all we do this year to support our workforce, within focus areas:

1. Communications:

- Workforce director and team to lead ‘open’ themed sessions for staff throughout the year with regular temperature checks with our staff

- Review of myUCLH (intranet) to make it user-friendly and relevant to staff and their priorities.

2. Staff Development:

- Diversity and inclusivity will be embedded as a “golden thread” in our new leadership and management development framework.

3. Governance:

- Regular equality and diversity data on workforce that is accessible to all staff, that is easy to understand and that highlights what we do well and where we need to focus is our key theme for this year
- Formally build the role of networks as part of the governance structure in reviewing all policies and procedures at UCLH.

4. Recruitment and Retention:

- Positive action talent pool for staff with protected characteristics including shadowing/ secondment opportunities, protected slots on management development and leadership programmes and exclusive coaching/mentoring opportunities, including staff with disabilities. Priority access to staff with protected characteristics to interview training, mock interviews, application completion support and assessment centre participation practice, including staff with disabilities
- Analysis of all appointments band 7 and above from a protected characteristics point of view will be provided on a quarterly basis to the SDT and Trust Board. This review will be completed in line with the objectives set out in the Model Employer to support increasing black, Asian and ethnic minority representation at senior levels.

5. Staff with Disabilities:

- The flexible working steering group is re-writing the flexible working policy to ensure it is fit for purpose given the context of COVID-19 and to emphasise how flexible working can be used to support our staff with disabilities
- UCLH is reviewing its disability policy to strengthen the guidance to managers on the support that UCLH provides its staff with disabilities. This policy will cover an individual from the start of recruitment throughout their employment at the trust.

Our focused team continues to support and promote the work of our five staff networks: BAME, disability, LGBT+, mental health, and women in leadership. The aim of these networks is to give staff who have traditionally been under-represented at senior levels a collective voice. These networks are part of our strategy to deliver our equalities objectives and reduce inequalities among staff.

The characteristics of our workforce are broadly consistent with our local communities in terms of religion and ethnicity. We have more female employees and staff with BAME backgrounds compared with the local population.

Information about the importance of equality, diversity and inclusion is included in staff induction and we regularly audit data on new starters.

The ‘Starting at UCLH’ policy sets out how we give full and fair consideration to job applications made by disabled people. UCLH is a disability confident employer and guarantees that disabled candidates who meet the minimum criteria for a position will be interviewed. We regularly analyse the data relating to applications, shortlisting and

appointments as a way of monitoring whether our recruitment processes are fair and equitable.

Some 49 per cent of our staff are from a BAME background, yet this representation is not spread equally across all professions or grades. BAME staff make up 56 per cent of clinical and non-clinical staff in Agenda for Change (AfC) posts at band 7 and below. In contrast, only 24 per cent of staff in AfC posts at band 8a and above come from a BAME background. For medical and dental staff, 44 per cent of doctors-in-training have a BAME background, whereas 32 per cent of consultants have a BAME background.

Review of the 2019/20 Gender Pay Gap Report (based on the 2018/19 financial year position) confirms that the gender split at UCLH in 2019 indicates that the proportion of female employees has risen very slightly since the previous year, from 71.3 per cent to 71.8 per cent, and that female representation at the top of the organisation has slightly improved year-on-year. Female representation has increased in the bottom two quartiles of the organisation and reduced in the top two quartiles. Overall, there has been a slight improvement in the gender pay gap for AfC staff (from 16.0 per cent to 15.2 per cent) but there is still a lot of work to do, especially in the medical and dental workforce.

We continue to focus on taking action to reduce the gender pay gap at UCLH by improving representation in under-represented groups for our consultant clinical excellence award applicants with dedicated training, mentoring and support. Due to the pandemic, the national awards round in 2020 was cancelled and the allocation for the local awards round was distributed equally between all eligible consultants. In order to improve the gender pay gap we give part-time consultants the full allocation rather than a pro rata allocation

These initiatives have been well received by staff.

The diversity and equality steering group (DESG) meets every two months to monitor the actions that UCLH is taking to improve equality and diversity. The SDT and the Board of Directors review monthly reports of key diversity and equality indicators in order to identify and address emerging trends. Key indicators which are reviewed include the ratio of white candidates being appointed to posts compared with BAME candidates, and the ratio of white candidates undergoing a disciplinary process compared with BAME staff. We publish the WRES annually, as required by NHSEI, and this is included in our annual equality report. Based on our 2020 Workforce Race Equality Standard and Workforce Disability Equality Standard reports, we have formed a priority action plan that supports the five focus areas highlighted above. Delivery of this action plan is monitored by the DESG and Workforce Committee, which reports directly into the Trust Board.

We are committed to the principles of equality and fairness for our patients and work with different communities to deliver better patient care that is inclusive, accessible and fair. See section 2.1.9 Equality reporting (patients).

2.4 Code of governance disclosures

UCLH 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.

Throughout our annual report we describe how we meet the code. A summary of where details can be found on the issues we are required to disclose is given in the following table.

Code reference	Section
A.1.1.	2.1.1 UCLH board and committees 2.1.2 Governors and members
A.1.2	2.1.1 UCLH board and committees 2.1.2 Governors and members
A.5.3	2.1.2 Governors and members
Additional requirement	2.1.2 Governors and members
B.1.1	2.1.1 UCLH board and committees
B.1.4	2.1.1 UCLH board and committees
Additional requirement	2.1.1 UCLH board and committees 2.1.2 Governors and members
B.2.10	2.1.2 Governors and members
Additional requirement	2.1.2 Governors and members We used an external search consultancy and open competition for the appointment of one non-executive director.
B.3.1	2.1.1 UCLH board and committees
B.5.6	2.1.2 Governors and members
Additional requirement	Not applicable
B.6.1	2.1.1 UCLH board and committees 2.1.2 Governors and members
B.6.2	Not applicable
C.1.1	2.6 Statement of accounting officer's responsibilities 2.7 Annual governance statement
C.2.1	2.7 Annual governance statement
C.2.2	2.1.1 UCLH board and committees
C.3.5	Not applicable, the council of governors accepted the audit committee's

Code reference	Section
	recommendation
C.3.9	2.1.1 UCLH board and committees
D.1.3	Not applicable
E.1.4	2.1.1 UCLH board and committees 2.1.2 Governors and members
E.1.5	2.1.2 Governors and members
E.1.6	2.1.2 Governors and members
Additional requirement	2.1.2 Governors and members
Additional requirement	2.1.1 UCLH board and committees 2.1.2 Governors and members
B.1.2	The board considers all its non-executive directors to be independent in character and judgement. They are also all independent of management, with the exception of Professor David Lomas, vice provost of UCL (health), who holds an honorary contract with UCLH.
B.6.3	The chair's annual evaluation is undertaken jointly by a governor (chair of the nomination, appointments and remuneration committee) and the senior independent director (a non-executive director).
D.2.3	We are following NHS England and NHS Improvement guidance on the remuneration of chairs and non-executive directors, issued in September 2019

2.5 NHS oversight framework

NHS England and Improvement's oversight framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach, or suspected breach, of its licence. We are currently in segment 2.

2.6 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of University College London 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 University College London 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 University College London Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance

- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Tim Jaggard
Acting chief executive

14 June 2021

2.7 Annual governance statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of UCLH, 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 UCLH NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

In addition to the internal governance and control framework, fulfilling the wider objectives of UCLH requires effective partnership working across the wider health community within North Central London's sustainability and transformation partnership. The North London Programme Delivery Board oversees delivery of the plan. There is an executive steering group made up of a cross section of representatives from across North London. This group is specifically responsible for providing accountability for the implementation of the work stream plans.

Capacity to handle risk

UCLH is committed to a comprehensive, integrated trust wide approach to the management of risk. Support and leadership is provided by the risk coordination board (RCB), senior directors team (SDT), and the audit committee (AC) which report to the board. Risk management is part of the remit of the clinical boards and of other committees such as the quality and safety committee (QSC), the finance and investment committee (FIC), the workforce committee, and the research and innovation committee (RIC). The Trust is committed to an open and transparent risk management culture. This is embedded in the approach UCLH takes to the reporting of incidents and risks.

Throughout 2020/21, the Trust Board has had regular oversight of the trust wide Board Assurance Framework (BAF), which identifies the strategic risks associated with the trust high level objectives. Each BAF risk has a single senior director 'owner' to ensure accountability.

Board members receive training in risk management awareness. The risk manager also provides one-to-one and group training, as required. Guidance on risk management is available on the UCLH intranet. Good practice is shared through the RCB.

The risk and control framework

Fundamental to the success of the risk management process is the ability of all stakeholders to identify, evaluate and control risk. The risk management policy and procedure is available to all staff on the UCLH intranet. Risk reports, including the top risks, are reviewed monthly by the RCB and SDT with quarterly oversight from the AC.

Quality governance

UCLH's quality governance structure and arrangements enable UCLH to maintain and continually improve quality from 'ward to board'. There are clearly defined corporate and local indicators for data quality. This structure delivers the well-led CQC framework and provides clear assurance from wards upwards, and from the Board to the clinical areas.

Quality governance has a number of elements. These include the QSC which reports to the Board. The QSC is responsible for ensuring that effective arrangements are in place for the oversight and monitoring of all aspects of clinical quality and safety, including identifying potential risks to the quality of clinical care. The Board relies on the committee to provide advice on clinical quality, patient safety and risk, and for assurance on areas of clinical governance and audit. It focusses on promoting a culture of openness and organisational learning. On behalf of the Board, the QSC reviews compliance and receives assurance in meeting regulatory standards set by the CQC.

Performance is also monitored via the SDT and the elective access board (EAB). In addition to being subject to internal audit, data quality is also subject to commissioner scrutiny.

A key component of quality governance is information governance. It covers information relating to patients and staff, as well as corporate information, and helps ensure the information is handled appropriately and securely. In 2020/21 UCLH's Records and Information Governance Group (RIGG), chaired by the Caldicott Guardian or the Senior Information Risk Owner, started reporting directly to the digital healthcare board (DHCB) on a quarterly cycle, with an opportunity to raise urgent matters every month. The DHCB is chaired by the medical director for digital healthcare and reports to the Trust Board.

One national measure of data management is the Data Security and Protection toolkit, which assesses compliance with the National Data Guardian's ten data security standards. All organisations that have access to NHS patient data and systems must self-assess using this toolkit which sets out specific criteria based on submitted evidence and assertions. There are three possible outcomes—standards met, standards not fully met (plan agreed), and standards not met. For more information about the DSP toolkit please visit http://www.dsptoolkit.nhs.uk . UCLH's submission for 2020/21 is not due until 30 June 2021. The 2019/2020 submission was submitted as required on 30 September 2020, with an outcome of standards not fully met (plan agreed).

The AC continues to monitor progress against the toolkit criteria via regular reporting of progress and an annual assessment by internal audit.

Major risks

As at March 2021, the principal risks affecting the attainment of the Trust's corporate objectives (including significant clinical risks, risks to foundation trust licence condition four, in-year and future risks, how the risk will be managed and mitigated, and how outcomes will be assessed) are as detailed below:

COVID-19:

As with all healthcare providers in the UK, the COVID-19 pandemic has fundamentally altered the day-to-day operations of UCLH during the response period. Throughout 2020/21 we prioritised emergency and urgent care on our main site. We are working within nationally-approved clinical guidelines to ensure patients requiring priority cancer treatments or time-sensitive urgent treatments receive these through designated hubs created on sites that are not directly treating patients with COVID-19 or have defined separate pathways for this care. This limited scope of activity during the response period will prolong waiting times for patients already referred on routine pathways. As the restrictions on routine services are lifted, newly referred cases could also experience delays for treatments due to lack of sufficient capacity to treat this enhanced level of demand within usual timescales. There is also risk to clinical outcomes as we may not quickly identify routine cases which should be upgraded to urgent pathways, as well as to patients who defer their attendances and then have to be rebooked.

Data Quality:

The implementation of the Electronic Health Record System (EHRS) in March 2019 impacted upon patient administrative processes, and data quality. There are mitigating and control factors in place which are overseen by the DHCB and improvements have been made to both system configuration and correct use of the system and the position has improved.

Emergency department flow:

UCLH aims to provide emergency department care within the four hour target. The risk of insufficient bed capacity and operational resilience across the emergency pathway (at UCLH and the wider community) continued throughout most of the financial year, until emergency activity dropped significantly due to the COVID-19 outbreak. We have continued to invest in the improvement of service provision within UCLH and continue to work with partners across our healthcare sector to improve access for those most in need of emergency care.

Foundation trust governance

The Trust continually considers performance against the well-led framework considering the effectiveness of leadership and governance. The Board of Directors sets the vision, values and strategic direction of UCLH and is collectively responsible for the performance of the Trust. The Board agrees its strategy and objectives annually, as set out in section 1.1.6 of the annual report. The Council of Governors receives regular updates on clinical and financial performance and reports relating to service delivery. Governors input into the annual forward plan. Governors also meet separately with the non-executive directors four times during the year. This enables the governors to discharge their duties.

The AC oversees and monitors governance including the effectiveness of the risk management system. Internal audit (KPMG) and external audit (Deloitte) work closely with this committee and undertake reviews and provide assurances on the systems of control operating within UCLH.

The FIC, QSC, RIC, Workforce and Remuneration committees, each chaired by a non-executive director, provide oversight of UCLH's performance in these areas. Reports providing the assurance are submitted to the Board.

The SDT meets regularly to review the performance of its clinical and corporate boards against financial, workforce and clinical indicators. This information forms part of a performance information pack which is reviewed by the Board monthly.

UCLH has a clinical leadership model delivered through medical directors and its chief nurse. Three of the medical directors manage the operational service through three clinical boards and 18 divisions supported by corporate functions, such as finance and workforce. One medical director is responsible for digital healthcare.

UCLH has a well-established performance management framework that ensures that key indicators across a range of the business are scrutinised on a monthly basis, with key exceptions analysed further at clinical team, clinical board and UCLH board level as appropriate.

The board receives the board performance pack at its meetings. The QSC also receives a monthly performance report focused on quality issues.

Performance metrics are reviewed on an annual basis to ensure that all national and local priority indicators are included.

The Board can self-certify the validity of its Corporate Governance Statement, as required under NHS Foundation Trust condition 4(8)(b).

The process for reviewing the effectiveness of the system of internal control has been reviewed by:

- The Board, which has considered the risk report and the management of risks to the delivery of the objectives set out in the BAF
- The AC, which has reviewed governance and risk management policies and monitored the implementation of these
- The QSC, which has reviewed compliance against the CQC standards, reviewed clinical audit and clinical governance arrangements
- A number of compliance self-assessments, including from the chief financial officer. This provides assurance on financial performance and the opinions and reports of both internal and external audit.

Stakeholder involvement in risk management

UCLH actively works with key partner organisations across the local health economy. Wherever possible, and where appropriate, it works closely with the partner organisations to identify and mitigate risks that might impact upon them. These include, but are not limited to:

- UCL Partners
- The North Central London Cancer Alliance
- Our joint venture partners; and
- Our partners within NCL.

UCLH also has well established arrangements in place for engaging with a diverse public, patient and stakeholder community in a number of ways. However face to face activity has had to be held in abeyance due to the national emergency. Examples are as follows:

- Council of Governors: governor representatives on the QSC, the Workforce Committee and the RIC

- Governors: participation in walk rounds and Patient-Led Assessment of the Care Environment (PLACE) inspections, clinical excellence award panels (although these activities have not taken place in 2020/21 due to the national COVID-19 emergency)
- Public and patients: Annual Members' Meeting; Members' Meets; annual research open event; patient focus groups; residents meetings about our capital developments; patient surveys
    - Members: participation in PLACE inspections (although these have not been held during the COVID-19 pandemic) and on the CQRG
    - Overview and scrutiny committees
    - Healthwatch
- National and local patient surveys; exhibitions and mail outs; Patient Advisory Liaison Service (PALS) and UCLH Magazine
- Staff: annual staff survey, Meet the CEO sessions, joint staff forum, executive and non-executive walk-arounds
- Health Partners: integrated care board; GP practice relationship visits and GP newsletter; GP engagement events and seminars, joint strategic and service planning meetings

Risks identified through these channels are filtered into the overall trust risk management structure

Other control measures

An integrated workforce and financial planning process is led through our clinical boards and corporate directorates, supported by their embedded workforce and finance leads. This process ensures that workforce plans are strategically aligned, affordable and in accordance with the plans of our partners in health and social care and Health Education England (HEE) requirements, with whom we work in close partnership. In developing their plans, we ask divisions to consider clinical productivity (e.g. reviewing long term bank and agency usage, improved job planning, etc.), workforce redesign, workforce benefits realisation and operational delivery (including seasonal fluctuation and recruitment lead-in times).

Systematic reviews and checks have been built into the workforce planning process. These include Board-level workforce plans being reviewed by finance and workforce specialists and triangulated with activity plans; a central consistency review being held against the overall trust service strategy; review of the plan against previous year projection and plan is also undertaken; and board-specific local QIA processes to measure the patient care and service quality impact of any CIP with a workforce impact.

A gap analysis against the NHS Improvement workforce safeguards has been completed. The Trust is fully compliant with this in nursing and midwifery. Delivery of the workforce plan, including performance against agency limits and review of projects that will enable the Trust to more effectively deploy its workforce, are regularly reviewed by the SDT. Workforce indicators are also reviewed as part of the commissioning quality review group (CQRG) meeting and as part of the monthly CEO performance pack provided to the Board (e.g. vacancy and turnover rates; temporary staffing utilisation; sickness; appraisal; mandated training and compliance). The workforce committee is the Trust's responsible governance committee for the workforce strategy and is responsible to the Board for:

- assuring that appropriate arrangements are in place to achieve the Trust's strategic priorities for our workforce;
- devoting focused attention in areas where those priorities encourage improvement;
- forecasting future strategic priorities for our workforce, including those shared with our partners; and

- providing the Board with assurance that operational metrics are being reviewed and monitored.

The workforce committee monitors starters' and leavers' data closely to assess any emerging trends. We continue to monitor all risks relating to Brexit through our governance and risk frameworks, as well a working closely with NHSEI and our suppliers.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality Impact Assessments are carried out for all new service developments and when reviewing policies.

UCLH has undertaken risk assessments and has a sustainable development management plan (the green plan) in place which takes account of UK Climate Projections 2018 (UKCP18). UCLH ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The green plan considers global, national and local plans and UCLH will seek to collaborate with other organisations to achieve common goals.

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

During 2020/21 the Trust has continued to use various benchmarking sources to identify cost or productivity opportunities. Where the Trust Board identifies key risks and issues in relation to the Trust's use of resources, it will instruct the FIC to undertake 'deep dive' reviews of such concerns to ensure that a sufficient degree of assurance can be obtained.

The oversight roles of the Trust Board and the FIC 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 SDT provides opportunities through the clinical boards for divisional financial and operational performance to be scrutinised and monthly reviews with the chief financial officer and each clinical board medical director allow for a regular oversight of the performance across divisions.

Information governance

Information governance policy and guidance is continually reviewed and training and awareness raising programmes target all staff. Information governance training uses a national tool with an assessment incorporated. We have supplemented training by specific "phishing" drills through the year to raise awareness of cybersecurity risk.

Strengthened technical controls implemented as part of the DSP Toolkit actions reduce the risk of specific types of data loss. Any breach that is likely to result in a high risk to individuals' rights and freedoms must be reported via the DSP incident reporting tool. Similarly, under the Security of Network and Information Systems Regulations 2018 any network and information systems incident which has a 'significant impact' on the continuity of

our essential service should be reported via the DSP incident reporting tool. For 2020/21 UCLH reported 4 incidents via the tool.

Each of these incidents has been reported to the Information Commissioner's Office (ICO):

- A mailing was sent to patients later deemed to be marketing. ICO outcome: no further action necessary.
- PC and laptops thefts from the hospital. Whilst no data can be stored to the PC, cached email and internet data may be accessible. ICO outcome: no further action necessary.
- Patient feedback sought via email using the 'to' rather than 'bcc' email distribution. ICO: no further action necessary.
- A camera went missing including diaries of patient appointments. ICO outcome pending at the time of writing.

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

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

Data quality and governance

There are a number of assurances and controls in place to assure the Board that appropriate controls are in place to ensure the accuracy of data. This includes, but is not limited to:

- Clearly defined corporate indicators for data quality
- Data quality indicators and report monitored, validated and provided to clinical divisions
- Audits of waiting list management processes in divisions
- Guidance on data quality in the data capture policy and access policy
- Monitoring of performance at SDT meetings, EAB and QSC
- Monitoring and management of performance within the clinical boards through clinical board meetings, divisional performance reviews and RTT patient target list / improvement meetings.
- Reporting to and scrutiny of clinical and quality data by the Board and its sub-committees, including an annual review of controls and assurances for the chief executive performance report metrics
- Scrutiny of data quality by commissioners, and
- External assurance statements on the quality report, provided by key stakeholders.

The Board has regularly reviewed the Trust's performance on referral to treatment (RTT), diagnostics, emergency department and cancer access standards. It has also discussed the findings of internal and external audit reports and the plans in response to them.

The AC reviews, on behalf of the Board, data quality issues to give the Board assurance that performance can be understood and managed. It also recognises the need for data and its sources to be constantly reviewed and the ongoing improvements that are needed, for example those set out above.

The EAB reports to the SDT on a monthly basis and oversees improvements to elective waiting time, data quality for RTT, diagnostics and cancer.

Risks specifically related to Electronic Health Record data quality are managed through the board assurance framework and risk management framework. The monthly Digital Healthcare Board receives regular reports on data and analytics. Digital Healthcare sub-committees work on specific aspects of data quality

We continue to raise awareness about the need for accurate record keeping and validation.

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 AC and the QSC and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The clinical audit programme also supports my review of the effectiveness of the system of internal control. A review of each clinical audit is undertaken and actions taken to address any identified risks and improve the quality of healthcare that is provided.

The role of the Board, AC, QSC, FIC, Workforce Committee and RIC in maintaining and reviewing the Trust's systems of internal control is described above. The internal audit programme provides a further mechanism for doing this. KPMG, the Trust's internal auditors, identify high, medium and low priority recommendations within their audit reports, which are monitored in an internal audit recommendations tracker, and which is reviewed at each AC.

Internal audit completed thirteen reviews in 2020/21, the findings of which were reported to the AC. One review received partial assurance. Three high priority recommendations were raised. Actions to address these have been agreed and are in the process of being implemented. The head of internal audit opinion has given 'significant assurance with minor improvement opportunities' opinion on the overall adequacy and effectiveness of the framework of governance, risk management and control. This provides assurance that there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas reviewed.

Significant control issues

There were 8 never events in the year ended 31 March 2021. These related to:

- 2 unintentional connection of oxygen tubing to air incidents;
- 1 retained foreign object post-surgery;
- 2 wrong site surgery;
- 1 interventional procedure on the wrong patient;
- 1 misplaced nasogastric tube with feed administered; and
- 1 wrong route of administration of medication.

All the incidents are subject to detailed investigations and the actions and assurances monitored through the clinical boards, the QSC and reported to the commissioners who approve the action plans.

Conclusion

Overall UCLH has a strong control environment, with minor improvement opportunities identified during the year as concluded in the head of internal audit opinion.

Aside from the never events noted above, no other significant control issues were identified during the year.

Tim Jaggard
Acting Chief Executive

14 June 2021

3. Annual accounts

Forward to the accounts

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

Tim Jaggard
Acting chief executive

14 June 2021

Independent auditor's report to the council of governors and board of directors of University College London Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of University College London 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 the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England (the 'Accounts Direction').

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- 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 on page 85;
- the table of pension benefits of senior managers and related narrative notes on page 85;
- the table of pay multiples and related narrative notes on page 89; and
- the table of exit packages and related narrative notes on page 105.

The financial reporting framework that has been applied in their preparation is applicable law and the 'Accounts Direction'.

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 trust is adopted in consideration of the requirements set out in the Accounts Direction, 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, 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 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.
- determination of whether the foundation trust has recorded revenue that is not valid, accurate or valued appropriately.

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, 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.

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 trust's arrangements and include any 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 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 trust's resources.

We are required under the Code of Audit Practice and section 21(3)(c), as amended by schedule 13 paragraph 10(a) of the Act to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We 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 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 trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021. Other findings from our work, including our commentary on the trust's arrangements, will be reported in our separate Auditor's Annual Report.

3.1 *Governance statement and reports in the public interest or to the regulator*

We are also required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Trust Development Authority (NHS Improvement);
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the trust, or an officer of the 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; or
- we issue a report in the public interest under section 24 of the Act.

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 Council of Governors and Board of Directors ("the Boards") of University College London 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.

Craig Wisdom FCA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St Albans, United Kingdom
15 June 2021

NHS Foundation Trust – Audit certificate issued subsequent to opinion on financial statements

Independent auditor's report to the council of governors and board of directors of University College London Hospitals NHS Foundation Trust

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 15 June 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 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 15 June 2021, we had not completed our work on the foundation trust's arrangements and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 15 June 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 to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of University College London 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.

Craig Wisdom (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
07 July 2021

Statement of Comprehensive Income

	Note	£000	£000
Operating income from patient care activities	3.1	1,102,226	982,699
Other operating income	3.2	240,252	234,601
Operating expenses	4	(1,410,622)	(1,215,907)
Operating (deficit)/surplus from continuing operations		**(68,144)**	**1,393**
Finance income	9	-	1,648
Finance expenses	10	(38,216)	(38,081)
PDC dividends payable		(5,876)	(10,511)
Net finance costs		**(44,092)**	**(46,944)**
Other (losses) on disposal of assets		(3,411)	(4,659)
Share of profit of associates / joint arrangements	16.1	4,129	1,802
(Deficit) for the year		**(111,518)**	**(48,408)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	15	(11,142)	2,381
Revaluations	15	1,232	9,600
Total other comprehensive (expense)/income		(9,910)	11,981
Total comprehensive (expense) for the period		**(121,428)**	**(36,427)**

The note below describes the primary view used by the Board of Directors to monitor UCLH's financial performance, which excludes the impact of estate revaluation and other exceptional items that are reported within the comprehensive income figure above but are non-operational in nature.

Adjusted financial performance (control total basis):		
(Deficit) for the year	(111,518)	(48,408)
Remove net impairments not scoring to the Departmental expenditure limit	127,410	37,602
Remove I&E impact of capital grants and donations	(2,364)	(3,993)
Remove exceptional net loss on disposal of assets	-	4,659
Remove 2018/19 post audit PSF reallocation (2019/20 only)	-	(917)
Remove other exceptional items	(789)	(8,500)
Remove net impact of inventories received from DHSC group bodies for COVID response	(978)	-
Adjusted financial performance surplus / (deficit)	**11,761**	**(19,557)**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	11.1	29,833	30,395
Property, plant and equipment	12.1	932,110	1,002,891
Investments in associates and joint ventures	16.1	24,349	20,220
Receivables	18.1	16,915	15,199
Total non-current assets		**1,003,207**	**1,068,705**
Current assets			
Inventories	17	17,371	16,326
Receivables	18.1	89,768	159,969
Cash and cash equivalents	19	325,023	219,312
Total current assets		**432,162**	**395,607**
Total assets		**1,435,369**	**1,464,312**
Current liabilities			
Trade and other payables	21	(261,437)	(224,684)
Borrowings	23	(20,007)	(14,193)
Provisions	25	(17,026)	(5,027)
Other liabilities	22	(30,108)	(26,426)
Total current liabilities		**(328,578)**	**(270,330)**
Total assets less current liabilities		**1,106,791**	**1,193,982**
Non-current liabilities			
Borrowings	23	(522,506)	(541,994)
Other financial liabilities	22	(15,201)	(3,726)
Provisions	25	(13,054)	(7,491)
Total non-current liabilities		**(550,761)**	**(553,211)**
Total assets employed		**556,030**	**640,771**
Financed by			
Public dividend capital	SOCITE	373,787	337,100
Revaluation reserve	SOCITE	74,651	84,561
Income and expenditure reserve	SOCITE	107,592	219,110
Total taxpayers' equity		**556,030**	**640,771**

Vicky Clarke
Acting chief financial officer
14 June 2021

Tim Jaggard
Acting chief executive
14 June 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		**337,100**	**84,561**	**219,110**	**640,771**
(Deficit) for the year	SOCI	-	-	(111,517)	**(111,517)**
Impairments	15	-	(11,142)	-	**(11,142)**
Revaluations	15	-	1,232	-	**1,232**
Public dividend capital received		36,687	-	-	**36,687**
Taxpayers' and others' equity at 31 March 2021		**373,787**	**74,651**	**107,593**	**556,031**

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		**301,856**	**72,580**	**267,518**	**641,954**
(Deficit) for the year	SOCI	-	-	(48,408)	**(48,408)**
Impairments	15	-	2,381	-	**2,381**
Revaluations	15	-	9,600	-	**9,600**
Public dividend capital received		35,244	-	-	**35,244**
Taxpayers' and others' equity at 31 March 2020		**337,100**	**84,561**	**219,110**	**640,771**

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

This reserve comprises the cumulative surplus/deficit reported by the Trust, including amounts brought forward from when it was an NHS trust.

Statement of cash flows

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating (deficit)/surplus		(68,144)	1,393
Non-cash income and expense:			
Depreciation and amortisation		34,982	30,098
Net impairments	15	127,410	37,602
Income recognised in respect of capital donations		(4,861)	(6,481)
Decrease in receivables and other assets	18.1	70,697	15,786
(Increase) in inventories	17	(1,045)	(1,251)
Increase in payables and other liabilities	21	55,006	22,036
Increase in provisions	25	17,547	4,562
Other movements in operating cash flows		(430)	284
Net cash flows (used in)/from operating activities		**231,162**	**104,029**
Cash flows (used in)/from investing activities			
Interest received		-	1,648
Purchase and sale of financial assets		-	(3,000)
Purchase of intangible assets		(1,633)	(14,088)
Purchase of PPE		(101,838)	(146,322)
Sales of PPE		-	55
Receipt of cash donations to purchase assets		866	6,481
Net cash flows from investing activities		**(102,605)**	**(155,226)**
Cash flows (used in)/from financing activities			
Public dividend capital received		36,687	35,244
Movement on loans from DHSC		(7,604)	32,194
Movement on other loans		-	(100)
Capital element of finance lease rental payments		(183)	(177)
Capital element of PFI, LIFT and other service concession payments		(5,859)	(5,495)
Interest on loans		(4,832)	(4,678)
Interest paid on finance lease liabilities		(22)	(24)
Interest paid on PFI, LIFT and other service concession obligations		(33,375)	(33,273)
PDC dividend (paid)		(7,658)	(10,525)
Net cash flows (used in)/from financing activities		**(22,846)**	**13,166**
Increase / (decrease) in cash and cash equivalents		**105,711**	**(38,031)**
Cash and cash equivalents at 1 April - brought forward		**219,312**	**257,343**
Cash and cash equivalents at 31 March		**325,023**	**219,312**

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, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2. Going concern

These accounts have been prepared on a going concern basis. The directors have given serious consideration to the financial sustainability of UCLH as an entity and in relation to UCLH's available resources:

- In relation to UCLH as an entity, the directors have a reasonable expectation that UCLH has adequate resources to continue to service its debts and run operational activities for at least the next business period (considered to be 12 months) following publication of this report. UCLH has sufficient cash to ensure its obligations are met over this time period given the potential mitigations identified for a downside scenario.
- Beyond the 12 month period, financial sustainability will be dependent on how a number of factors develop, not least the funding regime.

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

Note 1.3. Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital

and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Joint ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The meaning of control is the same as that for subsidiaries. Joint ventures are accounted for using the equity method.

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Note 1.4. Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an 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.

Comparative period (2019/20)

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

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.

For 2020/21 and 2019/20

Where the effects of practical expedients mandated by the GAM are material, these are disclosed as accounting policies. These include: (1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

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

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when

performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset. Each year, the Compensation Recovery Unit advises a percentage probability of not receiving the income. For 2020/21 this figure is 22.43% (2019/20, 21.79%).

Note 1.5. Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.6. 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 employer, 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 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

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 to 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 1.7. 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 1.8. 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. Assets classified as in use are depreciated from the beginning of the next quarter.

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.

All land and buildings 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 or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. 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 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. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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

Depreciation

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

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure

reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

De-recognition

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

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

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

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation 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 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) transactions

PFI 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.

Lifecycle Replacement

An amount is set aside from the unitary payment each year into a Lifecycle Replacement Prepayment to reflect the fact that the Trust is effectively pre-funding some elements of future lifecycle replacement by the operator. Where the operator replaces a capital asset, the fair value of this replacement item is recognised as property, plant and equipment.

Where the item was planned for replacement and therefore its value is being funded through the unitary payment, the lifecycle prepayment is reduced by the amount of the fair value. The prepayment is reviewed periodically to ensure that its carrying amount will be realised through future lifecycle components to be provided by the operator. Any unrecoverable balance is written out of the prepayment and charged to operating expenses.

Where the lifecycle item was not planned for replacement during the contract it is effectively being provided free of charge to the Trust. A deferred income balance is therefore recognised instead and this is released to operating income over the remaining life of the contract.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed to use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the Operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operation's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Useful lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Buildings, excluding dwellings	20	49
Plant & machinery	5	10
Information technology	5	7
Furniture & fittings	5	7

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 1.9. 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 when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, for example, 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, for example, 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. Revaluation 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.

Note 1.10. Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method, recalculated at the point of receipt, based on contract cost. Differences between contract cost and actual cost are processed as price variances at the time of invoice.

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 1.11. Investment properties

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

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

Note 1.12. 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 1.13. Carbon Reduction Commitment scheme (CRC)

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

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

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

The final compliance year for CRC was 2018 – 2019, with the final surrender deadline being 31 October 2019. We continue to adhere to monitoring requirements.

Note 1.14. Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

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

The classification depends on the nature and purpose of the financial instrument and is determined at the time of initial recognition.

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.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

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

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

Impairment of financial assets

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

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

Contract and other receivables with other NHS organisations are not impaired. The Trust calculates a lifetime expected loss rate for difference categories of receivable organisation at the point of recognition of the asset. The expected loss rate is reviewed on an annual basis.

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.

De-recognition

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

ownership.

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

Note 1.15. 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 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 lessor

Finance leases

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

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are

added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16. 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	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
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	1.20%
Year 2	1.60%
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 25.1 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 1.17. 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. The Trust does not carry any contingent assets as at 31 March 2021.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.18. 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 in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts .

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

Note 1.19. 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 1.20. Corporation tax

NHS Foundation Trusts can be subject to corporation tax in respect of certain commercial non-core health care activities they undertake in relation to the Income Tax Act 2007 and the Corporation Tax Act 2010. The Trust does not undertake any non-core health activities which are subject to corporation tax, therefore does not have a corporation tax liability.

Note 1.21. Foreign exchange

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

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

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

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

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

Note 1.22. 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 1.23. 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 1.24. Gifts

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

Note 1.25. Early adoption of standards, amendments and interpretations

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

Note 1.26. Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Impairment of Receivables

The Trust calculates a lifetime expected loss rate for each category of customer traded with, based on analysis of historical collection rates for debts in that category. The Trust reviews collection rates annually.

Valuation of Land and Buildings

The District Valuer (DV) provided the Trust with a valuation of land and buildings. The valuation was completed in accordance with HM Treasury Guidance and leads to valuation adjustments as described in note 15. Future valuations may result in further changes to the carrying values of non-current assets.

The valuation exercise was carried out between November 2020 and February 2021 with the report finalised on the 31 March 2021.

The Trust's land and buildings are valued on the basis explained here and in note 12 to the accounts. In line with this policy specialised assets are valued on a Modern Equivalent Asset (MEA) basis. The basis of a MEA valuation is that the property being valued may be located or constructed in an alternative setting that allows the same service to be provided. If for example the same service could be provided in a smaller estate size, the MEA valuation is conducted on that basis. Within the MEA valuation of the Grafton Way Building, we have assumed such an efficiency in space arising. This is consistent with the original site business case.

Both physical and functional obsolescence is applied to buildings, to reflect their actual characteristics and value. As part of this process management consider whether an alternative rebuild location could be appropriate. In selecting a MEA location for each specialised asset, we have considered geographical limitations inherent within the service specification.

Inventory

In March 2021, the Trust was not able to perform all year end inventory counts as planned due to restrictions arising from COVID-19. 30 stock sites exist. For 13 of these where a physical count was not possible the Trust has used a three year historical average, where deemed reflective of existing activity. The largest single area of stock holdings for the Trust is pharmacy stock. Data for this area was extracted directly from the inventory stock system and subject to external audit validation.

Note 1.27. Sources of estimation uncertainty

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

Provisions

Provisions, note 25, have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of future cash flows and are dependent on future events. Any difference between expectations and actual future liability will be accounted for in the period when such determination is made.

Contract disputes

Per IAS 37, we have provided for contract disputes where we believe that the dispute resolution process evidences the existence of a past event deemed as giving rise to a present obligation, taking into account all currently available information.

Dilapidations

Where a property lease agreement creates an obligation to repair a property, we are of the view that a liability should be recognised when an obligating event (being wear and tear, structural alteration, or other damage to the property) occurs. We have recognised a dilapidations provision against leases held with fewer than 100 years remaining on the lease term, taking into consideration the probability of an outflow of resources.

All provisions are subject to review annually at the balance sheet date.

Note 1.28. 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 a rate

defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. 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.

We are fully prepared for the implementation of IFRS 16.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	£000
Additional right of use assets recognised for existing operating leases	124,346
Additional lease obligations recognised for existing operating leases	0
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2022	**124,346**
Estimated in-year impact in 2022/23	**£000**
Additional depreciation on right of use assets	(10,360)
Additional finance costs on lease liabilities	(1,074)
Lease rentals no longer charged to operating expenditure	9,603
Other impact on income / expenditure	0
Estimated impact on surplus / deficit in 2022/23	**(1,831)**
Estimated increase in capital additions for new leases commencing in 2022/23	**0**

The following table presents a list of recently issued IFRS standards and amendments that have not yet been adopted within the FReM and are therefore not applicable to the DHSC group accounts for 2020/21.

IFRS 14 Regulatory Deferral Accounts	Not EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 16 Leases	Standard is effective from 1 April 2022 per the FReM.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the *FReM*: early adoption is not therefore permitted.

** The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.*

Note 2. Operating segments

	Medicine		Specialist Hospitals		Surgery & Cancer		Research & Development		Education		Corporate		**TOTAL**	
	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Direct Income	216.0	219.6	467.0	456.3	396.0	385.5	35.5	41.6	32.9	34.1	150.6	51.3	1,298.0	1,188.4
Direct Costs	(234.5)	(230.4)	(336.2)	(340.6)	(345.0)	(330.9)	(36.0)	(36.1)	(36.8)	(37.1)	(251.9)	(151.5)	(1,240.4)	(1,126.6)
Internal Trading and Indirect Costs	16.3	16.6	(69.6)	(64.0)	(31.1)	(30.7)	(5.2)	(5.8)	-	-	89.5	84.0	(0.1)	0.1
CONTRIBUTION /EBITDA (at Trust level)	**(2.2)**	**5.8**	**61.2**	**51.7**	**19.9**	**23.9**	**(5.7)**	**(0.3)**	**(3.9)**	**(3.0)**	**(11.8)**	**(16.2)**	**57.8**	**61.6**
ITDA (before donation adjustments and exceptional items)	-	-	-	-	-	-	-	-	-	-	(72.4)	(72.8)	(72.4)	(72.8)
I&E (before donation adjustments and exceptional items)	**(2.2)**	**5.7**	**61.3**	**51.8**	**20.0**	**23.8**	**(5.7)**	**(0.4)**	**(3.9)**	**(3.0)**	**(84.2)**	**(89.0)**	**(14.7)**	**(11.1)**
Additional / Incentive PSF/FRF	-	-	-	-	-	-	-	-	-	-	-	0.9	-	0.9
Disposal (Losses)	-	-	-	-	-	-	-	-	-	-	(3.4)	(4.7)	(3.4)	(4.7)
Exceptional items included in Control Total	-	-	-	-	-	-	-	-	-	-	(0.8)	(0.1)	(0.8)	(0.1)
I&E surplus/(deficit) after exceptional items	**(2.2)**	**5.7**	**61.3**	**51.8**	**20.0**	**23.8**	**(5.7)**	**(0.4)**	**(3.9)**	**(3.0)**	**(88.4)**	**(92.9)**	**(18.9)**	**(15.0)**
Exceptional items excluded from Control Total	-	-	-	-	-	-	-	-	-	-	*(93.7)*	*(33.5)*	(93.7)	(33.5)
Net (Deficit)/Surplus	*(2.2)*	*5.7*	*61.3*	*51.8*	*20.0*	*23.8*	*(5.7)*	*(0.4)*	*(3.9)*	*(3.0)*	*(182.1)*	*(126.4)*	*(112.6)*	*(48.5)*

Notes

*Total position agreed to (deficit) for the year per the Statement of Comprehensive Income (SOCI).

1) At segmental level, positions are reported at the level of "Contribution". At Trust level this equates to "EBITDA".

2) The I&E position before donation adjustments reflects the old (pre-2012/13) NHS accounting rules. The Trust reports under both the old accounting regime (as the best measure of underlying financial performance as it is unaffected by the timing of charitable donations) and the new accounting regime, which accounts for charitable donations as income in the period in which they are received.

3) ITDA is the total of interest, taxation, depreciation and amortisation. EBITDA is earnings before interest, taxation, depreciation and amortisation.

4) Total assets and liabilities are not reported to the Chief Operating Decision Maker by reportable segment.

5) Exceptional items excluded from control total consist of impairments and reversals of impairments before the effect of accounting policy adjustments and donation adjustments which represent the accounting for donations in the year of receipt rather than matching with depreciation over the life of the donated asset.

6) PFI costs including interest are allocated to and reported within the relevant segments, predominantly Medicine and Surgery & Cancer who occupy the majority of the PFI buildings.

Note 3. Operating Income by Nature

	2020/21	2019/20 (restated)
	£000	£000
Acute services		
Block contract / system envelope income*	988,415	548,668
High cost drugs income from commissioners (excluding pass-through costs)	14,657	129,402
Other NHS clinical income	68,477	258,045
All services		
Private patient income	7,353	25,005
Additional pension contribution central funding**	23,324	21,578
Other clinical income	-	-
Total income from activities	**1,102,226**	**982,698**
Total other operating income (see note 3.2)	**240,252**	**234,601**
Total operating income	**1,342,478**	**1,217,299**

* 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 3.1. Operating Income by Nature

	2020/21	2019/20
Income from patient care activities received from:	**£000**	**£000**
NHS England	566,859	507,754
Clinical commissioning groups	512,294	439,476
Other NHS providers	440	2,853
NHS other	1,716	1,465
Local authorities	-	-
Non-NHS: private patients	5,873	21,773
Non-NHS: overseas patients (chargeable to patient)	1,717	2,386
Injury cost recovery scheme	722	734
Non NHS: other	12,605	6,258
Total income from activities	**1,102,226**	**982,699**
Of which:		
Related to continuing operations	1,102,226	982,699
Related to discontinued operations	-	-

Note 3.2. Other Operating Income Recognised in Accordance with IFRS 15

	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	19,147	24,325	**43,472**	20,243	29,244	**49,487**
Education and training	36,259	-	**36,259**	35,578	-	**35,578**
Non-patient care services to other bodies	8,698	-	**8,698**	20,478	-	**20,478**
Provider sustainability fund and Financial recovery fund (2019/20 only)	-	-	**-**	26,104	-	**26,104**
Reimbursement and top up funding	67,279	-	**67,279**	7,800	-	**7,800**
Income in respect of employee benefits accounted on a gross basis	3,818	-	**3,818**	6,566	-	**6,566**
Receipt of capital grants and donations*	-	3,995	**3,995**	-	6,481	**6,481**
Charitable and other contributions to expenditure**	-	13,751	**13,751**	-	11,270	**11,270**
Rental revenue from operating leases	-	4,024	**4,024**	-	4,778	**4,778**
Pharmacy sales	38,760	-	**38,760**	41,280	-	**41,280**
Other income***	20,195	-	**20,196**	24,779	-	**24,779**
Total other operating income	**194,156**	**46,096**	**240,252**	**182,828**	**51,773**	**234,601**
Of which:						
Related to continuing operations	194,156	46,096	240,252	182,828	51,773	234,601

* for 2020/21 this row includes donated equipment from group bodies for COVID response.

** for 2020/21 this row includes £10.3m donated inventories of which £9m was utilised at 31 March and equipment below capitalisation threshold for COVID response.

*** Other income contains £3m of staff accommodation rental (£3m 2019/20).

Note 3.3. Overseas Visitors (relating to patients charged directly by the Trust)

	2020/21	2019/20
	£000	£000
Income recognised this year	1,717	2,386
Cash payments received in-year	399	1,519
Amounts added to provision for impairment of receivables	1,790	521
Amounts written off in-year*	1,631	140

* Amounts written off include items from previous financial years. Bad debt provision was held for all amounts written off.

Note 3.4. Additional information contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end (i.e. release of deferred IFRS 15 income)	26,026	25,585
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 3.5. Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2021 £000	31 March 2020 £000
within one year	29,708	26,026
after one year, not later than five years	11,875	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**41,583**	**26,026**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 3.6. Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2020/21	2019/20
	£000	£000
Income	-	-
Full cost	-	-
Surplus / (deficit)	**-**	**-**

Note 4. Operating Expenses

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	27,313	20,817
Purchase of healthcare from non-NHS and non-DHSC bodies	14,172	11,738
Staff and executive directors' costs	642,264	594,700
Remuneration of non-executive directors	209	202
Supplies and services - clinical (excluding drugs costs)*	98,600	87,500
Supplies and services - general	13,836	11,597
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	207,327	203,814
Inventories written down**	153	-
Consultancy costs	4,775	3,952
Establishment	6,682	8,575
Premises	112,855	98,012
Transport (including patient travel)	10,137	10,070
Depreciation on property, plant and equipment	31,722	29,366
Amortisation on intangible assets	3,259	732
Net impairments	127,410	37,602
Movement in credit loss allowance: contract receivables	(1,084)	1,073
Audit fees payable to the external auditor		
• audit services- statutory audit	180	115
• other auditor remuneration (external auditor only)	-	-
Internal audit costs	262	238
Clinical negligence	21,033	19,164
Legal fees	510	478
Research and development	19,570	18,179
Education and training	3,324	3,145
Rentals under operating leases	14,232	15,531
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	24,458	23,778
Losses, ex gratia & special payments	469	10
Other services, e.g. external payroll	397	335
Other	26,557	15,185
Total	**1,410,622**	**1,215,908**
Of which:		
Related to continuing operations	1,410,622	1,215,908
Related to discontinued operations	-	-

* For 2020/21 this row includes £9m utilisation of donated consumables (personal protective equipment).

** For 2020/21 this row includes all inventory write downs (including inventories donated for COVID response).

Note 5. Auditor's remuneration

	2020/21	2019/20
	£000	£000
Auditor remuneration paid to the external auditor:		
1. Audit of accounts of the trust	160	105
2. Audit-related assurance services	20	10
Total	**180**	**115**

Note 5.1. Auditor's liability

There is a £2m limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 6. Employee Benefits

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	442,450	405,595
Social security costs	51,132	46,846
Apprenticeship levy	2,265	2,119
Employer's contributions to NHS pensions*	76,756	70,848
Temporary staff (including agency)	77,085	82,942
Total gross staff costs	**649,688**	**608,350**
Recoveries in respect of seconded staff	(6,164)	(5,488)
Total staff costs	**643,524**	**602,862**
Of which		
Costs capitalised as part of assets	(1,259)	(8,162)
Total staff costs excluding capitalised costs	**642,264**	**594,700**

* Pension costs included £23,324k (2019/20, £21,578k) in relation to increased employers pension contributions funded centrally. The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2020/21 and 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 7. Retirements due to ill-health

During 2020/21 there was 1 early retirement from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2020). The estimated additional pension liabilities of that ill-health retirements is £14k (£175k in 2019/20).

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

Note 8. Operating leases

Note 8.1. As lessor

This note discloses income generated in operating lease agreements where University College London Hospitals NHS Foundation Trust is the lessor.

	2020/21	2019/20
	£000	£000
Operating lease revenue		
Minimum lease receipts	4,024	4,778
Contingent rent	-	-
Other	-	-
Total	**4,024**	**4,778**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,316	578
- later than one year and not later than five years;	5,263	2,310
- later than five years.	-	3,900
Total	**6,579**	**6,788**

Note 8.2. As lessee

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

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	-	-
Contingent rents	14,232	15,531
Less sublease payments received	-	-
Total	**14,232**	**15,531**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	11,592	12,660
- later than one year and not later than five years;	25,107	24,657
- later than five years.	12,080	10,904
Total	**48,779**	**48,221**

Note 9. Finance Income

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	1,648
Total finance income	**-**	**1,648**

Note 10. Finance Expenses

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

	2020/21	2019/20
	£000	£000
Interest expense:		
Other loans	4,806	4,761
Finance leases	20	24
Main finance costs on PFI and LIFT schemes obligations	33,375	33,273
Total interest expense	**38,201**	**38,058**
Unwinding of discount on provisions	15	23
Other finance costs	-	-
Total finance costs	**38,216**	**38,081**

Note 11.1. Intangible assets

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**31,761**	**-**	**-**	**31,761**
Additions	1,500	132	-	**1,632**
Revaluations	-	-	-	**-**
Reclassifications	1,140	-	-	**1,140**
Disposals / derecognition	(772)	-	-	**(772)**
Valuation / gross cost at 31 March 2021	**33,629**	**132**	**-**	**33,761**
Amortisation at 1 April 2020 - brought forward	**1,364**	**-**	**-**	**1,364**
Provided during the year	3,259	-	-	**3,259**
Disposals / derecognition	(695)	-	-	**(695)**
Amortisation at 31 March 2021	**3,928**	**-**	**-**	**3,928**
Net book value at 31 March 2021	**29,701**	**132**	**-**	**29,833**
Net book value at 1 April 2020	**30,397**	**-**	**-**	**30,397**

Note 11.2. Intangible assets

	Software licences	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**-**	**-**	**-**	**-**
Additions	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**31,761**	**-**	**-**	**31,761**
Amortisation at 1 April 2019	**-**	**-**	**-**	**-**
Provided during the year	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2020	**-**	**-**	**-**	**-**
Net book value at 31 March 2020	**31,761**	**-**	**-**	**31,761**
Net book value at 1 April 2019	**-**	**-**	**-**	**-**

Intangible fixed assets represent application software identified IT projects. For all categories of intangible assets, the Trust considers that depreciated historic cost is an acceptable proxy for current value in existing use, as the UEL is considered to be a realistic reflection of the lives of assets and the depreciation methods used reflects the consumption of the asset.

Note 12.1. Property, plant and equipment

	Land	Buildings excluding dwellings*	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**85,009**	**508,286**	**328,148**	**137,102**	**272**	**44,953**	**31,180**	**1,134,951**
Additions	-	7,572	70,117	23,096	-	1,504	448	**102,736**
Impairments	(3,108)	(8,213)	(109,703)	-	-	-	-	**(121,024)**
Reversals of impairments	-	179	-	-	-	-	-	**179**
Revaluations	325	(29,167)	-	-	-	-	-	**(28,842)**
Reclassifications	-	3,160	(6,996)	2,100	-	532	64	**(1,140)**
Disposals / derecognition	-	(761)	-	(4,932)	-	(8,460)	(309)	**(14,462)**
Valuation/gross cost at 31 March 2021	**82,226**	**481,056**	**281,567**	**157,365**	**272**	**38,528**	**31,383**	**1,072,398**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**2,719**	-	**78,765**	**195**	**25,380**	**25,003**	**132,061**
Provided during the year	-	13,541	-	11,298	39	5,348	1,496	**31,722**
Impairments	-	17,916	-					**17,916**
Reversals of impairments	(149)	(59)	-	-	-	-	-	**(209)**
Revaluations	149	(30,223)	-	-	-	-	-	**(30,074)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(452)	-	(3,695)	-	(6,734)	(247)	**(11,128)**
Accumulated depreciation at 31 March 2021	**-**	**3,441**	**-**	**86,369**	**234**	**23,994**	**26,252**	**140,290**
Net book value at 31 March 2021	**82,226**	**477,616**	**281,567**	**70,997**	**39**	**14,534**	**5,131**	**932,110**
Net book value at 1 April 2020	**85,008**	**505,567**	**328,148**	**58,337**	**77**	**19,573**	**6,177**	**1,002,887**

Note 12.2. Property, plant and equipment

	Land	Buildings excluding dwellings*	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**89,875**	**412,818**	**328,172**	**116,666**	**272**	**40,291**	**30,003**	**1,018,097**
Additions	-	10,421	113,769	19,409	-	1,382	1,026	**146,007**
Impairments	-	(278)	-	-	-	-	-	**(278)**
Reversals of impairments	-	2,659	-	-	-	-	-	**2,659**
Revaluations	(4,867)	(19,854)	(138)	-	-	(1,696)	-	**(26,555)**
Reclassifications	-	102,520	(113,654)	1,673	-	9,309	151	**(0)**
Disposals / derecognition	-	-	-	(646)	-	(4,333)	-	**(4,979)**
Valuation/gross cost at 31 March 2020	**85,008**	**508,286**	**328,148**	**137,102**	**272**	**44,953**	**31,180**	**1,134,949**
Accumulated depreciation at 1 April 2019	**0**	**1,318**	**-**	**69,295**	**156**	**22,534**	**23,314**	**116,617**
Provided during the year	-	12,083	-	9,828	39	5,726	1,689	**29,366**
Impairments	5,139	34,432	138	-	-	1,696	-	**41,405**
Reversals of impairments	-	(15,934)	(138)	-	-	-	-	**(16,072)**
Revaluations	(5,139)	(29,180)	-	-	-	(1,696)	-	**(36,015)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(358)	-	(2,881)	-	**(3,239)**
Accumulated depreciation at 31 March 2020	**0**	**2,719**	**-**	**78,765**	**195**	**25,380**	**25,003**	**132,062**
Net book value at 31 March 2020	**85,008**	**505,567**	**328,148**	**58,337**	**77**	**19,573**	**6,177**	**1,002,887**
Net book value at 1 April 2019	**89,875**	**411,500**	**328,172**	**47,372**	**116**	**17,757**	**6,688**	**901,480**

* Buildings accumulated depreciation is eliminated annually on revaluation at 31 March through entries in 'impairments charged to revaluation reserve', 'impairments recognised in operating expenses' and 'revaluation surpluses'. The 1 April buildings opening value is as per the net book value advised by the District Valuer.

Note 13.1. Property, plant and equipment financing

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	82,227	209,309	280,355	56,109	28	14,234	4,758	**647,020**
Finance leased	-	-	-	858	-	-	-	**858**
On-SoFP PFI contracts and other service concession arrangements	-	231,427	412	-	-	-	-	**231,839**
Owned - donated/granted	-	36,880	800	14,030	11	300	373	**52,393**
NBV total at 31 March 2021	**82,227**	**477,616**	**281,567**	**70,997**	**39**	**14,534**	**5,131**	**932,110**

Note 13.2. Property, plant and equipment financing

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020								
Owned - purchased	85,009	220,292	322,940	50,496	52	19,228	5,754	**703,771**
Finance leased	-	-	-	1,060	-	-	-	**1,060**
On-SoFP PFI contracts and other service concession arrangements	-	245,817	813	-	-	-	-	**246,630**
Owned - donated/granted	-	39,459	4,395	6,781	25	345	423	**51,428**
NBV total at 31 March 2020	**85,009**	**505,569**	**328,148**	**58,337**	**77**	**19,573**	**6,177**	**1,002,891**

Note 13.3. Property, plant and equipment

End of Year Valuation

In the year ending 31st March 2021 a desktop valuation exercise was carried out on UCLH's properties by the District Valuer (DV) together with an onsite valuation of the Grafton Way Building (GWB). The last full site valuation was in 2018.

The on-site visit to the GWB was carried out in November 2020, with the desktop valuation finalised on 31st March 2021. This resulted in a number of revaluation adjustments, both upwards and downwards, some of which related to assets with existing revaluation reserve balances and some of which related to assets with no revaluation reserve balance. See note 15 for further details.

The valuations were undertaken having regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and the requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition. As in previous years, management have elected to use an alternative site basis for the valuation of specialised assets and have valued the PFI assets net of VAT.

Basis of Valuation

Non-operational assets, including surplus land, are valued on the basis of Market Value, on the assumption that the property is no longer required for existing operations, which have ceased.

There is an assumption that properties valued will continue to be in the occupation of the NHS for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

a) Depreciated Replacement Cost

The basis used for the valuation of specialised operational property for financial accounting purposes is Depreciated Replacement Cost (DRC). The RICS Standards at Appendix 4.1, restating International Valuation Application 1 (IVA 1) provides the following definition: "The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation."

Those buildings which qualify as specialised operational assets, and therefore fall to be assessed using the Depreciated Replacement Cost approach, have been valued on a modern equivalent asset basis. This method of valuation allows an alternative location for replacement to be used if this can be demonstrated to meet the requirements of the service. In 2017/18 management have determined that the needs of the service could be met from locations away from the current sites and the valuation has been completed on this basis. This principle was revisited for the Phase 4 and a consistent methodology as per 2017/18 was validated and applied.

b) Existing Use Value (EUV)

The basis used for the valuation of non-specialised operational owner-occupied property for financial accounting purposes under IAS 16 is fair value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation. This can be equated with EUV, which is defined in the RICS Standards at UK PS1.3 as: "The estimated amount for which a property should exchange on the date of valuation

between a willing buyer and a willing seller in an arm's-length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

c) Market Value (MV)

Market Value is the basis of valuation adopted for the reporting of non-operational properties, including surplus land, for financial accounting purposes. The RICS Standards at PS3.2 define MV as:
"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's-length transaction after proper marketing wherein the parties had each acted knowledgeably, prudently and without compulsion."

Variations to RICS Valuation Standards

In order to meet the underlying objectives established by HM Treasury and the Department of Health for capital accounting and the capital charges system, the following variations from the RICS Valuation Standards were required and agreed between UCLH and the DV.

For assets valued using depreciated replacement cost, the replacement cost figures include VAT and professional fees but exclude finance charges, with an "instant building" being assumed.
The valuation figures reflect physical obsolescence and have been reduced to reflect functional obsolescence.
Assets in the course of construction at the valuation date are included at the cost incurred to the valuation date in accordance with current capital charging arrangements. When stating the certified cost of work carried out (as at the valuation date), no deduction has been made for the risk of failure to complete the project.

As regards alternative use values, it is confirmed that unless otherwise indicated operational assets have been valued to Fair Value on the assumption that their market value reflects the property being sold as part of the continuing enterprise in occupation. The value ascribed to the operational assets does not reflect any potential alternative use value, which could be higher or lower than the stated Fair Value.

Assumptions arising from use of a Prospective Valuation Date

The following assumptions were made in respect of giving a prospective valuation as at 31st March 2021, on valuations carried out in November 2020:

- The age and remaining lives of buildings and their elements have been assessed as at the valuation date. The assumption is that building elements will continue to be maintained normally over the period from the date of inspection to the valuation date and that there will be no untoward changes.
- With respect to non-specialised operational property valued to fair value assuming the continuance of occupation for the existing use, non-operational properties valued to Market Value and the land element of DRC properties, their valuations have been prepared having regard both to the market evidence available at the date of the report and to likely and foreseeable local and national market trends between the date of carrying out the valuation and the valuation date.

Interaction with Private Finance Initiative (PFI) Contracts

UCLH's PFI asset (the UCH and EGA hospital facilities) has been valued to fair value on the market value, subject to the assumption of continuance of the existing use, with the DRC approach being adopted because the asset is specialised. As in previous years, the value of the asset is shown net of VAT after detailed consideration of the obligations of the PFI company within the contract.

Note 15. Impairments and Revaluations

Land and buildings were valued independently by the District Valuer (DV) as at 31 March 2021. The valuation included positive and negative valuation movements. Revaluation gains were taken to the revaluation reserve, unless they related to a property which had previously been impaired through operating expenses in which case the revaluation gain was taken to operating income. Revaluation losses were taken to the revaluation reserve to the extent that there was a revaluation surplus for that property. Any losses over and above the revaluations surplus were charged to operating expenses. The movement arising from the external valuation is summarised below:

	2020/21			2019/20		
	Income and expenditure	**Reserves**	**Total**	**Income and expenditure**	**Reserves**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Summary of impairments and revaluations:						
a) Impairments and reversals						
Impairment reversals credited to I&E - valuation*	209	-	209	15,934	-	15,934
Impairments charged to operating expenses - valuation*	(126,829)	-	(126,829)	(53,398)	-	(53,398)
Impairments charged to operating expenses - abandonment *	(789)	-	(789)	(138)	-	(138)
Impairments charged to revaluation reserve - valuation**	-	(11,142)	(11,142)	-	2,381	2,381
Total impairment (charge)/reversal	**(127,409)**	**(11,142)**	**(138,551)**	**(37,602)**	**2,381**	**(35,221)**
b) Revaluations						
Credited to revaluation reserve as above - valuation	-	1,232	1,232	-	9,600	9,600
Total revaluations	**-**	**1,232**	**1,232**	-	9,600	9,600

* Of the net £127.4m impairment above, £108.9m relates to the Grafton Way building valuation.

** Of the net £11.1m impairment above, £2m relates to the Grafton Way land valuation.

Note 16. Investment in Joint Ventures

UCLH holds an investment in the joint venture, Health Services Laboratories LLP (HSL LLP) with partners The Doctors Laboratory (TDL) and the Royal Free London NHS Foundation Trust (RFL) which performs pathology testing. UCLH has a 24.5% stake in this operation (TDL 51%, RFL 24.5%) with joint venture status agreed as a result of a series of significant decisions requiring unanimous agreement. This joint venture went live in April 2015 and is accounted as an investment using the equity method.

UCLH made no additional capital contribution in 2020/21 (2019/20, £3m). The UCLH projected a trading profit of £4.1m during 2020/21 (2019/20, (£1.8m)).

Note 16.1. Investment in Joint Ventures

	2020/21	2019/20
	£000	£000
Carrying value at 1 April	**20,220**	**15,418**
Share of profit	4,129	1,802
Other equity movements	-	3,000
Carrying value at 31 March	**24,349**	**20,220**

Note 16.2. Subsidiaries

UCLH has a wholly owned subsidiary company, MyUCLH Ltd, limited by guarantee, which was incorporated in England and Wales in April 2015 and commenced trading in 2016/17.

UCLH has not presented group and trust accounts due to immateriality. Balances in respect of MyUCLH are included within reported UCLH figures.

Note 17. Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	8,096	8,828
Consumables	9,178	7,409
Energy	97	89
Other	-	-
Total inventories	**17,371**	**16,326**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £207,328k (2019/20: 183,621k). Write-down of inventories recognised as expenses for the year were £153k (2019/20: £0k).

In response to the COVID-19 pandemic, the Department of Health and Social Care (DHSC) centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £10,368k 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 18.1. Trade and other receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables (IFRS 15)	53,298	90,527
Contract receivables (non IFRS 15)	2,306	41,689
Capital receivables	2,474	2,044
Allowance for impaired contract receivables / assets	(7,957)	(10,571)
Prepayments (non-PFI)	33,469	34,138
PDC dividend receivable	2,295	513
VAT receivable	3,707	1,367
Other receivables	176	263
Total current receivables	**89,768**	**159,970**
Non-current		
Contract receivables (IFRS 15)	-	-
Contract receivables (non IFRS 15)	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Prepayments (non-PFI)	-	-
PFI lifecycle prepayments	16,915	15,199
PDC dividend receivable	-	-
VAT receivable	-	-
Other receivables	-	-
Total non-current receivables	**16,915**	**15,199**
Of which receivable from NHS and DHSC group bodies:		
Current	21,884	83,131
Non-current	-	-

Note 18.2. Trade and other receivables

	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	**10,572**	**-**	**10,282**	**-**
New allowances arising	6,719	-	1,439	-
Reversals of allowances	(7,803)	-	(366)	-
Utilisation of allowances (write offs)	(1,530)	-	(783)	-
Allowances as at 31 March	**7,958**	**-**	**10,572**	**-**
(Gain)/ loss recognised in expenditure	**(1,084)**		**1,073**	

Note 19. Cash and cash equivalents

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	**219,311**	**257,342**
Net change in year	105,711	(38,031)
At 31 March	**325,022**	**219,311**
Broken down into:		
Cash at commercial banks and in hand	103	234
Cash with the Government Banking Service	324,920	219,077
Total cash and cash equivalents as in SoFP	**325,023**	**219,311**
Total cash and cash equivalents as in SoCF	**325,023**	**219,311**

Note 20. Third Party Assets

UCLH held £13k (2019/20, £13k) cash and cash equivalents at 31 March 2021 in relation to monies held on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 21. Trade and other payables

	31 March 2021	31 March 2020
	£000	£000
Current		
Trade payables	30,668	31,128
Capital payables*	19,404	22,501
Accruals	148,530	118,738
Other taxes payable	22,603	20,573
Other payables	40,232	31,745
Total current trade and other payables	**261,437**	**224,685**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	35,561	26,080
Non-current	-	-

* these items are considered non operational and are excluded from the movement in payables shown in the cash flow statement.

Note 22. Other liabilities

	31 March 2021	31 March 2020
	£000	£000
Current		
Deferred income: contract liabilities (IFRS 15)	29,708	26,026
Deferred income: other (non IFRS 15)	400	400
Total other current liabilities	**30,108**	**26,426**
Non-current		
Deferred income: contract liabilities (IFRS 15)	11,875	-
Deferred income: other (non IFRS 15)	3,326	3,726
Total other non-current liabilities	**15,201**	**3,726**
Total other liabilities	**45,309**	**30,152**

Note 22.1. Reconciliation of movements in contract liabilities recognised under IFRS 15

	31 March 2021	31 March 2020
	£000	£000
Opening Deferred Income	26,026	25,585
Released (performance conditions met)	(16,223)	(17,241)
Arising (performance conditions not met)	31,780	17,682
Closing Deferred Income	**41,583**	**26,026**

Note 23. Borrowings

	31 March 2021	31 March 2020
	£000	£000
Current		
Loans from DHSC	13,565	8,143
Other loans	8	8
Obligations under finance leases	187	183
Obligations under PFI, LIFT or other service concession contracts	6,247	5,859
Total current borrowings	**20,007**	**14,193**
Non-current		
Loans from DHSC	303,275	316,328
Other loans	-	-
Obligations under finance leases	784	971
Obligations under PFI, LIFT or other service concession contracts	218,447	224,694
Total non-current borrowings	**522,506**	**541,994**

Note 24. Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**324,471**	**8**	**1,154**	**230,554**	**556,187**
Cash movements:					
Financing cash flows - payments and receipts of principal	(7,604)	-	(183)	(5,859)	**(13,646)**
Financing cash flows - payments of interest	(4,832)	-	(21)	(18,938)	**(23,791)**
Non-cash movements:					
Application of effective interest rate	4,806	-	20	18,937	**23,763**
Carrying value at 31 March 2021	**316,841**	**8**	**970**	**224,694**	**542,513**

Note 24.1. Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2019	**292,193**	**109**	**1,332**	**236,048**	**529,682**
Cash movements:					
Financing cash flows - payments and receipts of principal	32,194	(100)	(177)	(5,495)	**26,422**
Financing cash flows - payments of interest	(4,678)	-	(24)	(18,471)	**(23,173)**
Non-cash movements:					
Application of effective interest rate	4,761	-	24	18,471	**23,256**
Carrying value at 31 March 2020	**324,470**	**9**	**1,155**	**230,553**	**556,186**

Note 25. Provisions

	Pensions: early departure costs*	Pensions: injury benefits	Legal claims**	Other***	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**1,211**	**50**	**296**	**10,961**	**12,518**
Arising during the year	218	32	1,226	20,343	**21,820**
Utilised during the year	(299)	(41)	(246)	(2,036)	**(2,622)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	-	(41)	(1,610)	**(1,651)**
Unwinding of discount	15	-	-	-	**15**
At 31 March 2021	**1,145**	**41**	**1,235**	**27,658**	**30,080**
Expected timing of cash flows:					
- not later than one year;	299	41	1,235	**15,451**	**17,026**
- later than one year and not later than five years;	603	-	-	**7,807**	**8,410**
- later than five years.	243	-	-	**4,401**	**4,644**
Total	**1,145**	**41**	**1,235**	**27,658**	**30,080**

* Staff pensions are calculated using a formula supplied by the NHS Pensions Agency. These pensions are the costs of early retirement of staff resulting from reorganisation.

** Legal claims are estimates from UCLH legal advisors on employer and public liability claims. The risks are limited to the excess of the policy excesses with the NHS Litigation Authority.

*** Other includes contractual disputes and dilapidations.

Note 25.1. Provisions

	31 March 2021	31 March 2020
	£000	£000
Amount included in provisions of the NHS Resolution in respect of clinical negligence liabilities of UCLH	224,113	210,553

Note 26. Contingent liabilities

UCLH has no contingent liabilities as at 31 March 2021. (31 March 2020: nil.)

Note 27. Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	46,251	62,297
Total	**46,251**	**62,297**

Note 28. Private Finance Initiative contracts

Note 28.1. PFI schemes ON-STATEMENT OF FINANCIAL POSITION

University College Hospital - Private Finance Initiative

A contract for the development of the hospital was signed on 12th July 2000, to build and run the hospital. The scheme is in conjunction with Health Management (UCLH) Plc (HMU), a consortium entity. The HMU consortium now consists of Semperian (part of Trillium group), Credit Suisse, Interserve PFI Holdings Ltd and Dalmore Capital.

The scheme is contracted to end on 1 June 2040, at which time the building will revert to the ownership of UCLH NHS FT.

The St Martin site, upon which the hospital has been constructed, was purchased in 2000/01 to provide the site for the hospital. A 40 year lease has been granted to the PFI partners, who contracted to build the hospital.

The new building was handed over in two phases, phase 1 on 19th April 2005 and phase 2 on 5th August 2008. Over the period, we, and our partners HMU Plc, invested £422m in building and equipping the new hospital. A number of existing UCLH NHS FT properties were sold and most of the income invested in the scheme.

UCLH NHS FT is committed to pay quarterly PFI unitary charge payments in advance which commenced with the opening of phase 1 of the development in 2005. This was initially at a reduced rate until phase 2 opened in 2008. After phase 2 was handed over to UCLH, UCLH NHS FT is committed to annual unitary charge building availability payments to the end of the contract in 2040, with the original per annum figure of £27.9m uplifted by the Retail Price Index each year since the opening of the PFI. The total availability fee payable in 2020/21 was £41.0m (2019/20 £41.4m), of which £33.4m (2019/20 £33.3m) was charged as interest (including contingent rent of £14.4m (2019/20 £14.8m)), £5.8m (2019/20 £5.5m) allocated to repayment of capital, and £1.7m (2019/20 £2.9m) payment into the lifecycle replacement fund, which at 31 March 2021 totals £16.9m (2019/20 £15.2m) and which is included in non-current trade and other receivables. These costs are transferred to Property, Plant and Equipment as and when the operator undertakes lifecycle modifications to the asset. This pre-payment was re-estimated in 2015/16 based on a new assessment of the required level of pre-payments required to cover future lifecycle expenditure under the contract.

The PFI agreement has been assessed under IFRIC 12 and the asset is deemed to be on Statement of Financial Position. The substance of the contract is that UCLH has a finance lease and payments comprise three elements – imputed finance lease charges, lifecycle fund and service charge.

Note 28.2. Finance Lease Obligations

Total finance lease obligations for on-statement of financial position PFI contracts due:

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**385,632**	**405,930**
Of which liabilities are due		
- not later than one year;	20,296	20,296
- later than one year and not later than five years;	81,186	81,186
- later than five years.	284,150	304,447
Finance charges allocated to future periods	(160,938)	(175,376)
Net PFI, LIFT or other service concession arrangement obligation	**224,694**	**230,554**
- not later than one year;	6,247	5,859
- later than one year and not later than five years;	29,409	27,582
- later than five years.	189,038	197,113

Total Future PFI Commitments

UCLH is committed to the following future payments in respect of the on-SoFP and off-SoFP PFI contracts:

	31 March 2021	31 March 2020
	£000	£000
PFI scheme expiry date:		
Not later than one year	**72,796**	70,814
Later than one year, not later than five years	**312,147**	303,645
Later than five years	**1,531,812**	1,613,110
Total	**1,916,755**	**1,987,569**

Note 28.3. Charges to expenditure

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	**68,457**	**67,126**
Consisting of:		
- Interest charge (including contingent rent)*	33,375	33,273
- Repayment of balance sheet obligation	5,859	5,495
- Service element and other charges to operating expenditure	24,458	23,778
- Capital lifecycle maintenance	4,765	4,581
Total amount paid to service concession operator	**68,457**	**67,127**

*Interest charge includes contingent rent of £14.4m in 2020/21 (£14.8m in 2019/20).

Note 29. Financial instruments

Financial risk management

UCLH's financial risk management operations are carried out by the Trust's treasury function, within parameters defined formally within the policies and procedures manual agreed by the Board of Directors. This activity is routinely reported and is subject to review by an internal and/or external auditor.

UCLH's financial instruments comprise cash and liquid resources, borrowings and various items such as trade debtors and creditors that arise directly from its operations. UCLH does not undertake speculative treasury transactions.

In accordance with IFRS 7, we evaluate the nature and extent of risks arising from financial instruments to which we are exposed at the end of the reporting period. These risks include, but are not limited to:

Currency Risk and Interest Rate Risk

UCLH is principally a domestic organisation with the majority of transactions, assets and liabilities being in the UK and sterling based. As such, UCLH undertakes very few transactions in currencies other than sterling and is therefore not exposed to movements in exchange rates over time. UCLH has no significant overseas operations.

UCLH has loans from the Independent Trust Financing Facility (previously known as the Foundation Trust Financing Facility) with fixed repayments and fixed interest rate. Therefore UCLH's exposure to interest rate fluctuations is minimal.

Market Price Risk of Financial Assets

UCLH has no investments in overseas banks. Surplus cash is invested in the Office of the Government Banking Service.

Credit Risk

Due to the fact that the majority of UCLH's income comes from legally binding contracts with other government departments and other NHS Bodies UCLH is not exposed to major concentrations of credit risk. UCLH's investments in money market funds and money market deposits does expose UCLH to credit risk. This is managed by Treasury Policies limiting the investments to highly rated institutions and spreading the investments to restrict exposure. In 2020/21 no significant deposits were placed outside of the Trust's Government Banking Service account.

UCLH uses a simplified lifetime expected loss model to assess credit losses against defined customer groups. UCLH has a robust credit management policy and manages debt and debt impairment within this policy.

Liquidity Risk

UCLH has only utilised external borrowings in year associated with its PFI investment and Independent Trust Financing Facility Loan.

UCLH currently has substantial cash balances and is not currently exposed to any liquidity risk associated with inability to pay creditors.

Note 29.1. Carrying values of financial assets

We disclose below the carrying value of assets / instruments in accordance with IFRS 7, paragraph 8(a).

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	49,723	-	-	**49,723**
Other investments / financial assets	24,349	-	-	**24,349**
Cash and cash equivalents	325,023	-	-	**325,023**
Total at 31 March 2021	**399,095**	**-**	**-**	**399,095**

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	123,934	-	-	**123,934**
Other investments / financial assets	20,220	-	-	**20,220**
Cash and cash equivalents	219,312	-	-	**219,312**
Total at 31 March 2020	**363,466**	**-**	**-**	**363,466**

Note 29.2. 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	316,840	-	**316,840**
Obligations under finance leases	971	-	**971**
Obligations under PFI, LIFT and other service concession contracts	224,694	-	**224,694**
Other borrowings	8	-	**8**
Trade and other payables excluding non financial liabilities	179,198	-	**179,198**
Provisions under contract	31,181	-	**31,181**
Total at 31 March 2021	**752,891**	**-**	**752,891**

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	324,471	-	**324,471**
Obligations under finance leases	1,154	-	**1,154**
Obligations under PFI, LIFT and other service concession contracts	230,554	-	**230,554**
Other borrowings	8	-	**8**
Trade and other payables excluding non financial liabilities	204,112	-	**204,112**
Provisions under contract	12,518	-	**12,518**
Total at 31 March 2020	**772,817**	**-**	**772,817**

Note 29.3. Maturity of financial liabilities

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

	31 March 2021	31 March 2020 restated*
	£000	£000
In one year or less	20,483	20,479
In more than one year but not more than five years	81,970	81,949
In more than five years	284,150	304,655
Total	**386,603**	**407,083**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 30. Related parties

The Department of Health and Social Care is regarded as a related party as it exerts influence over the number of transaction and operating policies of UCLH. During the year ended 31 March 2021 UCLH had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department of those entities. Per IAS 24, the Trust must provide a note of the main entities within the public sector that the trust has had dealings with. Note that no information needs to be given about these transactions. We outline the Trust's related parties below.

Trusts must disclose all linked NHS charities as a related party where these are not consolidated. The nature of the relationship and the details of material transactions between the trust and the linked charities must be disclosed. Per the remuneration report, no compensation, expense allowances or similar items was paid to management in the ordinary course of the trust's operations.

UCLH is a member of UCL Partners Limited (a company limited by guarantee) acquired by a guarantee of £1. The company's costs are funded by its partners who contribute to its running costs on an annual basis. During the year UCLH made payment to UCLP of £0.0m (2019/20: £0.3m). Additionally, UCLH provided services to UCL Partners Limited of £0.1m (2019/20, £0.0m) which are recorded in other income.

As noted in Note 16, UCLH has a 24.5% share in HSL LLP, a pathology joint venture with The Doctors Laboratory (TDL) and Royal Free London NHS Foundation Trust. During the year UCLH received services from HSL of £46.7m (2019/20 £49.1m), which are recorded in operating expenses. Additionally, UCLH provided services to HSL of £1.4m (2019/20, £1.6m).

Included within other creditors is the sum of £10.3m (2019/20: £6.5m) representing sums due to HSL. Included within other debtors is the sum of £0.2m at 31 March 2021 (2019/20, £0.0m) representing sums due from HSL.

UCL is classed as a related party, with one Executive Board Member directly employed by UCL. During the year UCLH received services from UCL of £35.4m (2019/20, £44.0m), which are recorded in operating expenses. Additionally, UCLH provided services to UCL of £13.9m (2019/20, £10.5m) which are recorded in other income. Included within other creditors is the sum of £29.5m (2019/20. £33.2m) representing sums due to UCL. Included within other debtors is the sum of £3.8m (2019/20, £12.7m) representing sums due from UCL.

During the year UCLH made payments to HMRC in relation to the Income Tax deducted at source and Social Security costs as per Note 6, and relating to Value Added Tax payments / refunds. Included within Trade and Other Debtors is a VAT debtor of £3.7m (2019/20, £1.4m).

Included within tax payable in Trade and Other Creditors is £13.8m (2019/20. £13.2m) owed to HMRC. Included within tax payable in Trade and Other Creditors is £8.2m (2019/20, £7.4m) owed to NHS Pension Agency.

During the year UCLH made payments to The London Borough of Camden principally for Business Rates of £10.9m (2019/20, £9.3m). Included within accruals is £0.1m (2019/20, £0.1m). Per note 16.2, UCLH has a wholly owned subsidiary, MyUCLH that was formed in 2015/16. There are no material transactions during this year with MyUCLH. Related party transactions were made on terms equivalent to those that prevail in arm's length transactions.

Note 30.1. Related party transactions

UCLH had material transactions with the following entities:

Organisation	2020/21			
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
NHS England	620,000	0	8,000	4,000
NHS North Central London CCG	310,000	2,000	0	16,000
Health Education England	49,000	0	0	1,000
Department of Health and Social Care	25,000	0	0	3,000
NHS Central London (Westminster) CCG	22,000	0	0	0
NHS City and Hackney CCG	17,000	0	0	0
NHS South East London CCG	14,000	0	0	0
Central and North West London NHS Foundation Trust	14,000	3,000	1,000	2,000
NHS Herts Valleys CCG	12,000	0	0	0
NHS Brent CCG	10,000	0	0	0
NHS East and North Hertfordshire CCG	9,000	0	0	0
NHS South West London CCG	9,000	0	0	0
NHS East Berkshire CCG	9,000	0	0	0
NHS Kent and Medway CCG	8,000	0	0	0
NHS Waltham Forest CCG	7,000	0	0	0
NHS West London (K&C & QPP) CCG	6,000	0	0	0
NHS Harrow CCG	6,000	0	0	0
NHS Redbridge CCG	5,000	0	0	0
NHS Tower Hamlets CCG	5,000	0	0	0
NHS West Essex CCG	4,000	0	0	0
NHS Newham CCG	4,000	0	0	0
NHS Ealing CCG	4,000	0	0	0
NHS Surrey Heartlands CCG	4,000	0	0	0
NHS Hammersmith and Fulham CCG	4,000	0	0	0
NHS Havering CCG	3,000	0	0	0
NHS Bedfordshire CCG	3,000	0	0	0
NHS Hillingdon CCG	3,000	0	0	0
Royal Free London NHS Foundation Trust	2,000	11,000	2,000	4,000
NHS Basildon and Brentwood CCG	2,000	0	0	0
NHS Hounslow CCG	2,000	0	0	0
NHS West Sussex CCG	2,000	0	0	0
Barts Health NHS Trust	2,000	10,000	3,000	4,000
Great Ormond Street Hospital for Children NHS Foundation Trust	2,000	1,000	2,000	5,000
The Whittington Health NHS Trust	1,000	3,000	1,000	2,000
NHS Pension Scheme	0	77,000	0	0
NHS Resolution	0	21,000	0	0
NHS Blood and Transplant	0	8,000	0	0

Note 30.2. Related party transactions

UCLH had material transactions with the following entities:

Organisation	2019/20			
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
NHS England	531,000	0	40,000	1,000
NHS Camden CCG	95,000	2,000	6,000	6,000
NHS Islington CCG	76,000	0	2,000	1,000
Health Education England	37,000	0	0	0
NHS Barnet CCG	35,000	0	1,000	1,000
Department of Health and Social Care	29,000	0	0	2,000
NHS Haringey CCG	25,000	0	1,000	0
Central and North West London NHS Foundation Trust	24,000	4,000	11,000	3,000
NHS Central London (Westminster) CCG	21,000	0	0	0
NHS Enfield CCG	17,000	0	0	0
NHS City and Hackney CCG	16,000	0	0	0
NHS Herts Valleys CCG	12,000	0	0	0
NHS Brent CCG	9,000	0	0	0
NHS East and North Hertfordshire CCG	9,000	0	0	0
NHS East Berkshire CCG	9,000	0	1,000	0
NHS Waltham Forest CCG	7,000	0	0	0
NHS West London (K&C & QPP) CCG	6,000	0	0	0
NHS Harrow CCG	5,000	0	0	0
NHS Redbridge CCG	5,000	0	0	0
NHS Tower Hamlets CCG	5,000	1,000	0	1,000
NHS Ealing CCG	4,000	0	0	0
NHS Newham CCG	4,000	0	0	0
NHS West Essex CCG	4,000	0	0	0
NHS Bedfordshire CCG	3,000	0	0	0
NHS Hammersmith and Fulham CCG	3,000	0	0	0
NHS Havering CCG	3,000	0	0	0
NHS Hillingdon CCG	3,000	0	0	0
NHS Lambeth CCG	3,000	0	0	0
NHS Wandsworth CCG	3,000	0	0	0
Royal Free London NHS Foundation Trust	3,000	9,000	3,000	8,000
Great Ormond Street Hospital for Children NHS Foundation Trust	2,000	1,000	2,000	6,000
NHS Barking and Dagenham CCG	2,000	0	0	0
NHS Basildon and Brentwood CCG	2,000	0	0	0
NHS Bromley CCG	2,000	0	0	0
NHS Cambridgeshire and Peterborough CCG	2,000	0	0	0
NHS Croydon CCG	2,000	0	0	0
NHS Greenwich CCG	2,000	0	0	0
NHS Hounslow CCG	2,000	0	0	0
NHS Lewisham CCG	2,000	0	0	0
NHS Luton CCG	2,000	0	0	0

Organisation	2019/20			
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
NHS Mid Essex CCG	2,000	0	0	0
NHS Richmond CCG	2,000	0	0	0
NHS Southwark CCG	2,000	0	0	0
NHS West Kent CCG	2,000	0	0	0
NHS Resolution	0	19,000	0	0
Barts Health NHS Trust	0	6,000	3,000	3,000
The Whittington Health NHS Trust	1,000	1,000	1,000	2,000

Note 31. Losses and special payments

NHS Foundation Trusts are required to report to the Department of Health and Social Care any losses or special payments, as the Department still retains responsibility for reporting on these to Parliament. By their very nature such payments ideally should not arise, and they are therefore subject to special control procedures compared to payments made in the normal course of business.

In the twelve months to 31 March 2021 the value of losses and special payments was £2.4m (2019/2020 £0.8m) relating to 495 cases (2019/20, 837 cases). This includes write-offs of Private and Overseas Patient debt, charged to the provision for impairment of receivables.

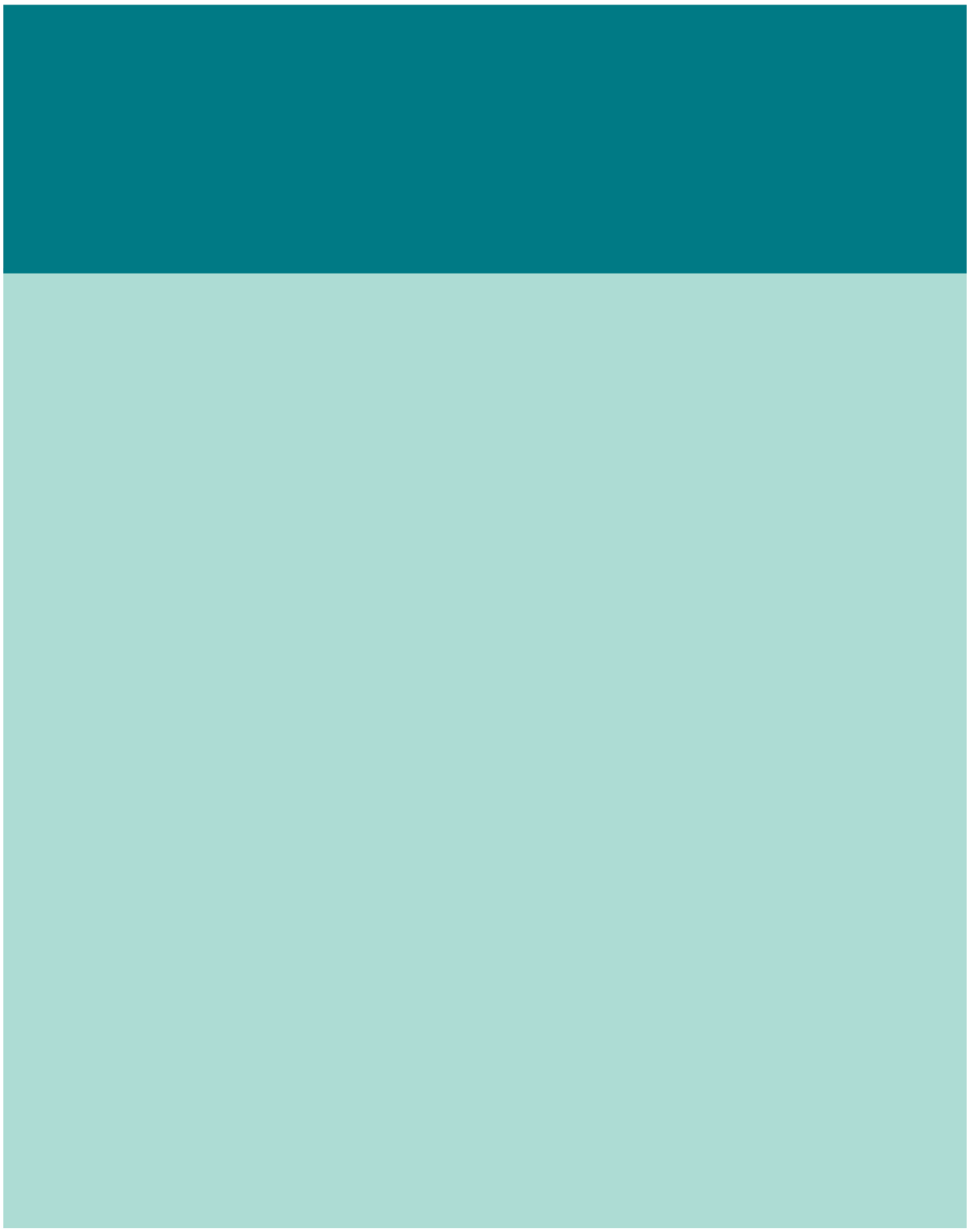
Losses and special payments are reported on an accruals basis, and exclude provisions for future losses.

	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	-	-	-	-
Fruitless payments and constructive losses	7	91	-	-
Bad debts and claims abandoned	470	2,259	821	726
Stores losses and damage to property	-	-	-	-
Total losses	**477**	**2,350**	**821**	**726**
Special payments				
Compensation under court order or legally binding arbitration award	7	63	4	44
Extra-contractual payments	-	-	-	-
Ex-gratia payments	11	7	12	8
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**18**	**70**	**16**	**52**
Total losses and special payments	**495**	**2,420**	**837**	**778**
Compensation payments received		-		-

No individual special payments were made over £300k (2019/20: nil)

Note 32. Events after the reporting date

There were no events to report as at 31 March 2021.



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